



25

Partnerships between the Public Sector
and Non-governmental Organizations:
Contracting for Primary
Health Care Services

A State of the Practice Paper

Partnerships between the Public Sector and
Non-governmental Organizations: Contracting
for Primary Health
Care Services

A State of the Practice Paper

Wendy B. Abramson, MPH
Abt Associates Inc.

August 1999

This publication was produced by the Partnerships for Health Reform (PHR) project, financed by the United States Agency for International Development (USAID) under contract No. HRN-C-95-00024, in partnership with the Latin America and Caribbean Health Sector Reform Initiative, financed by USAID under contract no. HRN-5974-C-00-5024-00.

The opinions stated in this document are solely those of the author(s) and do not necessarily reflect the views of USAID.

TABLE OF CONTENTS

Acronyms	v
Acknowledgements	vii
Executive Summary.....	ix
1. Introduction: The Latin America and Caribbean Regional Health Sector Reform Initiative	1
2. Health Sector Reform and Contracting	3
3. Methodology and Selection Criteria for Case Studies	5
3.1 Methodology	5
3.2 Selection Criteria	6
4. Case Studies	11
4.1 Colombia	11
4.2 Costa Rica.....	13
4.3 Guatemala	15
4.4 Peru.....	16
4.5 Dominican Republic	17
5. Developing a Contract: Issues to Consider.....	19
5.1 Why Countries Choose to Contract.....	19
5.1.1 Why the Public Sector Contracts with NGOs.....	19
5.1.2 Why NGOs Contract with the Public Sector	20
5.2 The Political Environment and the Legal Framework	20
5.3 Contracting Capabilities	20
5.3.1 Government.....	20
5.3.2 NGO Contracting Capabilities	22
5.4 Negotiating a Contract.....	23
5.4.1 The Range of Contract Types	23
5.4.2 Interests of the Purchaser and Provider	23
5.4.3 Contract Negotiations and the Level of Decentralization.....	23
5.4.4 Analytic Framework	24
6. Lessons Learned and Conclusions	31
Annex A. Types of NGOs.....	35
Annex B. NGO Contracting Capabilities	37
Annex C. Definitions and Use of Terms	39
Annex D. Payment Mechanisms	41

Annex E. Bibliography	43
Publications of the Regional Initiative of Health Sector Reform for Latin America and the Caribbean.....	45

List of Tables

Table 1. Summary of Cases/Contracts Examined.....	6
Table 2. Characteristics of Public Sector Contracting Experiences in Selected Countries of Latin America and the Caribbean.....	8

List of Boxes

Box 1: International Contacts	5
Box 2. Illustrative Performance Indicators.....	26

ACRONYMS

CARE	Cooperative for American Relief Everywhere
CCS	<i>Caja Costarricense de Seguro Social</i>
CLAS	<i>Comites Locales de Administración de Salud</i>
COOPESALUD	<i>Cooperativa Autogestionaria de Salud</i>
EPS	<i>Entidades Promotoras de Salud</i>
IPPF	International Planned Parenthood Federation
LAC	Latin America and the Caribbean
LAC/HSR	Latin America and Caribbean Health Sector Reform
NGO	Non-governmental Organization
PAHO	Pan American Health Organization
PHC	Primary Health Care
PHR	Partnerships for Health Reform
PROFAMILIA	<i>Asociación Pro-Bienestar de la Familia, Inc.</i>
PSI	Population Services International
SESPAS	<i>Secretaría de Salud Pública y Asistencia Social</i>
SIAS	<i>Sistema Integral de Atención en Salud</i>
USAID	United States Agency for International Development

ACKNOWLEDGEMENTS

This document was written by Wendy B. Abramson of the Partnerships for Health Reform (PHR) Project, with valuable contributions from Dr. Luis Bernardo Sáenz, a consultant to PHR. The author wishes to acknowledge Dr. Marty Makinen of Abt Associates, Inc., who was responsible for technical review.

