The role of contractual arrangements in improving health system performance

Report on a regional meeting
Cairo, Egypt, 18–20 April 2005
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1. **Introduction**

There is increasing realization of the importance of awareness creation and capacity-building within ministries of health in contracting out publicly financed health services to the private sector. Resolution WHA56.25, issued by the World Health Assembly in 2003, asks Member States to assess the role of contractual arrangements in improving health systems’ performance. Although contracting is being used in the countries of the Eastern Mediterranean Region, experience and documentation on public–private partnership in health are limited among countries of the Region, although several are at various stages of implementing health sector reforms. Furthermore, a comprehensive regional strategy to address the issue is not currently in place. To address these shortcomings, a regional meeting on role of contractual arrangements in improving health sector performance was organized at the World Health Organization's Regional Office for the Eastern Mediterranean (WHO/EMRO) in Cairo, Egypt, on 18–20 April 2005.

The meeting was opened with a message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. In his message, Dr Gezairy stressed that contracting was not an end in itself but an instrument which could be used to achieve the goal of Health for All. He highlighted the fact that contracting was increasingly becoming an element in the ongoing health system reforms in many countries and cautioned that contracting also had pitfalls which must be taken into account when considering contracting for health.

Dr Belgacem Sabri, Director, Health Systems and Services Development, WHO/EMRO, presented the objectives of the meeting and discussed the overall need for understanding contractual arrangements in the Region. The main objectives of the meeting were to acquire understanding of the nature, extent and presence of factors that influence contracting in health; disseminate the findings of the studies conducted on the contractual arrangements in 10 Member States; develop a regional strategy on contracting based on
regional and international evidence; and recommend whether contracting could be used as instrument for outsourcing publicly financed health services.

The meeting programme and list of participants are included as Annexes 1 and 2. The full text of the Regional Director’s message is attached as Annex 3. A background document on the role of contractual arrangements in improving health sector performance is attached as Annex 4, and a checklist for assessing the role of contractual arrangements in improving health sector performance is included as Annex 5. The technical sessions were chaired by representatives from the health ministries by rotation.

2. Technical presentations

2.1 The role of contracting for health services in improving health system performance

Dr Jean Perrot

Dr Perrot traced the history of development of health systems and identified contracting as a tool to organize relationships between different components of the health systems. Contracting is increasingly being used in countries and recognition to its enhanced role and potential must be given. There are three types of contracting: delegation of responsibility, purchasing of services and contractual cooperation. Contracting is an important tool for improvement of the health system, and responsibility rests with the ministry of health to use it as an instrument for improvement.

Discussion

The presentation was well received by the participants and use of contracting as an instrument for improving the health system was appreciated by the participants. Questions on the requirements for human resources for implementing and monitoring the contracting process and accountability issues were discussed. The robustness of
the general contracting framework as a major input for contracting out health services was also highlighted. The pitfalls of contracting being a first step to unregulated privatization and abdication of the regulatory and supervisory role of Ministry of Health were viewed as a potential concern. The unionization of the workforce and implications of job losses in the public sector were also discussed as having an important impact on the overall contracting environment in the countries.

2.2 Contracting out publicly financed health services
Dr Sameen Siddiqi

Dr Siddiqi presented the definitions and a review of a framework for evaluation of contracting out for primary health care. Contracting is defined as a purchasing mechanism used to acquire a specified service, of a defined quantity and quality, at an agreed-on price, from a specific provider, for a specified period, while contracting out in the health sector was generally defined as the development and implementation of a documented agreement by which one party (purchaser) provides compensation to another party (provider) in exchange for a defined set of health services for a defined target population.

He discussed the role of government and the private sector in the contracting process, discussed the potential drawbacks and capacities required (see Figure 1). A number of important questions are facing ministries of health in the Region: Should governments opt for contracting out publicly financed health services? Under what circumstances, for what services, and with what capacities? When should governments not opt for contracting out and retain its role as the principal guardian of the essential health system functions?
Discussion

The participants agreed that monitoring and evaluation is a primary function and responsibility of the government which cannot be abdicated. Within countries, areas need to be identified where the public sector is deficient and support is required from the private sector. Duplication of services should be avoided and resources thus freed up could be utilized to improve health services in other priority areas.

2.3 Contracting and payment mechanisms

Dr Hossein Salehi

Contracting is an instrument that allows splitting the financing of health care from the provision of health services, meaning that while the government may be the financier of health care, responsibility for its provision is outsourced to a non-state or private entity. Linked to this are the provider payment methods, which are important to consider any time a government or a payor wants to improve the efficiency and the quality of health services with the use of its funds (Figure 2).
Figure 2. Splitting financing from provision

Changes in provider payment methods are often pivotal to broader health reform measures to contain costs and use existing resources effectively and also to improve quality of care and equitable financial access to care. Provider payment method refers to the way in which money is distributed from a source of funds, such as the government, an insurance company or other payor (all also referred to as fund holders), to a health care facility (including a laboratory or a pharmacy), or to an individual provider, such as a physician, a nurse, a physical or psychotherapist. Each provider payment method carries a set of incentives that encourage providers to behave in specific ways in terms of the types, amounts, and quality of services they offer. Health sector reform often requires policy-makers to rethink the incentives they wish to set for providers.

The relationship between the financing agents, providers, and consumers was discussed in detailed and the principal agent problem, moral hazard, adverse selection and information asymmetry was presented in detail. Provider payment focuses on providers' incentives to change their behaviour and the way they practice with regard to staff mix, choice of technology, choice of services, and interaction with consumers. The infrastructure required to support these methods is minimal: financial and management
information system; integration to delivery system; utilization management and quality assurance; and legal and judicial systems.

Discussion

The discussion centred on the role of the taxation systems and importance of involvement of insurance funds in the discussions to formulate a contracting policy. The effects of payment mechanisms on cost containment and quality was discussed and the importance of monitoring bodies to safeguard patient rights in the process of contracting and service provision not only by the private but also the public sector was highlighted. It was pointed out that social insurance and provision of financial protection is a very important topic which is currently very high on the health agenda in the Region.

2.4 Background of country studies

Dr Sameen Siddiqi

The country studies on contracting of publicly financed services to the private sector were undertaken between January and September 2004 (Annex 4). Ten countries were identified to represent the entire Region, covering 22 in all, based on the size of the private sector, on anecdotal evidence of experience with contractual arrangements, and on the existence of a programme or project in which contractual arrangements with the private sector was the principal implementing strategy. The countries were Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, Pakistan, Syrian Arab Republic and Tunisia.

