What Is Performance-Based Contracting?

Introduction

This section provides some background about performance-based contracting and sets contracting within the context of other ways of organizing health services. It answers the following questions:

**What is contracting?** Contracting is a mechanism for a financing entity to procure a defined set of health services from a nonstate provider (NSP). The definition of services includes what services, where, to which group of beneficiaries, for how long, and so on.

**What is performance-based contracting?** It is a type of contracting with (1) a clear set of objectives and indicators, (2) systematic efforts to collect data on the progress of the selected indicators, and (3) consequences, either rewards or sanctions for the contractor, that are based on performance.

**What kinds of services can be contracted?** Many different types of health services have been successfully contracted, including primary health care, HIV prevention services, and hospital management.

**How is contracting different from other approaches to organizing health services?** Contracting implies that it is the
purchaser (rather than the NSP) that defines what services will be provided, where, and how they will be evaluated while leaving to NSPs how resources will be managed.

What approaches to contracting work best in common situations? It is difficult to be prescriptive, but some situations are more conducive to specific forms of contracting than others.

How is contracting related to paying for performance (P4P)? Performance-based contracting is a form of paying for performance and can be used as a way of implementing P4P.

What Is Contracting?

Contracting is a mechanism for a financing entity (such as a government ministry, insurance entity, or development partner) to acquire a specified set of services, with specified objectives, of a defined quantity, quality, and equity, in a particular location, at an agreed-on price, for a specified period, from a particular NSP (such as an NGO, private sector firm, or private practitioner). Like all contracts, contracts for health services are voluntary, meaning both parties enter them freely.

A few other terms related to contracting should be defined:

Nonstate providers. Nonstate providers of services include any nongovernmental entity such as NGOs, faith-based organizations (FBOs), community-based organizations (CBOs), or private for-profit entities or individuals.

Contractor. The contractor is the NSP implementing and managing the services defined in the contract. Another useful term for contractor is “partner,” although the term “contractor” is used throughout this toolkit for the sake of simplicity.

Purchaser. The purchaser is the entity that awards the contract, provides the financial and other resources for the services, and has the fiduciary responsibility for ensuring that the terms of the contract are met. Purchasers of health services are typically government agencies, parastatal organizations, insurance entities, or development partners.
Public-private partnerships. Contracting is one form of public-private partnership. A partnership sometimes implies that both parties bring financial or other resources into the relationship, but this is not always the case.

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Performance-based contracting is a form of contracting that explicitly includes three characteristics:

- Clear definition of a series of objectives and indicators by which to measure contractor performance
- Collection of data on the performance indicators to assess the extent to which the contractors are successfully implementing the defined services
- Performance leading to consequences for the contractor, such as provision of rewards or imposition of sanctions. Rewards can include continuation of the contract in situations in which there is a credible threat of termination, provision of performance bonuses, or public recognition. Sanctions can include termination of the contract, financial penalties, public criticism, and debarment from receiving future contracts.

What Kinds of Health Services Can Be Contracted?

A large variety of health services can be, and have been, contracted. These include the following:

- Providing primary health care services in rural or urban areas
- Offering HIV prevention services among high-risk groups
- Providing HIV/AIDS treatment services to people living with HIV
- Establishing a health insurance system
- Setting up and operating a voucher project
• Acting as an intermediary in providing P4P to public health care providers
• Offering behavior change communication activities and information, education, and communication
• Providing maintenance and cleaning services in a hospital
• Providing social marketing of health products, such as contraceptives
• Working as an “umbrella” agency that oversees the work of many smaller NGOs and CBOs involved in delivering primary health care, nutrition services, or HIV services
• Operating an ambulance system
• Acting as an intermediary with many for-profit providers, for example, in strengthening the management of tuberculosis patients
• Managing a hospital
• Operating diagnostic facilities within public health care facilities
• Providing ancillary services such as equipment maintenance, cleaning, waste management, food preparation, and security.

Sample terms of reference for some of these services are provided in appendix E; others are available at http://www.worldbank.org/hnp/contracting.

How Is Contracting Different from Other Approaches to Organizing Health Services?