On behalf of the Latin American and Caribbean Regional Health Sector Reform Initiative and the PHR Project the author wishes to express her appreciation to those who made substantive contributions to this document. Special thanks is due to the participants from five countries who attended the regional meeting held in May 1999 in Santo Domingo, Dominican Republic, for their contributions: specifically, Ms. Magaly Caram, Executive Director of PROFAMILIA, Dominican Republic; Ms. Hedi Deman, Coordinator for Health Service Expansion and Reprogramming, Ministry of Health, Guatemala; Dr. Ricardo Díaz Romero, Specialist for Shared Management with Local Health Management Committees, Peru; Dr. Danilo Fernández, Coordinator for the Program for Management Agreements and Shared Management Coordination, Ministry of Health, Peru; Mr. Otoniel Gamboa Javier, General Manager for the Talita Kumi Foundation for Indigenous Women's Development and Education, Guatemala; Mr. Luis Jaime Guevara Delgado, Manager for Health Services, PROFAMILIA, Colombia; Dr. Ana Guzmán, Director of Health Service Contracts, Social Security Fund, Costa Rica; Dr. Luz Elena Monsalve Ríos, Program Chief, Ministry of Health, Colombia; Dr. Virgilio Rodríguez, General Director for Systems and Planning, Secretariat of Public Health and Welfare, Dominican Republic; Mr. Guillermo de la Rosa Berges, Executive Director of the National Health Institute, Dominican Republic; Mr. Francisco Villalobos Amador, General Manager of COOPESALUD, RL, Costa Rica.

EXECUTIVE SUMMARY

The cases studied in this paper are PROFAMILIA (Asociación Pro-Bienestar de la Familia, Inc.) and the Ministry of Health, Colombia; COOPESALUD (Cooperativa Autogestionaria de Salud) and the Costa Rican Social Security Fund, Costa Rica; the Talita Kumi Foundation and the Ministry of Health, Guatemala; Local Health Administration Committees and the Ministry of Health, Peru; and PROFAMILIA and the Secretariat of Public Health and Welfare, Dominican Republic.

This study has been carried out in a participatory manner. From the outset, the countries and cases involved were continually consulted regarding the accuracy of the information on their experiences.

This study is confined to the five aforementioned cases and is not intended to be exhaustive. The five are not the only instances of public agencies contracting non-governmental organizations (NGOs) for primary health care services but, rather, examples from which other countries in the region may wish to draw conclusions or lessons. The experiences reported may not necessarily lend themselves to extrapolation for other places and conditions; however, they may serve as points of reference that can contribute to contracting decisions made by governments in the region.

For the most part, the public sector chooses to contract out for primary health care services to NGOs in order to extend coverage, increase the availability of medicines and medical supplies, and improve the quality of care. In Peru and Guatemala, NGOs were contracted to provide improved quality of services and extend coverage to indigenous populations. In Costa Rica, the public sector originally contracted out to cooperatives under a strategy aimed at controlling public sector costs by shifting the risks to the cooperatives, while extending services to populations not previously covered. In Colombia, the public sector chose to contract out in order to increase efficient resource use, broaden basic services with the goal of making them universal, and promote quality assurance. In the Dominican Republic, the government is in the process of defining the reasons for contracting out to NGOs, but its major motivation is to improve the quality of care and extend coverage for reproductive health services. From the perspective of the NGOs in the five cases studied, there was a need to increase their financial resources by diversifying revenues while at the same time focusing on their social mission.

The legal framework and political environment in the countries have an enormous influence on contracting processes and their level of success. The Colombian legal framework facilitates contracting, but this is an exception to most of the cases studied, where legal and political obstacles have forced countries to find creative ways to contract with NGOs, such as contracting via projects.

In viewing public sector contracting capabilities, the study has targeted regulation, information and record-keeping systems, and the frequency of payments. With the exception of Costa Rica, the countries examined do not specify in writing who will regulate and ensure the quality of care of the provider. The issues concerning information systems, including record keeping and contract oversight and evaluation, are topics identified by the countries as areas needing improvement.

