



Contracting for Delivering Health

Current evidence indicates that contracting for health services is effective in improving access to and quality of services.

Background

Substantial improvement in the delivery of health services will be necessary to achieve the health-related Millennium Development Goals (MDGs). For example, it has recently been estimated that 63 percent of child deaths in developing countries could be prevented through the full implementation of a few effective and low-cost interventions. Unfortunately, the performance of the public health systems that could deliver these interventions remains weak in many countries. While there is likely a need for additional resources to strengthen health systems, previous experience suggests that simply throwing money at the problem of service delivery is unlikely to have much of an impact. Another response to the challenge of improving service delivery has been to use public funds to contract with nonstate providers (NSPs), including nongovernmental organizations (NGOs), individual practitioners, or for-profit firms.

Proponents of contracting see primary health care as relatively easy to buy because it is measurable, the market is easily contested, and it is widespread in high- and middle-income countries. They also argue that contracting has some potentially attractive features, including the possibility of:

- Ensuring a greater focus on the achievement of measurable results
- Utilizing the private sector's greater flexibility and generally better morale to improve services
- Overcoming "absorptive capacity" constraints and improving the distribution of trained health workers
- Increasing managerial autonomy and decentralizing decision making to managers on the ground

- Using competition to increase effectiveness and efficiency
 - Allowing governments to focus more on other roles that they are uniquely situated to carry out, such as planning, standard setting, financing, regulation, and various public health functions.
- Critics of contracting have raised a number of concerns, including:
- Contracts will not be feasible at a sufficiently large scale to make a difference at country level
 - NGOs and other nongovernment entities will not want to work in remote or difficult areas and are less capable of providing services to the very poor, thus increasing inequities in health service delivery
 - Governments will have limited capacity to manage contracts effectively
 - They will be more expensive than government provision of the same services, partly reflecting greater transaction costs
 - Even if successful, contracting will not be sustainable.

A review of developing country experience with contracting for health service delivery was undertaken to examine its effectiveness, determine the extent to which the posited difficulties actually occur in practice, and make recommendations regarding future efforts in contracting.

Methodology

The focus of the review was instances in developing countries of governments contracting with NSPs to deliver primary health care services including nutrition (but excluding hospital care or ancillary services such as

Contracting has many attractive features, but success requires addressing some practical issues

All the studies that compared government and contractor performance found that contractors were more effective

drug procurement and distribution). To be included in the review, the example had to have been explicitly evaluated using measures of quality of care, or outputs such as increase in the amount of services provided. The evaluations also had to, at a minimum, involve before and after or controlled designs. The review excluded grants to NGOs in which the latter determined the locations or type of services to be delivered. Also excluded were contracts between different levels of governments. Examples of contracting were found through discussions with experts from a variety of institutions, previous reviews of contracting, a computerized search of the published literature using a variety of databases, and manual review of journals that often publish articles related to health systems in developing countries. Structured interviews were conducted with people who had intimate knowledge of the examples that met the inclusion criteria.

Results

Ten examples of contracting were found that met the inclusion criteria and all ten concluded that contracting with NSPs improved service delivery. Good results were achieved in a variety of settings and for a variety of different services ranging from nutrition services in Africa to primary health care in

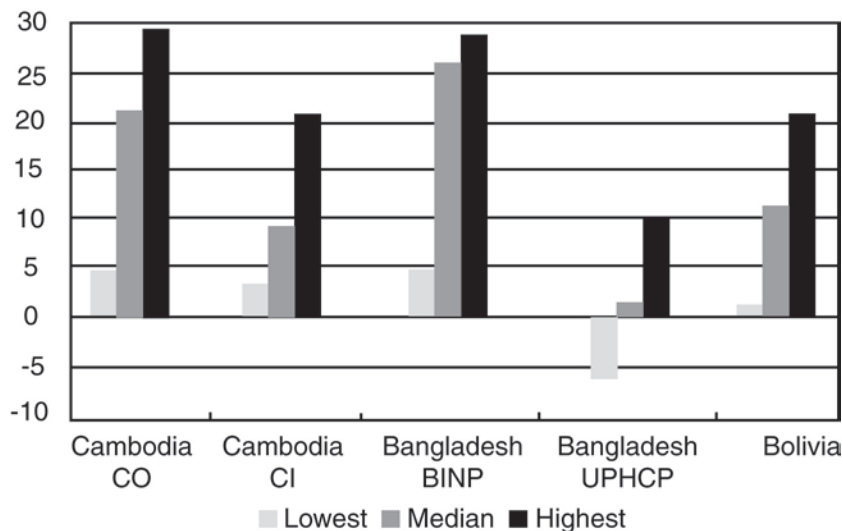
Guatemala. Improvements were also achieved fairly rapidly, usually within two to three years. The most rigorously evaluated cases tended to demonstrate the largest impact. There were four cases with controlled, before, and after evaluations that allowed the calculation of double differences (follow-up minus baseline in the experimental group, minus follow-up, minus baseline in the control group). In these four studies, the median double difference of the various parameters studied ranged from 2 to 26 percentage points (Figure 1). The parameters varied between examples, but most included coverage of services such as immunization, outpatient visits, and pre-natal care.