A generic assessment checklist to facilitate data collection was developed (Annex 5), which had two sections: overall capacity of the ministries of health and the status of contracting of health services; review of a specific project/programme that has taken up contractual arrangements as its principal implementation strategy. The purpose of the checklist was to serve as a guide to country researchers in data collection and at the same time allowing for the comparability of country studies.
Given the limited experience with contracting of health services in the Region, inclusion criteria were relaxed in the selection of a specific programme. Contracting out of projects was selected in the study in the following order of preference: primary health care services; hospital services; non-clinical services. Those contracts that used some system of monitoring or evaluating performance were given preference. Several countries studies covered experience with contracting in two or more service categories.

An electronic network was established with all the country researchers to monitor progress, share experience, and resolve problems as they occurred. Occasional monitoring in the countries was done by the Regional Office staff during visits to the countries.

3. Country presentations

3.1 Afghanistan

Dr Mustafa Mastoor

In 2002, according to the Afghanistan National Health Resources Assessment, around 80% of the health facilities were functioning through nongovernmental organization setups, which were receiving direct funding from various donors or in the case of the World Bank through the Contract Management Unit of the Ministry of Public Health.

At present, external financial resources are provided either through the Ministry of Public Health (The World Bank) or jointly with the Ministry (USAID, European Community, Asian Development Bank). There are two service delivery mechanisms for the Basic Package of Health Services (BPHS): the Ministry of Public Health Strengthening Mechanism, and contracting out to nongovernmental organizations. By January 2005 the committed funds for implementation of the BPHS could ensure contracting of this package to roughly 71% of the population through nongovernmental organizations and about 5% of the population through Ministry of Public Health Strengthening Mechanism.
Financing and delivery of secondary level health care is still the main responsibility of the government. The Ministry of Public Health, in order to have a standard package for hospital services in the country, developed the Hospital Policy and just recently finalized the Essential Package of Hospital Services (EPHS). Funding this package, which is comparatively more expensive than the BPHS, will be a challenge for the Ministry. A strategy to implement the EPHS is currently being debated in the Ministry. Programmes like EPI, nutrition, malaria, tuberculosis, HIV/AIDS are not yet fully integrated into the BPHS, and their mechanisms for implementation are through vertical approaches. United Nations agencies such as UNICEF, WHO and UNFPA and the Global Fund are supporting the Ministry of Public Health technically in this regard and to some extent financially.

Civil society (non-profit organizations) in Afghanistan had a major role in the provision of primary health care in rural parts of the country for more than two decades. Currently they are working under the agreed regulation of and in close coordination with the Ministry of Public Health. They are contracted to provide BPHS for 71% (16.5 million) of the population.

The BPHS has two purposes: 1) to provide a standardized package of basic services which forms the core of service delivery in all primary health care facilities; and 2) to promote a redistribution of health services by providing equitable access, especially in underserved areas. The BPHS provides a comprehensive list of services such as: maternal and newborn health; child health and immunization; public nutrition; communicable diseases; mental health; disability; and supply of essential drugs. The services to be offered at four standard levels of health facilities within the health system: the health post, basic health centre comprehensive health centre, and district hospital.

The BPHS, which was developed earlier with the technical assistance of WHO, costs approximately US$ 4.5 per capita. Initially the World Bank committed US$ 46.3 million as a grant, USAID committed US$ 60 million of its funding and European Community committed Euro 8 million with possible additional annual grants for
implementation of BPHS. The Ministry of Public Health agreed to identify certain number of provinces out the 34 provinces for the earmarked funds. Through this process 10 provinces (later 11 after the Government divided Parwan into Panjshir and Parwan) were earmarked to World Bank for funding, 13 to USAID and 9 provinces to the European Community (later 10 after the Government divided Uruzgan into Daikundi and Uruzgan). Later, the Asian Development Bank, KFW (a German nongovernmental organization) also joined this process and total 11 districts in Kandahar, Badakhshan, Ghor and Badghis.

Discussion

Participants were impressed by the efforts of the Ministry of Public Health in trying to promote health system development in Afghanistan despite the many difficulties encountered at the field level. They pointed out the importance of unifying the effort across Afghanistan and adopting a common framework for all organizations and donors assisting the Ministry in its efforts. More clarification is needed as to why spending on health is low (US$ 4 per capita), especially in areas with complex situations. Nongovernmental and other organizations should focus on sustainable development. It was agreed that the Ministry of Public Health should be strengthened and investments should be directed to empower employees. The participants were told that lack of human resources in Afghanistan is a major problem and that measures are currently being taken to correct it. Lack of adequate human resources has forced the Ministry of Public Health to adopt the work of nongovernmental organizations until they build the capacity of their own staff.

3.2 Bahrain

Dr Ahmed Omran

The Ministry of Health has been contracting out various non-clinical services for a long time, but there is no experience with contracting out direct health care services. At the other extreme, the
Ministry of Health is studying future privatization options and issues for the new King Hamad General Hospital, in line with the recent economic policy of Bahrain to promote privatization.

In the experience with contracting under two non-clinical support services in the Ministry of Health, the selection was based on bid price as well as the quality of technical proposal, and a high level of transparency and fairness of the selection process was ensured by involving an expert third party – The Tender Board. Although the contract design included the standards of expected services and contactor performance was strictly monitored, it did not include clearly specified performance indicators.

The legal framework is robust enough to facilitate contracting between the public and private sectors. The public and private sector are quite capable to undertake a cost and price analysis for support services prior to negotiations. The Ministry of Health does not have a comprehensive information system to dynamically compute costs of various services; however, it has adequate cost information for “make or buy” decisions.

Discussion

Bahrain has a very well developed contracting model, and application of it to health sector especially for services is being considered. Concern was raised whether contracting out for services would affect the provision of care by the public sector facilities; it was clarified that the process would only be undertaken after carefully considering the situation and comprehensive evaluation of the projected benefits. Gulf Cooperation Council countries already have good health services and their focus is on how foreign investment and increasing the interventions offered would prevent local patients from going abroad and also attract foreign patients from abroad.
3.3 **Egypt**  
*Dr Hassan Salah*

The Health Sector Reform Programme in Egypt has established the Family Health Fund, under a governmental decree, to develop as the main contracting and purchasing agency for quality health care services on behalf of the beneficiaries, the Egyptian population, although at present it is functioning as a pilot unit. Its purpose is to: 1) separate service finance from service provision and ensure competition between service providers to contract with the Fund based on the quality of services offered; 2) act as an agent and contractor to purchase health services for families, insured and non-insured, through public, private and nongovernmental organization units; and 3) act as a forerunner of a national health insurance fund.

The Family Health Fund is in its second year of operation and has contracted with a range of public and private providers. It is being piloted in five governorates of the country and a formal evaluation has yet to be undertaken. Nevertheless, based on preliminary information, the main role of the Fund is to purchase a package of primary health care services for registered families in a community. In addition to contracting with private providers and nongovernmental organizations, the Fund has initiated contracts with the reformed public sector facilities that fall under the district provider organizations in the governorates and provide a defined package of services to the district population. All providers, whether public or private, can only enter into a contractual arrangement after having received an accreditation certificate from the Ministry of Health and Population. Payment mechanisms are still being piloted on a per capita as well as fee-for-service basis. A set of 11 coverage, utilization and quality indicators have been identified that will be used for all contracting facilities to allow fair competition.