Public sector expertise and competence in purchasing services and making timely payments to NGOs have great impact upon the type of NGO with which the government will contract. For example, PROFAMILIA in Colombia has experienced delays in payments from the public sector and has had to cover operating expenses with funds from other sources. The other NGOs studied lack

large cash reserves, so arrears in government payments risk their inability to fulfill contractual commitments to beneficiaries.

As non-profit agencies with relatively informal organizational structures, NGOs have to adapt their financial and administrative systems to meet the needs and requirements of their contracting clients, in this case, the public sector. This research did not attempt an in-depth analysis of the capabilities that an NGO contractor should have, but the success of a contract is certainly dependent on the capabilities of both parties.

Costing and price estimates to determine payment levels to service providers were rarely carried out in the cases under examination. However, COOPESALUD in Costa Rica and PROFAMILIA in Colombia utilize cost estimates as an instrument to determine the level of payments required to make provision of health services cost-effective. Likewise, COOPESALUD performed cost estimates as a basis for negotiating payment for services with the public sector.

The Costa Rican and Colombian cases were used to analyze payment schemes and incentives and their inherent risks. Although no examination was carried out of the impact of payment mechanisms on service providers' performance in Costa Rica or Colombia, the risks involved in these cases are examined in this document.

Scant empirical information is available on the risks and incentives involved in contracting under each of the payment mechanisms, and their direct and indirect relationship to performance under the contracts studied here. These topics, along with the monitoring and evaluation of contracts and the cost estimates and pricing determinations, were among the topics NGO representatives identified as of importance for future study and in-depth analysis.

1. INTRODUCTION: THE LATIN AMERICA AND CARIBBEAN REGIONAL HEALTH SECTOR REFORM INITIATIVE

The Latin America and Caribbean Regional Health Sector Reform (LAC/HSR) Initiative is a five-year effort (1997–2002) to promote equitable and effective delivery of basic health services through the development of a regional support network. The LAC/HSR Initiative is a combined effort of the Pan American Health Organization (PAHO), the United States Agency for International Development (USAID), and USAID’s Partnerships for Health Reform (PHR), Data for Decision Making, and Family Planning Management Development projects. The Initiative funds regional support activities to a maximum total amount of \$10.2 million. Its target countries are Bolivia, Brazil, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, and Peru.

The LAC/HSR focuses on four key strategic areas:

- ? Development, testing, and dissemination of methodologies and tools for the analysis, design, implementation, and monitoring of national health sector reforms in order to enhance public, private and non-governmental organization (NGO) sector interaction, strengthen health finance decisions, and improve policy analysis and planning.
- ? Acquisition, processing, and dissemination of information on national health reform efforts, and making this information widely available through an electronic resource center, a series of topical bulletins, a clearinghouse on health reform papers, and an electronic network.
- ? Monitoring of reform processes and outcomes as well as equitable access to basic health services by developing and implementing tools, and disseminating information obtained to countries, donors, and other partners.
- ? Helping countries to share experiences and assistance through regional conferences and workshops, institutional linkages, a regional forum for researchers, and study tours.

Health sector reform often includes a deliberate effort to change the role of the public sector in terms of the provision, financing, purchasing, and regulation of health care. As a result, health sector reform also entails a change in the role of other organizations and institutions involved in the delivery of health services. In this context, the LAC/HSR Initiative addresses issues related to public sector–NGO partnerships (see Annex A, “Types of NGOs”). Its activities reflect the belief that these formal and informal partnerships have the potential to enhance health sector reform strategies and promote greater equity and access to services.

Some of the activities sponsored by the Initiative are geared to provide planners with more information about NGO roles and experiences in the region and to develop materials for better-informed assessments of potential NGO linkages. For NGOs, key issues relate to effects of reform on current operations and resources and the new roles implicit with reform. Initiative activities to address these issues emphasize improved management capacity for NGOs and greater familiarity with reform processes in the region.