Six of the ten studies compared contractor performance to government provision of the same services. All six studies found that the contractors were more effective than the government, based on parameters related to both quality of care and coverage of services. The current weight of evidence indicates that contracting with NSPs will provide better results than government provision of the same services.

Specific Examples of Contracting

Cambodia: Many years of war and political upheaval left Cambodia with a limited health infrastructure, particularly in rural areas. Health worker morale was poor and management capacity at the district level was very weak. A 1998 Demographic and Health Survey found that nationwide only 39 percent of children were fully immunized. To address these serious issues, the Ministry of Health (MOH), with financing provided by the Asian Development Bank, contracted with NGOs in two different ways: (i) contracting out (CO), in which the contractors had complete responsibility for service delivery, including hiring, firing, setting wages, and procuring drugs and supplies; and (ii) contracting in (CI), in which the contractors worked within the MOH system and could not hire or fire staff, although they could request staff transfers. Drugs and supplies were provided to the district through the normal MOH channels. In control districts, the management of services remained in the hands of the district health management team, which received technical assistance and management training.

Figure 1. Double Differences in Performance Parameters in Four Examples with Controlled, Before, and After Evaluations



Note: CO = Contracting Out, CI = Contracting In, BINP= Bangladesh Integrated Nutrition Project, UPHCP = Urban Primary Health Care Project.

Twelve districts with a combined population of 1.5 million were randomly assigned to the three different approaches, and baseline household and health facility surveys were carried out. Follow-on surveys were conducted about 2.5 years after implementation began. As shown in Figure 2, there were much larger improvements in immunization coverage, the use of antenatal care, and other indicators in the CO and CI districts than in the control districts, although they were quite similar at baseline. The poor appear to have benefited disproportionately from contracting, with concentration indices showing that services became more pro-poor in the contracted districts and less pro-poor in the control districts.

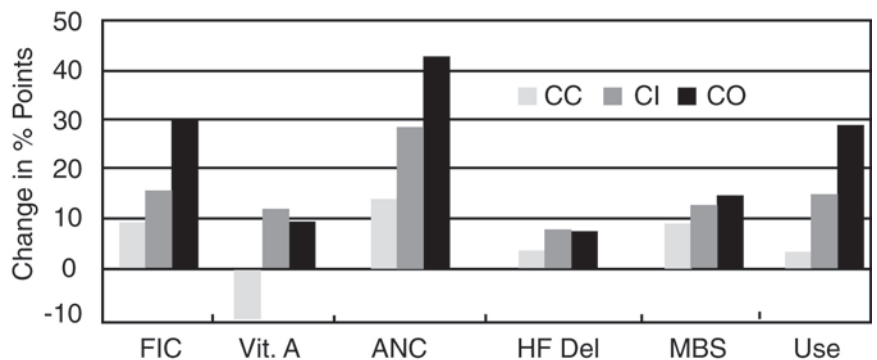
Pakistan: There is a widespread feeling in Pakistan that first level facilities known as basic health units (BHUs) are providing only a limited amount of services to the rural population despite the investment of a large amount of resources in their construction, staff, equipment, and supplies. In a poorly performing district of Punjab, an NGO, the Punjab Rural Support Program (PRSP), was given a contract to manage all the BHUs and considerable autonomy to implement changes in organization and management. The NGO was given the same budget as had previously been allocated for the 104 BHUs in the district that served 3.3 million people. The NGO quickly introduced a number of innovations, including: (i) bringing in talented managers who were paid at market rates; (ii) increasing the salaries of doctors 150 percent and having them cover three different BHUs instead of one; and (iii) improving the supply of drugs and renovating the BHUs.

Information from the routine reporting system on the number of outpatient visits in the district was tracked over time. As can be seen in Figure 3, there was a dramatic increase (threefold) in the number of outpatient visits to the BHUs after the government gave the NGO the authority and budget to run the system.

Insights from the Evidence

The global experience with contracting provides some insights on the concerns that have been raised about the approach. The fear that contracts are unlikely to provide services on

Figure 2. Change in Key Indicators in Cambodia, Follow on—Baseline in Percentage Points