**Discussion**

The Family Health Fund has a positive experience in the contracting process with 230 accredited facilities in both the public
and private sector; however, the exact numbers and details of utilization are not available, although anecdotal data suggest that utilization has improved in the project facilities.

3.4 Islamic Republic of Iran

Dr Abdoulghassem Pourezza
Dr Hamidreza Jamshidi

Despite the fact that the private sector has always had a role in provision of health services in the Islamic Republic of Iran, it is still a dominant view that providing and delivering health care services is the role of the government. However, public and private sectors in the health service delivery domain operated in parallel until recent years, without close partnership or collaboration.

In the past 5 years, through the Third Socioeconomic Development Plan, national authorities have tried to strengthen partnership between the two sectors through expanding privatization, devolution and contracting out, in order to increase efficiency, access, and appropriate utilization of resources. Article 192 specifically requires the Ministry of Health and Medical Education to purchase services from the private sector. With regard to supportive legal, administrative and political environment, the Ministry and universities of medical sciences began contracting out services and developing partnership with the private sector.

The Ministry mainly contracts out non-medical services such as transport, publications, food, etc. However, universities of medical sciences purchase medical and non-medical services from the private sector. In terms of medical services, preventive and public health services are main priority for the universities. Para-clinical services also are frequently contracted out by the universities. Non medical services purchasing seems to be dominant in this respect among all universities.

Five major medical sciences universities, together with the Ministry of Health and Medical Education, participated in the study. Findings show that the process of outsourcing, despite some achievements in terms of improving access, downsizing paperwork,
increasing income and containing costs, difficulties remain and there is still more room for improvement. It is hoped to learn more from analysing data and experiences of seven pilot universities in this respect in the near future.

The second part of the presentation was the plan for performance-based service contracts for health in the Islamic Republic of Iran. The plan is to provide health services to the population through family health physicians in rural areas, currently covered by 2500 health centres. A package of services has been identified, and its basic parameters, such as time required and expected results, have been outlined. In addition, detailed plans on how to assess the performance and scoring the levels of performance have been made with clear criteria linking performance to payment levels. The system will be initiated in 2005 and initial results should be available at the end of 2006.

Discussion

Concerns were expressed about the performance-based contracting system proposed by the Ministry of Health and Medical Education. The human resource requirements and technical capacity to monitor the contracts is very large. The Islamic Republic of Iran has the capacity to monitor primary health care successfully, and the systems are in place which will be used in monitoring the contracts. The important message from this activity is that contracting out of services should only be done where the relevant capacities exist in the system.

3.5 Jordan

Dr Musa Taha Ajluni

The Ministry of Health in Jordan has been contracting out health services to the private sector and other autonomous public sector organizations over the past three decades. Contracts are mostly given by the Health Insurance Directorate of the Ministry of Health for the provision of hospital services. Of the eight formal contracts for
purchase of services by the Ministry, five are with private hospitals and three with autonomous public providers. Of these, six are reimbursed according to fee-for-service while two receive a fixed payment against leasing a specific number of hospital beds. Currently, the Ministry of Health with the support of Partnership for Health Reform Plus is implementing a health insurance pilot project to enhance the capacity of the Ministry of Health in contract design, monitoring and enforcement.

There is some evidence that contracting has contributed to improving access and promoting equity through extension of subsidized Ministry of Health activities to the poor and vulnerable. In terms of efficiency, the cost per admission in some autonomous hospitals was less than 300 Jordanian dinars (JD) as compared with over JD 1500 in private hospitals without contracts. There is no evidence, however, that contracting has contributed to improving the quality of services.

Discussion

The discussion focused on whether the bed-leasing arrangements were financially beneficial to the Ministry in the long term and how capital investment by the private sector is better utilized through these arrangements. The arrangement has improved accessibility for the community. The importance of pre-contracting accreditation to ensure quality of service and the need for mechanisms to do this were highlighted.

3.6 Lebanon

Dr Nabil Kronfol

Lebanon, which has a large private health sector, uses contractual arrangements extensively to provide health care and other services to its citizens. Over 80% of Lebanese receive health care based on one form or another of contractual arrangements. The Ministry of Public Health uses contracting as one of the main tools at its disposal to support its functions. This includes contracting with
primary care centres and hospitals to provide care for the uninsured and with local nongovernmental organizations to support social welfare.

There are many limitations to the current contracting arrangements. Some of these include fragmentation of contracting mechanisms, lack of public capacity for monitoring of performance and outcomes, the limited leverage of the public sector as compared with the private sector, and the inability of current arrangements to contain escalating health care costs. Many perceive current arrangements as providing public–private cash transfers which do not serve the government or the Lebanese citizen in the long term.

Considering that recent large-scale health sector reform projects have not been successful, contracting can be used an entry point to gradual reform. Several recommendations for improving performance of current arrangements can be made which include creation of a central contracting body, linking inpatient and outpatient care, and unifying tariffs across financing agencies.

Discussion

The reasons for contracting out health services in Lebanon are mainly historical and political. One of the reasons for the high cost of health care in Lebanon has been private provision. Political factors constrain the efficiency of the system.

3.7 Morocco

Dr Moulay El Hachemi El Miri
Dr Abdelghani Drhimeur
Dr Mahmoud Berrahal

The Ministry of Health recognizes the competencies and innovative management procedures of the private providers and encourages contracting with them. The types of contractual arrangements are what have been called purchasing, delegation, and cooperation. Purchasing involves the traditional contracting in of a private provider on a regular salary to work within a public health
institution and provide health services that are not well covered. Such arrangements have been on the decline with the expansion of public health services.

More recent experience in Morocco relates to its policy of hospital autonomy and decentralization of district services and entering into a contractual arrangement with them. The Ministry of Health and the Ministry of Finance and privatization concluded what have been called work-plan contracts with two university hospitals to meet their statutory responsibilities: care, training and education and research. The idea underlying this twin intervention of decentralization and contracting is that these institutions shall improve management, optimize use of resources, be more accountable and improve overall performance. The terms and conditions of the contract include a global budget and set of agreed upon performance monitoring indicators. A similar arrangement called programme contracts has been made with the decentralized facilities of the Ministry of Health, which are responsible for providing district health services.

Another form contractual arrangement based on cooperation exists between the public sector and the nongovernmental organizations covering such activities as contact tracing for infectious diseases, family planning and diagnostic and treatment services. The public contribution to nongovernmental organizations does come through formal contractual payments but annual subsidies, provision of medicines and supplies, sharing of infrastructure and human resources. Such agreements usually do not anticipate the means and tools necessary to control, monitor and follow up the input of nongovernmental organizations.