For activities underway, four aspects of partnerships between the public sector and NGOs were identified for specific consideration: participation in health policy dialogue, the effects of

decentralization, the contracting out of services, and quality assurance activities. For each of these areas, a paper was drafted on the “State of Practice.” These papers draw on the experiences of a select group of NGOs and public sector agencies in the region; they develop a general overview of the essential issues that need to be addressed so that partnerships can benefit from further work in these four areas.

This study examines and analyses the experiences of five cases in five countries of Latin America and the Caribbean (LAC) where the public sectors contracted out primary health care services to NGOs as part of their efforts to expand access to, and improve quality and control costs of health care. The cases studied were the following:

- ? COOPESALUD (*Cooperativa Autogestionaria de Salud*) and the Costa Rican Social Security Fund (*Caja Costarricense de Seguro Social, CCSS*), Costa Rica;
- ? PROFAMILIA (*Asociación Pro-Bienestar de la Familia, Inc.*) and the Ministry of Health, Colombia;
- ? Talita Kumi Foundation and the Ministry of Health, Guatemala;
- ? Local Health Administration Committees (*Comites Locales de Administración de Salud, CLAS*) and the Ministry of Health, Peru; and
- ? PROFAMILIA and the Secretariat of Public Health and Welfare (*Secretaría de Salud Pública y Asistencia Social, SESPAS*), Dominican Republic.

2. HEALTH SECTOR REFORM AND CONTRACTING

The governments of Latin America and the Caribbean acknowledge they are facing difficulties in their attempt to meet the basic health needs of their populations. Many public systems are unable to meet demand for services and prospects for expanding public provision flounder amid lack of resources and inflexible legal constraints. Governments therefore are contracting with for-profit companies and NGOs¹ in order to increase both the coverage and quality of health care for underserved populations. For their part, the private sector organizations need to assume new service delivery responsibilities as health ministries focus less on care provision and more on purchasing services, making policy, and regulating care. Moreover, given the comparative advantages enjoyed by the NGOs—strong community ties and a tradition of providing primary health care to the poor—these organizations can play a vital role in expanding access to and improving cost-efficiency and quality of health care.

Little has been written on the experiences of LAC-region governments that contract with NGOs to provide primary health care. This document seeks to address this gap by identifying innovative efforts in the region and discussing successes and obstacles encountered in these efforts. Increasingly, there are incentives for national authorities and ministries of health to find alternative providers for health care. For example, international projects to promote health care reform, with assistance of financial institutions and technical cooperation agencies, are supporting government efforts to change their traditional methods of providing health care.

¹ For purposes of this paper, NGOs are considered non-profit organizations

3. METHODOLOGY AND SELECTION CRITERIA FOR CASE STUDIES

The LAC Initiative has sought to identify and examine those cases in which public agencies entered into performance-based contracts with NGOs to provide primary health care. The idea was to study these cases with the intent to document the lessons learned in setting up contracts. This would then serve as a point of reference for countries considering performance-based contracts with NGOs as a method to extend health coverage and improve quality of care.

3.1.1 Methodology

This case study research on public sector–NGO contracting began in July 1998. The methodology

BOX 1: INTERNATIONAL CONTACTS
<ul style="list-style-type: none">◆ World Bank◆ Inter-American Development Bank◆ Pan American Health Organization◆ U.S.-based Cooperating Agencies◆ U.S. Private Voluntary Organizations; International Planned Parenthood Federation (IPPF), Western Hemisphere Region, New York; IPPF, Guatemala; CARE, Atlanta; CARE offices in selected LAC countries; several USAID-financed LAC projects; Plan International; Academy for Educational Development; Catholic Relief Services; Medical Assistance Program International; World Vision; and Population Services International.

included a search for cases using semi-structured interviews conducted by telephone or e-mail. Two initial lists of contacts were drawn up: One consisted of national authorities in the LAC region and international researchers and experts on the topic as well as international NGO personnel (see Box 1); the other list consisted of preliminary cases to be researched.

As each person on the list was contacted, the names of additional individuals and organizations were suggested. After discussions within

the project and with USAID on which cases to study, a final list was developed. Table 1 summarizes the cases, contracts, and NGOs selected for the case study.