Typology of Service Delivery. A number of different approaches exist for organizing health service delivery, so clarifying definitions will facilitate meaningful dialogue. Although this is a bit of a simplification, there are five important functions related to service delivery: (1) designing the services, that is, what services will be delivered, where, and with which indicators of success; (2) selecting the service provider; (3) actually managing the services; (4) establishing and controlling the “production infrastructure,” which includes personnel,
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equipment, drugs, clinics, and other facilities; and (5) financing the system (see table 2.1). As an example, under a management contract (arrangement 3 in table 2.1), a government will contract with an NSP or an individual to manage existing government services in a specified area. Under a service delivery contract (arrangement 4 in table 2.1), the government decides which services the contractor will provide and where, while the contractor will both manage and supply the production infrastructure. The arrangements described in table 2.1 are not exhaustive, and hybrids clearly exist. For example, the line between a management contract and a service delivery contract blurs when the contractor uses government health workers but pays them significantly more than their civil service salaries.

Intergovernment “Contracts.” There has been some experience with national governments signing agreements with local governments (arrangement 2 in table 2.1) that pertain to achieving certain goals. Although potentially interesting, this arrangement rarely involves a true contract that the parties enter into voluntarily and in which the contractor can be “fired” for nonperformance (although other rewards and sanctions may be available). Another issue with such contracts is that denying resources to poorly performing areas can be politically or ethically challenging.

The Difference between Grants and Contracts. Grants by government or donors to NSPs, often NGOs (see arrangement 5 in table 2.1), are quite common, particularly in HIV/AIDS prevention and treatment. These grants are usually given to organizations that submit a proposal to a funding agency. The most important difference between grants and contracts is who defines the services to be delivered. For grants, it is generally the NSP that decides what kinds of services will be delivered, where they will be delivered, and how they will be evaluated. As the funding agency defines more and more of the details of the services to be provided, the distinction between grants and contracts blurs. Grants can be very useful and have worked well in many situations. They are particularly helpful in beginning new types of services or providing an opportunity for creative innovations to address health problems. The downside to grants is that they can lead to an irrational distribution of services with gaps in some areas and duplication in others. For example, in Ghana epidemiologists believed that about 70 percent of HIV transmission involved female sex workers (FSWs). However, when a grant mechanism was introduced to control
<table>
<thead>
<tr>
<th>Arrangement</th>
<th>Service design</th>
<th>Provider selection</th>
<th>Services management</th>
<th>Infrastructure setup</th>
<th>Financing</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Inter-governmental</td>
<td>Government-1</td>
<td>Government-1</td>
<td>Government-2</td>
<td>Government-2</td>
<td>Government-1</td>
<td>Government transfers funds from federal to provincial governments</td>
</tr>
<tr>
<td>agreements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Management contracts</td>
<td>Government</td>
<td>Government</td>
<td>Private sector</td>
<td>Government</td>
<td>Government(^a)</td>
<td>Government hires a private sector manager to manage existing government health services</td>
</tr>
<tr>
<td>4. Service delivery contracts</td>
<td>Government</td>
<td>Government</td>
<td>Private sector</td>
<td>Private sector</td>
<td>Government(^a)</td>
<td>Government hires NGO to provide services where none exist</td>
</tr>
<tr>
<td>5. Government grants to NSPs</td>
<td>Private sector</td>
<td>Government or donor</td>
<td>Private sector</td>
<td>Private sector</td>
<td>Government (w/ or w/o NGO or community contribution)</td>
<td>NGOs submit proposals to government for needs identified by community or NGO</td>
</tr>
<tr>
<td>6. Private sector services</td>
<td>Private sector</td>
<td>Consumer</td>
<td>Private sector</td>
<td>Private sector</td>
<td>Consumer or NGO/donor</td>
<td>• NGO establishes health services in slum areas using its own funds</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• For-profit providers establish private clinic</td>
</tr>
</tbody>
</table>

Source: Author.

Note: Government-1 and Government-2 refer to different levels of government. NGO = nongovernmental organization; NSP = nonstate provider.

\(^a\) Financing may be supplemented by formal or informal user charges.
the epidemic, fewer than 1 percent of the grants went to NGOs working with FSWs, reflecting a shortage of grant proposals for this important type of service.

**What Approaches to Contracting Work Best in Common Situations?**

Because situations and contexts vary considerably, it is difficult to be prescriptive about which types of contracts will work best in a given set of circumstances. However, some situations are more conducive to some forms of contracting than others. Table 2.2 explores some of the options. This table is not meant to limit creativity; on the contrary, it should be seen as an encouragement to innovate and explore new ways of contracting.