Discussion

The important points discussed were the need for quality assurance of the service being provided by the private sector and the issues of certificate of needs for establishing new technology based facilities. The use of contracting to reduce the load on the public
sector was appreciated, but the issues of maintaining equity in care provision and quality of service were identified to be very important.

3.8 Pakistan

Dr Shahid Ansari

The contracting arrangements between the public purchasers and private providers vary with the levels of hierarchy, the type of contract and the set of services to be provided. The purchasers include mainly the Federal Ministry of Health, the provincial departments of health and social welfare, and the district governments. The private providers include mainly international and national nongovernmental organizations, institutions and private firms. The contract types include contracting out, cost sharing agreements, grants and loans. The set of activities covered in contractual arrangements comprise primary health care services, research and development services, and technical and management services.

The public sector rationale for contractual arrangements is to partner with the private sector to target priority health problems, expand coverage in less accessible areas, meet rising consumer expectations and test public-private innovations. The private sector interests include enhanced size and scope of activities, recognition and financial support, and humanitarian concerns.

There exists serious political commitment in favour of public-private partnership, and despite a cautious approach the number of pro-contracting bureaucrats has increased. The increasing number of projects with contractual arrangements is a testimony to the level of support. The initial success of the flagship project, the contracting out of primary health care services in district Rahim Yar Khan, has led to its premature replication in several districts of Punjab province.

The institutional arrangements for managing the contractual partnerships are inadequately developed. Although private sector partners have expressed overall satisfaction with the support received from their public counterparts during planning and implementation
of project activities, delays in payment have also been reported due to the complexity of government financial procedures.

Many national programmes have developed capacity in preparing bid details, inviting bids, evaluating the technical and financial proposals, negotiating the terms and awarding contracts. There is a wide variation in the technical, managerial and financial capacity of private providers, often addressed through short-term expert inputs. The majority of private providers rely on up-front project funding for initiating activities, which makes their long-term sustainability less certain.

The most common payment method has been block payment made against an agreed set of activities and outputs. However, there are examples of payments to private sector providers on the basis of fee-for-service, and indemnification and prepayment. The public sector managers as well as most private sector organizations have limited ability to undertake the cost and pricing analysis.

The Federal Ministry of Health does not have the capacity to efficiently monitor and evaluate ongoing projects, even if monitoring indicators are identified. There is thus no regular arrangement for collecting data on project outputs or outcomes. Sometimes independent reviews are undertaken through donor support. The Federal Ministry of Health does not maintain a database of the private sector partners according to their areas of expertise or work experience.

Discussion

The question of monitoring capacity at the Federal Ministry of Health to ensure that contractual obligations are being fulfilled was highlighted and the discussion also noted that the replication of this project in Pakistan was being conducted without a comprehensive assessment of the project. The long-term effects of such types of contracting arrangements are not known.
3.9 Syrian Arab Republic
Dr Mahmoud Dashah

Although the number of government contracts with the private sector almost doubled (from 260 to 492) between 2001 and 2003, most contracting in the Syrian Arab Republic is done for non-clinical services. The areas covered include maintenance of hospitals and equipments; catering, cleaning and construction services. The Ministry of Health continues to promote a policy of direct provision of health services through establishment of new hospitals and health centres instead of contracting out health services to the private sector. The Ministry of Health owns and operates 80% of the health institutions in the country and during the period 2006–2010 is planning to establish 74 new hospitals and 350 health centres.

The overall political and bureaucratic environment is currently not conducive to contracting out health services; nonetheless, there is greater keenness among the private sector to enter into contractual arrangements as it would offer a reliable source of revenue, raise the volume of under-utilized services and add to their credibility.

The lack of experience in contracting out of clinical services in the country may be attributed to several factors: historical trend of the government to follow the policy of direct provision in most social sectors; lack of knowledge and trust of the advantages that each has to offer; and lack of experience among the public and private sector in negotiation of contracts, their preparation, management, monitoring and evaluation.

Discussion

Health services are mostly provided by the strong public sector and the private sector infrastructure is not well developed. However most of the public sector doctors also work part time in the private sector. The lack of a vibrant private sector was discussed and the issue of the upper class going to neighbouring countries for care was highlighted. There is also a contractual mechanism through the doctors' association joint fund mechanism. On the whole the
government is committed to increasing the infrastructure of the public sector. The question of whether some of the investment to be made by the government in infrastructure could be saved through promotion of private sector investment was discussed. The participants agreed that the need was for a quality service provision either through the public sector or the private sector.

3.10 Tunisia

Dr Achour Noureddine

The Tunisian health system has been governed by contractual arrangements since 1970 when the social security fund agreed to pay a lump sum amount to the national treasury for health care provided to their affiliate members and their dependents. The process of contracting has greatly developed since then. Contracting with the private sector in Tunisia received a boost in 1987, when it was realized that the social security fund had to pay large sums of money to almost 60% of patients requiring cardiac surgery by sending them abroad.

Currently, the relationships between the health insurance organization (social security fund) and the health care providers (both public and private) are managed and regulated through contracting, which also helps achieve consensus on the often conflicting interests of the fund and the providers. Several specialized services were not provided for in the initial agreements made between the social security funds and the Ministry of Public Health. Most of these health care services are the subject of agreements and memoranda of understanding with the Ministry of Public Health, to which some private specialized care institutions and the Military Hospital have been included. There is no act or decree allowing the socially insured to receive health care in private health facilities. These agreements have proved useful as they have enabled the private facilities to be brought into the process of contracting of health services.

There are two types of health coverage schemes operational in Tunisia, the health cards and the reimbursement schemes.
Irrespective of the scheme, the affiliate members are entitled to all health care services provided in the terms of agreement. The wide range of services include highly sophisticated techniques such as lithotripsy; bone marrow, renal and heart transplants; other cardiovascular interventions; thermal treatments; haemodialysis; and all forms of scanning procedures.

In order to participate in the contractual arrangement, the private institutions are obliged to accept the following conditions: the reimbursement is made on the basis of a flat rate determined at the level of the Ministry of Public Health; private facilities are committed not to increase the agreed rates or charge co-payment under the agreement; for cardiovascular interventions, a justification for the procedure is required from the private institutions; and private facilities are subject to medical inspection, provided for in the agreements, which is also a requirement for public facilities.

Discussion

The Tunisian model presents an example of sharing of costs between the public and private sectors. However the inclination of the private sector to work exclusively for profit limits the efficiency gains from being passed on to the consumers.

4. Group work

Three working groups were formed to discuss the implications of contracting and synthesize the information from the country presentations for formulating recommendations towards a regional policy on contracting. The main questions considered by the working groups were:

- How should WIIO position itself in the area of contracting to improve health system performance? In what areas could contracting be beneficial? In which areas the risks outweigh the benefits?
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- What capacities are required among the public and the private sectors? How can these capacities be enhanced to make use of contracting as a tool to promote public health objectives?
- What actions are required by WHO and the ministries of health to use contracting as an effective tool to improve health system performance?