While similar cases to those described above could be identified, these five cases were chosen based on the willingness of both parties, the public sector and the NGOs, to collaborate with this study and collaborate with one another.

TABLE 1. SUMMARY OF CASES/CONTRACTS EXAMINED

PURCHASER AND PROVIDER	TYPE OF NGO AND SERVICES UNDER CONTRACT	YEAR ESTABLISHED	% REVENUES FROM PUBLIC SECTOR	ANNUAL NGO BUDGET	TYPE OF CONTRACT AND PAYMENT MECHANISM
Ministry of Health of Colombia – PROFAMILIA	IPPF affiliate; Reproductive health, outpatient services	1965	25-28%	US\$ 17-20 million	Service delivery. 50% fixed advance payment disbursed monthly; 50% case-based reimbursement
Costa Rican Social Security Fund – COOPESALUD	Cooperative; Primary health care, outpatient	1987	100%	US\$ 3 million	Integrated health services. Global budget calculated on basis of population and geographic area
Ministry of Health of Guatemala – Talita Kumi Foundation	Community, church; Primary health care	1991	40%	US\$ 1.2 million	Service delivery. Global budget calculated on basis of population and geographic area; budgetary transfers based on capitation
Ministry of Health of Peru – CLAS	Co-managed by community and Ministry of Health; Primary health care	1994	100%	NA	Administration/service delivery. Block grant
Secretariat of Public Health and Welfare, Dominican Republic – PROFAMILIA	IPPF affiliate Reproductive health	1966	<1%	US\$ 4.3 million	Service delivery. Subsidy

3.2 SELECTION CRITERIA

Before a case could be included in this study, a contract had to exist; that is, there had to be a legal agreement authorizing the transfer of funds from a government agency to an NGO. The contract would require the NGO to provide primary health care services directly to the end-user. It would exclude training activities; pharmacy, laundry, and food services; and leases. It would also exclude hospital services and contracts with hospitals for basic care.

The initial aim was to identify contracts that used some sort of system or method of monitoring and/or evaluating performance as opposed to agreements based on subsidies or donations. In reality, however, a wide-ranging search of the region revealed that there exist few examples of performance-based contracts (where payment is directly linked to performance). The five cases under study offer a gamut of contract modalities, ranging from those with no focus on performance (e.g., the Dominican Republic) to those with a moderate focus on performance (e.g., Costa Rica and Colombia), where contracts include performance indicators and periodic assessments.

It is important to understand the type and source of funding (donations or contracts, from national or international entities) the NGO receives and the relationship the NGO has with the community and with community organizations prior to the government's negotiation of formal agreements with the NGO. It is also important to recognize the funding mechanisms, the degree of emphasis on performance as well as the contract incentives, reporting, and presentation of data requirements, and the performance of NGO activities.

Under the LAC/HSR Initiative, PHR organized a regional meeting, held in Santo Domingo, Dominican Republic, on May 11–12, 1999. Table 2, a detailed description of the types and categories of NGO's, was produced at this meeting.

The table shows some of the characteristic variables of the contracts and the different categories that correspond to each. Contract execution and performance vary according to the combinations of features described, the impact of negotiations on service prices, and the payment mechanisms (which have built-in incentives and motivation for performance). Among the determining factors of these variables are the legal framework for each country, the political environment of each country, as well as the implicit objectives that both parties seek in establishing their contractual relations. All of these factors influence the complexity of the management systems, supervisory and evaluation requirements, and the incentives (whether or not financial risks are entailed) for both parties.

Several contracting options available to governments and NGOs are analyzed here, along with public sector and NGO capabilities, the reasons both consider contracting as a viable option, and other issues specific to the contracting process. The following questions are addressed:

- ? Why do LAC countries enter into health service contracts with NGOs? What is the interest of the NGOs in receiving public sector financing?
- ? How does the political environment and the legal framework influence the negotiation and execution of contracts?
- ? What are the capabilities that the purchaser and provider need in order to enter into a contract? What are the strengths and weaknesses of the public sector and NGOs 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 and evaluation systems are in place in these countries and what challenges exist in this area?