**Table 2.2  Types of Contracting to Consider in Some Common Situations**

<table>
<thead>
<tr>
<th>Context/situation</th>
<th>Options to consider</th>
</tr>
</thead>
</table>
| Limited rural health services but with “mission” clinics or other faith-based organizations | • SDC for specified geographical “catchment” area with a matching grant or subsidy  
  • SDC plus MC for the management of existing government services                    |
| Poorly performing districts, provinces, or states with existing government health services | • MC for management services                                                      
  • MC for management services plus P4P for health workers                           
  • SDC where government health workers join NSP                                      |
| Uncoordinated NGO-delivered services with multiple donors (for example, post-conflict situation) | • SDC for specified geographical areas                                             |
| Few services of any kind, or new kinds of services required (for example, HIV prevention, nutrition services, early childhood development services) | • SDC for specified geographical areas with emphasis on innovation and careful evaluation |
| Existing government services where improved management is needed or innovations are required | • MC for management services                                                      
  • MC for management services plus P4P for health workers                           |
| Urban primary health services with many different providers but limited coverage of preventive services for the poor | • SDC for specified geographical areas with focus on reaching the poor (slum and nonslum residents) with preventive and promotive services |

*Source:* Author.

*Note:* MC = management contract (contracting in); NGO = nongovernmental organization; P4P = pay for performance; SDC = service delivery contract (contracting out).
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How Is Contracting Related to Pay for Performance?

Pay for performance is a broad term that covers a number of approaches to rewarding the provision of more and better services. The basic idea of P4P is attractive because it compels providers to focus on important objectives and uses financial rewards to reinforce good performance. In some ways any contract that specifies explicit, measurable outcomes and allows for termination of the contract for nonperformance is a type of P4P. Contractors are rewarded for good performance by continuation of the contract and ongoing payment while poor performers have their contracts terminated. However, P4P is often used to refer to a more explicit link between performance and payment. Table 2.3 describes some of the forms of P4P and their relationship to contracting. Details of applying P4P in a contracting situation are given in section 3 (task 6).

For some types of P4P the evidence is compelling. Fee-for-service payments to individual providers (approach 3 in table 2.3) consistently lead to increased service provision (sometimes even too much). For other types of P4P the evidence, so far, is less strong. The use of performance bonuses in contracts makes sense and has worked well in some contexts, such as Afghanistan and Haiti, but less well in others, such as Uganda. For rewards to local governments (approach 1 in table 2.3) the evidence is still modest. This approach also suffers from an ethical issue because poorly performing areas that need the most help may receive fewer resources, which may only reinforce preexisting inequalities.
### Table 2.3  Types of Pay for Performance and Their Relationship to Contracting

<table>
<thead>
<tr>
<th>Type of P4P</th>
<th>Who receives the funds</th>
<th>What the funds can be used for</th>
<th>Who provides the funds</th>
<th>Example</th>
<th>Relationship to contracting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rewards for local governments</td>
<td>Local governments</td>
<td>Programs of local governments</td>
<td>National government</td>
<td>Burkina Faso “performance” agreements</td>
<td>“Performance agreements” rarely true contracts</td>
</tr>
<tr>
<td>2. Rewards to national governments</td>
<td>National governments</td>
<td>Programs of national governments</td>
<td>Development partners</td>
<td>GAVI Alliance payments for increased DPT3 coverage</td>
<td>Not related</td>
</tr>
<tr>
<td>3. Payment per service (fee for service)</td>
<td>Individual health workers</td>
<td>Personal uses</td>
<td>Government, individuals, or NSPs</td>
<td>Rwanda, where NGOs paid health workers based on number of services provided</td>
<td>May be easier to introduce in the context of contracting with NSPs</td>
</tr>
<tr>
<td>4. Performance bonuses</td>
<td>NSP</td>
<td>Other programs or at the discretion of the NSP</td>
<td>Purchaser</td>
<td>Haiti, where NGOs received bonuses for achieving specified targets</td>
<td>Sometimes used in health care contracting, very often used in other forms of contracting</td>
</tr>
<tr>
<td>5. Performance-based payment</td>
<td>NSP</td>
<td>At discretion of the NSP</td>
<td>Purchaser</td>
<td>Amount paid to an NSP is a function of the number of patients seen</td>
<td>Can be incorporated fairly easily into contracts</td>
</tr>
</tbody>
</table>

*Source:* Author.

*Note:* DPT3 = third dose of diphtheria/pertussis/tetanus vaccine; GAVI Alliance = formerly the Global Alliance for Vaccines and Immunization; NGO = nongovernmental organization; NSP = nonstate provider.