Overall direction

- Contracting is not an end in itself nor does it mean that the state divests itself from its responsibility for health. Used prudently, it could be an effective tool to serve and promote public health objectives.

- WHO should support "contracting" as one of the purchasing tools, when applied judiciously, could contribute to the improvement of health system performance.

- Contracting should be based on the goals of the national health care system and must be preceded by a careful stakeholder analysis.

- Contracting for health services is being conducted in many countries of the Region and its use should enable increasing coverage of health services and should not encourage duplication of services.

There is a diversity of contracting forms (contracting in, contracting out, leasing, etc.). From the public health point of view, the success of "contracts" depends on many factors: area concerned, conditions of implementation, institutional capacities, monitoring and evaluation modalities, and contractual arrangements. Contracting experiences differ among countries due to the country determinants.

The concept of contracting for health services needs to be clarified with a uniform definition. Contracting is a mechanism for purchasing health services from the private or public sector
institutions, and as such its importance increases with implementation of prepayment (premium based; social or private insurance) as a mode of financing health services. Contracting depends on the overall governance features of the country, such as the legal frameworks, rule of law and enforcement mechanisms in place. For successful design, implementation and execution of contracts, certain minimum capacities are required in the public as well as the private partners, and steps should be taken to strengthen and acquire these capacities. Contracting out (outsourcing) is one of the potential mechanisms available to improve efficiency of the health care systems; however, human resource requirements and policy options need to be carefully considered before embarking on contracting out for health services.

Risks of contracting

Contracting for services in developing countries often occurs to improve management, quality of services, efficiency, however capacity to monitor the contracts requires strong managerial skills and these are lacking in many countries. Several characteristics common to the environments of low- and middle-income countries, such as poorly developed institutional capacity, a shortage of administrative and contract-writing skills and poorly developed markets (which decrease the likelihood of the benefits of contracting being realized). The capacity of markets to behave competitively and transparently or of government to support the creation of such markets is likely to be limited in many such countries.

There are some fears which are related to contracting like siphoning of public sector expertise and issues of sustainability of services, which are related more to privatization and the overall economic environment of the country. Most importantly, a major risk may be forgetting the main goal of contracting: improvement of health system performance. Although conclusive evidence is not available, the following domains were considered “high risk” for contracting and ought to remain exclusively within the purview of the public sector: health policy, planning of health services,
epidemiological surveillance, and monitoring of the health outcomes. There is also a need to develop standards and indicators to assure equity, transparency, equal opportunity, monitoring, and impartial comparison of submitted bids.

5. Conclusions

- Contracting is recognized as an increasingly important tool for implementing health policies and programmes in the Region.

- To be effective, contracting requires ministries of health to have capacity to design, award and manage contracts.

- Enhanced capacity of the private sector to implement contracts and of ministries of health to monitor is equally important.

- Contracting is a means and not an end in itself, and should be used primarily to promote public health objectives.

- More research is needed for evaluating the impact of contracting on health outcomes in the Region.

6. Recommendations

Member States

Policy

1. Review the political, legal and administrative structure of ministries of health and ensure the presence of well functioning information systems that allow effective monitoring and supervision of the contracted out services.
2. Define public health goals in national health policies and use contractual arrangements primarily to help achieve these goals. A guiding principle is that delivery of health services may be contracted out, but not the authority and responsibility, or other aspects related to governance and oversight of the health system.

3. Ensure that contracting with the private sector seeks only to harness its role in achievement of public policy goals and is not considered as privatization of health care.

4. Review legislation and play a proactive part in development of legislation for contracting of services in the country.

5. Contracting can be used as one of the tools in national programmes to promote equity of health services through targeting the poor and vulnerable population.

6. To improve quality of health services and ensure that clinical guidelines are followed, include clearly defined indicators that assess quality of health care in the contractual arrangement.

Capacity development

7. Enhance capacities at national level to better implement and understand contracting.

- Managerial: contract design, information systems, accreditation of contractors
- Technical: knowledge of the areas under consideration
- Monitoring: developing indicators, measuring performance, protocols, standards
- Financial: cost–benefit analysis, health accounts
- Consumer satisfaction
- Governance capacity
- Relevant and adapted legal, economic and financial frameworks
- Human resource capacities
• Human resource negotiation capacities

WHO

8. Develop guidelines for evaluation of contractual arrangement of publicly financed services in accordance with the WHO performance analysis framework.

9. Promote and foster exchange of experiences between countries in the area of contracting, such as through organizing subregional workshops to share experiences (e.g. Gulf Cooperation Council, Maghrreb, countries in particular situations).

10. Enhance organizational capacity within WHO to provide relevant technical assistance to countries, especially in international contracting, support in-country workshops to discuss contracting issues and encourage the participation of the private sector in discussions on contracting.

11. Monitor ongoing contractual arrangements to gather information for analysis and dissemination about best practices.

12. Sponsor evidence-based research and studies to determine the impact of contracting on access, efficiency, equity and quality of health services in the Region.
Annex 1

Programme

Monday, 18 April 2005

08:30–09:00    Registration
09:00–09:15    Message by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean
09:15–09:35    Introduction to workshop objectives/ Dr Belgacem Sabri
09:35–09:45    Introduction of workshop participants

Session Chair: Dr Alsadig Gasm Allah (Sudan)
09:45–11:00    The role of contracting for health services in improving health system performance/Mr Jean Perrot
11:00–11:30    Contracting out publicly financed health services/Dr Sameen Siddiqi
11:30–14:00    Open discussion on contracting in health

Session Chair: Dr Mazen Khadra (Syrian Arab Republic)
14:00–14:15    Background of the country studies and overview of the process/Dr Sameen Siddiqi
14:15  14:45    Country Presentation: Jordan
14:45–15:15    Country Presentation: Egypt
15:15–16:00    Country Presentation: Bahrain

Session Chair: Dr Fawzi Amin (Bahrain)
16:00–16:30    Country Presentation: Morocco
16:30–17:00    Country Presentation: Lebanon
17:00          Individual meetings with country presenters
Tuesday, 19 April 2005

Session Chair: Dr Hedi Achouri (Tunisia)
08:30–09:20  Contracting and payment mechanisms/Dr Hossein Salehi
09:20–10:00  Country Presentation: Islamic Republic of Iran
10:00–11:00  Country Presentation: Pakistan

Session Chair: Dr Samir Foud (Egypt)
11:00–11:30  Country Presentation: Tunisia
11:30–12:00  Country Presentation: Syrian Arab Republic
12:00–14:00  Country Presentation: Afghanistan