TABLE 2. CHARACTERISTICS OF PUBLIC SECTOR CONTRACTING EXPERIENCES IN SELECTED COUNTRIES OF LATIN AMERICA AND THE CARIBBEAN

COUNTRY AND CASE STUDIED	TYPE OF SERVICE	SELECTION MECHANISM, LENGTH OF CONTRACT	REGULATION, WHO ENFORCES, AND AT WHAT LEVEL	PAYMENT MECHANISM	FINANCIAL AND OTHER INCENTIVES FOR THE PURCHASER AND PROVIDER	LEVEL OF PERFORMANCE-BASED MEASURES	LEVEL OF EFFORT IN MANAGEMENT AND ADMINISTRATION: PURCHASER	LEVEL OF EFFORT IN MANAGEMENT AND ADMINISTRATION: PROVIDER	GEOGRAPHICAL SCOPE OF CONTRACT (E.G., NATIONAL, REGIONAL, PROVINCIAL, MUNICIPAL)	MONITORING AND EVALUATION CHARACTERISTICS
Colombia: PROFAMILIA – Ministry of Health	Educational activities on violence and sexual reproductive health; health promotion and disease prevention services; outpatient services, e.g. laboratory, mammogram, pap smear; counseling and research.	Direct: 80% Invitation 10-15% Bids 5-10%	Laws 80 and 100 on contract terms and requirements. Accreditation by contracting party.	Educational, through training and apportioned services; promotion and prevention through training; curative, as per kind and quantity of services. 50% prepaid, 50% case-based reimbursement.		Increase in coverage; better productivity; provider satisfaction; better health conditions; goals met in reasonable timeframe.	Investments in establishments and technology; achieved investment in accreditation or information systems; management of disbursements.	Resource demands, locating funding, drafting contract rules; mobilizing resources for monitoring, evaluation and control activities.	National, regional, municipal, and local.	Both quantitative and qualitative. Concerned with results and effects of processes. Monitoring and control of records.
Costa Rica: COOPESALUD – Social Security Fund	Integrated health care established by CCSS.	Selected as model project in 1987; has three-year contract and commitment for annual operations.		Per capita annual estimate and monthly disbursement.	Up to 2% of annual budget, as per contract performance.	Predetermined indicators, according to performance.	Health care service provider.	Internal reorganization needed for CCSS Fund to separate functions and steer providers toward results.	Provide services to a county in province of San José with estimated population of 80,000.	Six-month evaluation.
Guatemala: Talita Kumi Foundation – Ministry of Health	Integrated primary care with emphasis on services.	Selection criteria used for public bid selection, considers the experience and organizational, economic, infrastructure, and communications ability; sole source used in	Departmental accreditation with national approval; quality assurance; supervisory system; training plan.	Per capita for fixed population in established geographic area.	Purchaser: Improve coverage; capitalize on existing infrastructure, reduction of cost. Provider: Opportunity to meet social commitment and strengthen organization;	By service, activity, quality, and productivity.	Provided under information system.	Supervision of financial operations, resource use.		Monitoring every two months, annual contract evaluation.