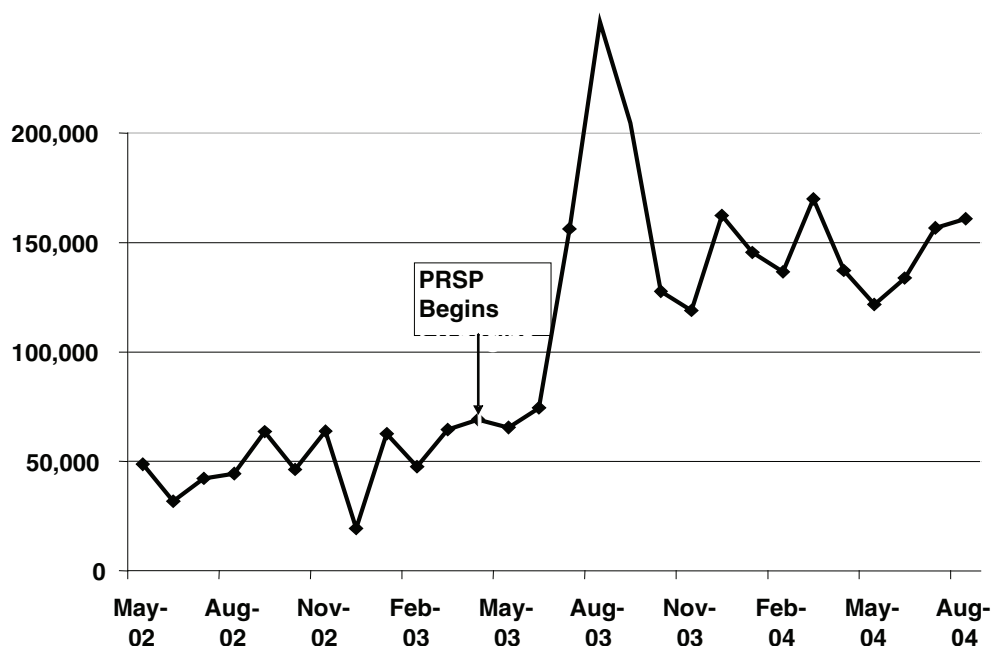
Note: FIC = percent of children 12–23 months of age who are fully immunized; Vit. A = proportion of children 6–59 months of age who received vitamin A supplements in the last 6 months; ANC = coverage of antenatal care, one or more visit; HF Del = proportions of infants delivered in a health facility; MBS = proportion of couples who have children 12–23 months of age who are using a modern form of birth spacing/contraception; Use = proportion of people sick in the last month who used a government health facility; CC = Control/Comparison; CI = Contracting In; CO = Contracting Out.

the large scale needed to make a difference at country level appears to be unwarranted. Half of the examples studied involved populations of millions of beneficiaries, and in one example, contracts now cover one-third of rural Bangladesh, more than 30 million people. The apprehension that nonstate providers will not want to work in remote or difficult areas and are less capable of providing services to the very poor also appears to be unwarranted. Given the resources and the explicit responsibility, many contractors were willing and able to work in difficult areas that had previously been underserved. However, only the evaluation in Cambodia explicitly addressed the issue of whether contracting could improve equity, and it found contractors were able to significantly improve health services for the most marginalized groups. Concerns about governments' ability to manage contracts appear to be justified. Contract management was seen as a significant issue in at least three of the examples studied; however, it did not prevent contractors from achieving significant improvements in health service delivery even under those circumstances.

There were instances where contracting was more expensive than government provision. However, in most of the cases, NSPs performed better even when public institutions had the same amount of resources.

The cost of provision of a basic package of primary health care in low income settings varied between \$3 AND \$6 per capita per year

Figure 3. Outpatient Visits per Month, before and after NGO Management



The actual prices paid for provision of a basic package of primary health care in the low income settings varied between US\$3 and US\$6 per capita per year, which represents a fairly small percentage of gross domestic product. Sustainability has also not been an issue. Of the seven examples with more than three year of elapsed experience, all seven have been continued and expanded.

Recommendations

Based on the success thus far, health services' contracting should be significantly expanded in developing countries as a way of helping achieve the MDGs and increasing accountability. While the evidence for contracting is reasonably good, future efforts should still include rigorous evaluations to obtain more robust estimates of the effects under various conditions and address unresolved issues, such as the effectiveness of performance bonuses and means for improving contract management. Based on global experience, it appears that contracting is a robust approach

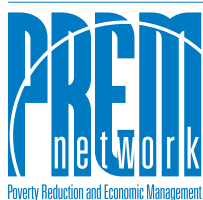
that can achieve good results under different circumstances. Nonetheless, there are practical considerations that can likely increase effectiveness and efficiency, such as assuring managerial autonomy, making the contracts large scale, and focusing on performance measurement.

This note was written by Benjamin Loevinsohn (Lead Health Specialist, South Asia Human Development) and April Harding (Senior Economist, Latin America and the Caribbean Human Development) and is based on their paper, *Buying Results: A Review of Developing Country Experience with Contracting*.

Further Reading

- Loevinsohn, B., and A. Harding. 2005. *Buying Results: A Review of Developing Country Experience with Contracting*. *The Lancet* 366(9486): 676–681. It is also available as a Health, Nutrition, and Population Discussion Paper at: <http://siteresources.worldbank.org/HEALTH-NUTRITIONANDPOPULATION/Resources/281627-1095698140167/Chapter11LoevinsohnHarding.pdf>.
- Jones, G., Steketee, R.W., and Black, R.E., et al. 2003. How many child deaths can we prevent this year? *Lancet* 362: 65–71.
- World Bank. 2004. *Making Services Work for Poor People*, World Development Report, International Bank for Reconstruction and Development, World Bank, Washington, DC.
- Harding, A., and A. Preker, Eds. (2003). *Private Participation in Health Services*. Washington, DC: World Bank (Chapter 3 is on Contracting for Health Services).

Achieving the health-related MDGs requires improvements in health service delivery for which contracting can play a useful role



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