Session Chair: Lebanon
14:00–14:30  Summary of the results of country studies/ Dr Tayyeb Masud
14:30–15:00  Open discussion
15:00–17:00  Working groups: Regional strategy on the role of contracting in improving health system performance in the Region
17:00  Individual meetings with country presenters

Wednesday, 20 April 2005

08:30–11:00  Working groups: Regional strategy on the role of contracting in improving health system performance

Session Chair: Dr Hamidreza Jamshidi (Islamic Republic of Iran)
11:00–12:00  Presentation of the draft strategy by Groups
12:00–13:00  Discussion on the draft strategy
13:00  Concluding session
Annex 2

List of Participants

AFGHANISTAN
Dr Mustafa Mastoor
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Grant and Contract Management
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BAHRAIN
Dr Fawzi Amin
Assistant Undersecretary for Planning and Training
Ministry of Health
Manama

Dr Ahmad Omran
Medical Consultant
Primary Health Care
Ministry of Health
Manama

EGYPT
Dr Samir Fouad
Director
General Planning Department
Ministry of Health and Population
Cairo

Dr Hassan Salah
Family Health Adviser
Health Sector Reform Programme
Ministry of Health and Population
Cairo
ISLAMIC REPUBLIC OF IRAN
Dr Hamidreza Jamshidi
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Dr Aboulghasem Pourreza
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Assistant Professor in Hospital Administration
University of Applied Sciences
Amman
LEBANON
Dr Nabil Kronfol
President
Health Systems and Health Manpower Development
Lebanese Health Care Management Association
Beirut

MOROCCO
Mr Moulay El Hachemi El Miri
Head of Budget Service
Ministry of Health
Rabat

Dr Abdelghani Drimeur
Directorate of Hospitals and Ambulatory Care
Ministry of Health
Rabat

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Director of Regional Hospital Centre
Province of Beni Mellal
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Ministry of Health
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Dr Alsadig Gasm Allah
Minister of Health
Al Gezira

Mr Kennedy Jaden Kwaji
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South Sudan

TUNISIA
Dr Hedi Achouri
Director Hospital Supervision
Ministry of Public Health
Tunis

Dr Nourreddine Achour
Director
National Institute of Public Health
Tunis
Other Agencies

The World Bank
Ms Hadia Samaha Karam
Operations Officer

WHO Secretariat
Dr Belgacem Sabri, Director, Health Systems and Services Development, WHO/EMRO
Mr Jean Perrot, Evidence and Information for Policy, WHO/HQ
Mr Toshio Ogawa, Health and Welfare Systems Centre Development Programme, WHO Kobe, Japan
Dr Raouf Ben Ammar, WHO Representative, WHO Morocco
Dr Jaouad Mahjour, Acting WHO Representative, WHO Lebanon
Dr Ahmed Abdullatif, Regional Adviser, Health Care Delivery, WHO/EMRO
Dr Sameen Siddiqi, Regional Adviser, Health Policy and Planning, WHO/EMRO
Dr Hossein Salehi, Regional Adviser, Health Economics Legislation and Ethics, WHO/EMRO
Dr Tayyeb Maced, Short-term Professional, Health Policy and Planning, WHO/EMRO
Dr Zine Eddine El Idrissi, Short Term Professional, Health Economics, Legislation and Ethics, WHO/EMRO
Mrs Hala Hassan, Secretary, WHO/EMRO
Ms Heba El Khoudary, Secretary, WHO/EMRO
Mr Ahmed Mohied, IT Support, WHO/EMRO
Annex 3

Message from the Regional Director

It is with great pleasure that I welcome you to the regional meeting on the role of contractual arrangements in improving health system performance. I am pleased to see that there is an appropriate mix of country researchers, ministry of health policy-makers and academia, as well as representatives from the WHO Kobe Centre in Japan and the World Bank. I am also pleased to see staff from WHO headquarters, especially Dr Jean Perrot, who is one of the key resource persons for this meeting.

Traditionally, ministries of health in most countries have been the financiers and providers of health services. In recent years, many countries have tried splitting the financing and provision functions by contracting out publicly financed services to private providers in an effort to improve access, efficiency, equity and quality of health services. Contracting thus is an important instrument in the hands of ministries of health to build partnership with the private sector. However, it can not be overemphasized that despite its growing use and importance, contracting is not an end in itself, but a means for achieving the time-honoured goal of Health for All.

Contracting is increasingly being used by the public sector for the purchase over time of specified services from the private sector, or in some cases through internal contracts with autonomous public facilities. Contracting is an important element of many countries' health sector reform programmes because it provides governments with a management tool that creates incentives for improved performance and increased accountability. Contracting has the potential to improve access, quality, efficiency and sustainability; promote public health goals; and create an environment conducive to public-private collaboration. However, the process is challenging and requires transparent bidding procedures, well-designed contracts, clear performance obligations and credible funding mechanisms. In addition, governments need to be able to monitor the contracts and must have credibility as trustworthy partners.
In 2003, the World Health Assembly endorsed resolution WHA56.25, requesting Member States to assess the role of contractual arrangements in improving health systems' performance. There has been limited experience and more so its documentation on the role of contracting in health among countries of the Eastern Mediterranean Region, although several are at various stages of implementing health sector reforms. Recognizing the increasing importance of this subject and the need for raising awareness and building capacity in ministries of health for contracting out publicly financed health services to the private sector, the Regional Office initiated studies on the subject in several countries of the Region. The objectives of the study were to: 1) understand the nature, extent and factors that influence contracting in health in countries of the Region; 2) assess in each country public health projects that have taken up contractual arrangements as the principal implementation strategy; 3) review capacities of ministries of health in outsourcing of publicly financed health services; and 4) assist in developing an evidence-based regional strategy on contracting in health.

I am pleased to see that the studies have now been completed in 10 countries of the Region and will be presented and discussed at length in this forum. The countries are Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, Pakistan, Syrian Arab Republic and Tunisia. The studies have documented experience with outsourcing of publicly financed health services to private sector organizations, both for-profit and non-profit, as well as the capacities of ministries of health in undertaking contractual arrangements. Many countries have undertaken contracting arrangements for delivery of primary health care services; others have contracts for hospital services, while some have only contracted out non-clinical services. You may wish to deliberate on the advantages and disadvantages of contracting out public health services during this meeting, as some countries would like to move in that direction.

It is important that we present an objective assessment of the role of contracting in improving health system performance in the context of this Region, thereby looking at the strengths and weaknesses of this management and regulatory tools. This would
greatly assist in developing an evidence-based regional strategy and position on this subject that we can offer our Member States.

I would close by saying that although contracting involves outsourcing of publicly financed health services to nongovernmental institutions, it in no way minimizes the role of the ministries of health, which remain the principal governing body for health in all countries of the Region. Contracting is potentially an important tool that is useful for the efficient implementation of health services; however, it requires different kinds of skills and capacities that need to be developed in the ministries of health.