COUNTRY AND CASE STUDIED	TYPE OF SERVICE	SELECTION MECHANISM, LENGTH OF CONTRACT	REGULATION, WHO ENFORCES, AND AT WHAT LEVEL	PAYMENT MECHANISM	FINANCIAL AND OTHER INCENTIVES FOR THE PURCHASER AND PROVIDER	LEVEL OF PERFORMANCE-BASED MEASURES	LEVEL OF EFFORT IN MANAGEMENT AND ADMINISTRATION: PURCHASER	LEVEL OF EFFORT IN MANAGEMENT AND ADMINISTRATION: PROVIDER	GEOGRAPHICAL SCOPE OF CONTRACT (E.G., NATIONAL, REGIONAL, PROVINCIAL, MUNICIPAL)	MONITORING AND EVALUATION CHARACTERISTICS
		most cases.			achieve financial stability; strengthen technical capacity, get government recognition.					
Peru: CLAS – Ministry of Health	Primary health care: curative and preventive services, health promotion.	Direct appointment as single provider; three-year contract with annual renewal.	Ministry of Health staff responsible for shared management program, regional health committee provides supervision.	Budget transfers take account of assigned population and provide for a package of basic services; each CLAS submits its budget.	<p>Purchaser: Reduction in administrative burden; allows concentration on planning for sector; improves coverage and access to quality services; planning based on demand.</p> <p>Provider: Operations based on transfers, use of existing infrastructure. Decisions on human resources made by Ministry of Health, contracts based on private sector rules.</p>				National scope with 700 centers and coverage for 4 million persons.	Regular reports from CLAS, indicating process and results; annual evaluation; technical and financial audits.
Dominican Republic: PROFAMILIA – SESPAS	Reproductive health services.	No selection mechanism; contracts are annual and renewable, based on global subsidies.	Project exists to develop rules, regulatory guidelines, and accreditation.	Budget receives subsidy; monthly payments.	No	No	Monthly reports are required.	Funding continues and followup is provided.	National	Nonexistent

The above questions are asked about the actual experiences of each contract studied and discussed in the case studies presented in the next section. The following section presents a technical analysis of issues to consider when establishing a contractual agreement or when analyzing a contract. It also discusses issues to be contemplated by both contract parties prior to and during contract negotiations as well as during contract implementation. Detailed information is not available on all the issues examined and future research based upon the findings may be needed or required.

4. CASE STUDIES

This section discusses the five contracts² on which this study focused.

4.1 COLOMBIA

Colombia stands out as an example of a country whose legal framework supports public sector contracting of private agencies. In fact, its experience is unique in the LAC region in terms of its open and intentional support for an open market and a culture of contracting, despite resistance from opposition groups that find contracting a threat to labor stability. As a result, a broad range of contracts between state agencies and providers—among them NGOs—can be found in the Colombian health sector. This paper looks at one contract, between the Ministry of Health in the Department of Antioquía and the NGO PROFAMILIA, the Colombian affiliate of the International Planned Parenthood Federation.

Until the early 1990s, the government social security health system in Colombia exerted a virtual monopoly over the management and provision of health services. The year 1993 saw passage of two pieces of legislation: Law 80, known as the Public Administration General Statute on Government Contracting; and Law 100, whose goals of universal coverage, improved efficiency in health care service provision, and assurance of an adequate level of quality laid the groundwork for radical reform of the public health system (Bitrán and Yip, 1998). These laws provided for government restructuring (including decentralization) particularly as it concerns health care provision. This restructuring strengthened the role of the Ministry of Health as a purchaser of health care and its role in the oversight and regulation of care at the national level. The laws also explicitly allowed for public agencies to contract out to the private sector (including NGOs) for the delivery of health services. Competition among providers, which includes public agencies, private for-profit providers, and especially NGOs, was expected to yield improvements in access to care as well as the management, efficiency, and quality of care. The Colombian Ministry of Health viewed NGO health service contracting as a cost-efficient means to boost the coverage and quality of health services.

The new social security health system entitles all Colombians to a basic benefits package and to choice of a health insurer (Bitrán and Yip, 1998). One type of insurer created, for persons with ability to pay premiums based on salary, was Health Promotion Entities (*Entidades Promotoras de Salud*, EPS). Currently, the Social Security Institute and EPSs coexist and both contract out to providers.

At the same time that this legislation was being enacted, PROFAMILIA was facing gradual reduction in donor funding and began to seek alternative sources of financing to ensure its sustainability. The new market environment in health services offered these opportunities, and PROFAMILIA began to restructure and reorganize itself and improve its physical and technological infrastructure to pursue them.