I wish you all a successful regional meeting and look forward to receiving your recommendations, which will contribute to strengthening the role of contracting in health in the Region. May you have a pleasant and fruitful stay in Cairo.
Annex 4

Background document: The role of contractual arrangements in improving health sector performance in countries of the Eastern Mediterranean Region

Background

Contracting is used by the public sector for the purchase over time of specified services from the private sector, or in some cases through internal contracts with autonomous public facilities. Contracting is an increasingly important element of many countries' health sector reform programmes because it provides governments with a management tool that creates incentives for improved performance and increased accountability. Contracting can improve access, quality, efficiency, and sustainability; promote public health goals; and create an environment conducive to public-private collaboration. However, the process is challenging, and requires transparent bidding procedures, well-designed contracts, clear performance obligations and credible funding mechanisms. In addition, governments need to be able to monitor the contracts and have credibility as a trustworthy partner.

Resolution WHA56.25 endorsed by the recent World Health Assembly asks Member States to assess the role of contractual arrangements in improving health systems' performance.\(^1\) There is limited experience and more so its documentation on public-private partnership in health among countries of the Eastern Mediterranean Region although several are at various stages of implementing health sector reforms. There is increasing realization within the Region, as in other regions,\(^ii\) of the importance of awareness creation and capacity building within ministries of health in contracting out publicly financed health services to the private sector.

Scope and objectives

The scope of this initiative is to undertake exploratory case studies to document experience with outsourcing of publicly financed health services to private sector organizations in those countries of the Region that have an active private and/or nongovernmental
organization sector, and to assist in developing a regional strategy on public private partnership in health in the Region.

The specific objectives of the study on the role of contractual arrangements in improving health sector performance in countries of Eastern Mediterranean Region are to:

- Acquire an in-depth understanding of the nature, extent and presence of enabling/disabling factors that promote/prevent public-private partnership in health in several countries of the region;
- Undertake in each country an in-depth study of a specific public health project/programme that has taken up contractual arrangements as its principal implementation strategy;
- Build capacities of the ministries of health in developing a culture of outsourcing of publicly financed health services that promote access, efficiency, equity and quality.
- Develop an evidence based regional strategy on public-private partnership in health that would promote effective implementation of priority health programmes in Member States of the Region.

**Approach and methods**

**Establishment of a Technical Committee**

This is the first major initiative on the subject of contractual arrangements in improving health sector performance in countries of Region. It is proposed that a technical committee chaired by the Director, Health Systems and Services Development be established with all Regional Advisers in the Health Systems Development area as its members. The Regional Adviser, Public Health Policy and Planning, will function as its secretary. The committee would over see the satisfactory implementation of the study. The specific tasks of the Committee would be to:

- Endorse the proposal and the various instruments developed for the purpose of the study;
- Monitor progress of study implementation in various countries while on duty travel;
• Review country reports and provide feedback;
• Organize and participate in the regional workshop and assist in development of a regional strategy on the subject.

**What are contractual arrangements?**

A good working definition includes three points. First, these are partnerships that involve at least one private for-profit organization and at least one private non-profit or public organization. Second, the partners have some shared objectives for creation of a social value, often for disadvantaged populations, finally the core partners agree to share both efforts and benefits.

This working definition contains many ambiguities, raising important questions and issues. One set of questions focuses on the nature of public and private. What is public? What is private? The public sector category certainly includes national governments and international agencies (such as WHO and the World Bank). And the private sector category certainly includes for-profit corporations. But where do national and international non-governmental organizations fit? Organizations such as médecins sans frontières are private in the sense that it does not belong to a governmental structure, yet it seeks to promote public interest. Such nongovernmental organizations belongs to the civil society, a third sector, sometimes called civil society organizations. Civil society organizations have been defined as an area of association and action independent of the state and the market in which the citizens can organize to pursue to social values and public purposes which are important to them, both individually and collectively.

For the purpose of this study on contractual arrangements, we would follow the above definition of public and private sector. In the case of nongovernmental organizations and civil society organizations, these would be considered as a third sector like the for-profit private sector with which the public sector could enter into contractual agreements.
Countries and institutions for undertaking the study

Countries shall be identified on the basis of the size of the private sector, experience with contractual arrangements, capacity and potential for outsourcing in health programmes and projects, and the existence of a programme or project in health implementing contractual arrangements with the private sector. The countries proposed for participation in the study are Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, Pakistan, Syrian Arab Republic and Tunisia.

Appropriate institutions from within these countries shall be identified to undertake the country case studies. The broad criteria for selecting these institutions include:

- Previous experience in undertaking health system research;
- Appropriate focal person available and assigned the task;
- Independent academic or research institution, NGO/CSO etc.;
- Experience of working with WHO in the past desirable.

Development of an assessment checklist

A generic assessment checklist to facilitate data collection shall be developed by the Division of Health System at WHO EMRO, which would be endorsed by the Technical Committee (Annex 1). The checklist would be open-ended and serve as a guide to country researchers in data collection. Institutions identified in each country would adapt the proposal/checklist developed by the Regional Office to their country-specific needs, however, each country would follow a similar methodology to keep the studies comparable.

The instrument would serve as a guide to the country research teams for seeking information on various technical issues related to contractual agreements. The study instrument shall have two sections:

- Overall status of contracting of health services between the public and the private sector;
- Review a specific project/programme that has taken up contractual arrangements as its principal implementation strategy.
The role of contractual arrangements in improving health system performance

The key technical questions to be addressed in each study include:

- Why do countries enter into health services contracts with nongovernmental organizations? What is the interest of the nongovernmental organizations in receiving public sector financing?
- How does the political environment and legal framework influence the negotiation and execution of contracts?
- What are the capabilities that the purchaser (Ministry of Health) and provider (private sector organization) need in order to successfully enter into a contract?
- What are the strengths and weaknesses of the public sector and the nongovernmental organizations that should be taken into consideration when entering into a contractual agreement?
- What risks and incentives does each party incur when entering into a contract? What are the payment mechanisms of each contract? Has cost and price analysis been performed prior to negotiations?
- What information systems do both parties need in order to carry out the contract? What monitoring mechanisms and evaluation systems are in place in these countries and what challenges exist in this area?

Selection of project/programme in the case study

Before a specific case is included in this study, a contract has to exist, that is, there has to be a legal agreement authorizing the transfer of funds from a government agency to a private sector or a civil society organization. Such a contract would be for health service provision and would exclude such activities as training, pharmacy, laundry, catering etc.

Those contracts that use some sort of system or method of monitoring or evaluating performance as opposed to agreements based on subsidies and donations shall be given preference. The framework for project assessment would cover the following areas:

- Country and the project to be studied;
- Type of service covered;
• Selection mechanism and length of contract;
• Regulation, who enforces and what level;
• Payment mechanism;
• Financial and other incentives for the purchaser and provider;
• Level of performance based measures;
• Purchasers level of effort in management and administration;
• Providers level of effort in management and administration;
• Geographical scope of contract;
• Monitoring and evaluation characteristics.

Monitoring quality of case studies

Close monitoring of the case studies in various countries is essential for ensuring quality. The following is being proposed:
• Clear terms of reference and expected outputs for the team of researchers;
• Identification of the most suitable institutions in each country;
• Establishment of an electronic network that would allow sharing of experiences while the study is being undertaken in the various countries;
• Interim report by the principal investigator mid-way through the study;
• Monitoring in the field by regional advisers during their visits to the countries.

National and regional workshops for strategy development

All country investigators shall be expected to organize a one-day national workshop to discuss and disseminate the study findings with the concerned stakeholders and to evolve a national strategy on the subject.

A workshop to develop a regional strategy on the role of contractual arrangements in improving health sector performance in countries would be organized in one of the countries of the Region. This would be in line with the EMRO’s stated response to the Resolution WHA56.25 endorsed by the recent World Health Assembly that has asked Member States to assess the role of contractual arrangements in improving health systems' performance.
Principal investigators studies shall be invited to present the results of their case studies from all the countries, in addition to experts on the subject from within and outside the Region. The outcome of the workshop would be to acquire a better understanding of the issues related to contractual arrangements, come up with a regional strategy based on best evidence, and publish a state-of-the-art report on the subject.

Write-up of reports

Each investigator shall prepare a comprehensive report in English on the case study covering the objectives, methodology, main results, critique of the findings and important recommendations. Some of these reports shall require translation to Arabic or French for which a small amount of resources shall be set aside.

The final report would include all country case studies and the regional strategy on the subject shall be published. It shall be disseminated to all Ministries of Health and other stakeholders from the private health sector and civil society organizations for use as a guide on contractual agreements in health.

A scientific paper on the role of contractual arrangements in improving health sector performance in countries shall be published in an international peer reviewed journal.

Deliverables and outputs

The following shall be the major deliverables of this effort:

- Report of case studies on contractual arrangements in health for the selected countries of the Region that would identify the reasons for the success or otherwise of these experiences.
- State-of-the-art report on the regional strategy on contractual arrangements in health, which shall be the outcome of a regional meeting on the subject and would be shared with all countries of the Region,
- Capacity development of the Ministries of Health and creation of an enabling environment for outsourcing of publicly financed health services that promote access, efficiency, equity and quality.
Ethical considerations

Research on contractual arrangements in improving health sector performance is an exploratory study to document its extent and potential for improving health services. Although not an interventional design, it involves interaction with functionaries of the governmental and nongovernmental institutions as well as review of existing records. The protection of privacy, dignity, and integrity of those who are the subjects of research shall be ensured and instructions shall be given to researchers on ethical considerations during the entire data collection and analysis process. Researchers from all countries would be requested to have the research proposal cleared by a recognized ethical review committee or an institutional review board of their respective countries.
Annex 5

Checklist for assessing the role of contractual arrangements in improving health sector performance

Assessment of the overall capacity for contracting health services in a country

1. What is the rationale for Ministries of Health to enter into health services contracts with nongovernmental organizations or the private sector?
2. What is the interest of the nongovernmental organization and private sectors in receiving public sector financing?
3. Is the political environment enabling/disabling for the execution of contractual arrangements in health sector? Does the political environment influence the negotiation and execution of contracts?
4. Does the bureaucratic set-up support contracting out of services to the private sector?
5. Is the legal framework robust enough to facilitate contracting between the public and private sectors.
   - Are there efficient mechanisms to recourse in the event of a dispute between the two contracting partners?
6. What are the capabilities of the purchaser (Ministry of Health) in order to successfully enter into a contract in terms of: (i) competitive bidding; (ii) awarding contracts; (iii) monitoring and supervision; (iv) regulation; (v) payment mechanisms; (vi) performance evaluation; (vii) other aspects?
7. What are the capabilities and experiences of the providers (private sector organizations) in terms of: (i) developing a proposal; (ii) technical capacity to implement; (iii) financial management capacity in order to fulfil the terms of the contracts?
8. What are the strengths and weaknesses of the purchaser (public sector) that should be taken into consideration when entering into a contractual agreement?
9. What are the strengths and weaknesses of the provider (nongovernmental organizations/private sector) that should be
taken into consideration when entering into a contractual agreement?

10. What risks and incentives does each party incur when entering into a contract?

11. What are the prevalent payment mechanisms of each contract? To what extent they promote efficiency, equity, and quality? How transparent are these?

12. Is there capacity among the public and private sector to undertake a cost and price analysis prior to negotiations?

13. What information systems/sources exist in the ministries of health in order to successfully carry out the contract and assess performance of the contracting private sector agency?

14. What monitoring mechanisms and evaluation systems are in place in the public sector and what challenges exist in this area?

Assessment of a project/programme in health that has taken up contractual arrangements as its principal implementation strategy

15. Who is the purchaser and who is the provider? When was the contract signed? What is the duration of the contract?

16. What is the type of private sector/civil society organization? When was it established/registered? What are the sources of its funding? What percent of its revenue come from the public sector? What is the major type of service it provides? What relationship does it have with the community if any?

17. What is the nature of the public sector organization/agency that is outsourcing its services? Is the financing source direct government funds or out of a donor financed project?

18. How was the civil sector organization or nongovernmental organization (CSO/NGO) selected? How transparent was the entire selection process with respect to announcement of the contractual agreement, competitive bidding, award of contract and negotiation between the purchaser and the provider?

19. How are the issues of expected service outputs, monitoring and evaluation, performance assessment, transfer of funds, settlement of disputes etc. addressed in the contractual agreement?
20. What are the types of services being given by the provider (CSO/NGO)? Has a package of services been agreed upon? Is it targeted to a specific population, vulnerable group or a geographic area?

21. How does the public sector agency monitor and/or evaluate the performance of the agency? What are the indicators agreed upon? How is information collected and to what extent is the information source independent of the provider?

22. Are there any financial or other risks/incentives built in the contract for the purchaser or the provider? How are these distributed across the purchaser and provider with respect to the terms of contract, price levels set, administrative costs, and the cost of supervision?

23. What are the administrative and transaction costs of the contract for the purchaser and the provider? Are 100% administrative and transaction costs being reimbursed?

24. What is the payment mechanism between the purchaser and the provider? Is it prospective such as subsidy, block grant, or based on performance or population coverage, or is it retrospective such as fee-for-service? Are there delays in the release of payments? What are the reasons for delay and how does the provider cope with it?

25. What are the means of financial audit of the provider and the mechanisms for addressing fiduciary issues? Have there been any such disputes between the purchaser and the provider and how were these settled?

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