Through contracts with public and private health agencies, PROFAMILIA has been able to make up for most of the international funding that was discontinued. (Whereas in 1993 30 percent of the PROFAMILIA budget came from international grants, in 1999 only 5 percent did.) In addition to the

² The five contracts are available (in Spanish) in hard copy only, from the PHR Resource Center.

department-level contract considered by this case study, PROFAMILIA has contracts with several other government agencies, including the Ministries of Education and of Justice. Recently, PROFAMILIA signed a fee-for-service contract with the Office of the Mayor of Bogotá for the provision of family planning services; prenatal, postpartum, and postnatal care; and postpartum family planning. This diversification of funding sources has reduced PROFAMILIA's financial vulnerability.

PROFAMILIA also benefited from contracting in that it has increased its influence over the activities of purchasers. PROFAMILIA has emphasized improvements in the quality of care by modernizing its clinical technology and boosting institutional efficiency through cost reductions and rationalized spending.

The PROFAMILIA health services contract examined by this case study stipulates a mix of payment methods: 50 percent is a prospective per-capita payment based on an estimated volume of services; the other 50 percent is case-based reimbursement. The department makes the prospective payment so that PROFAMILIA can maintain a cash reserve from which to pay providers. Each month PROFAMILIA invoices the department for the balance, determined by legally established, case-based charges. (These payment mechanisms are discussed in greater detail in the section “Funding and Payment Mechanisms.”)

In addition to the prospective and retrospective payments received from the department, PROFAMILIA charges copayments to the patients it serves. The contract between the Ministry's department-level office and PROFAMILIA is a clear example of a sliding scale of charges based on the patient's income, the services provided, and the social security system under which the patient is classified. For example, the Beneficiary Identification System for Social Programs (*Sistema de Identificación de Beneficiarios de Programas Sociales*), exempts many categories of patients—indigenous populations, indigents, and children under one year of age—and services—prenatal, delivery, and postpartum care as well as treatment of related complications—from copayment requirements. Other population groups are affiliated with subsidized systems that have different copayment scales.

Not all reform efforts in Colombia have gone smoothly. For example, the extreme complexity of health care decentralization, coupled with the rapidity at which it has been implemented, has resulted in difficulties with the information systems associated with contracts. The central Ministry of Health has revised the standardized formats for recording clinical histories, but, with contracts executed by numerous agencies at different levels of government, discrepancies occur between facility records and central statistical information systems. Under decentralization, Colombia has awarded to departments and municipalities responsibility not only for providing health care services but also for collecting and maintaining certain statistical data at those levels. Before a purchaser can pay for contracted services, the health care provider must supply that purchaser the information specified in the contract. Should any question arise about the information, the purchaser “highlights” the accounts and withholds payment until the issue is resolved.

The health system established under Law 100 is also under a critical financial strain, due in part to expansion of the basic benefits package. The expenses associated with this mandated expansion of the portfolio of services offered by all health care providers has not been covered with increased financial resources for health. As a result, there are considerable delays in payments to providers.

PROFAMILIA's experience with contracting has been mixed. This section has already discussed the benefits that PROFAMILIA has realized from contracting in terms of broadening its revenue base

and imposing standards of quality. Other aspects of contracting have not always gone smoothly. In terms of the population it serves and the size of its staff, PROFAMILIA is a relatively large organization by Colombian standards. It has extensive experience in handling funding from different sources. Nevertheless, the contract discussed here leaves PROFAMILIA exposed to financial risk, whereby reimbursement for services already provided depends largely on the NGO's ability to prepare several different types of invoices, depending on which insurer the patient is affiliated with and the corresponding levels of subsidies. Its revenues also depend on government agencies paying their bills in accordance with the invoices and in a timely way. Still, its size, its diversified financial base, and its careful planning in the use of its funds has allowed PROFAMILIA to accommodate delays in government payments and cover its activities with funds from other sources or reserves.

4.2 COSTA RICA

In order to serve previously unmet health care needs of its population, the government of Costa Rica took the step to expand the availability of health care providers by contracting out with NGO-like organizations, called “cooperatives.” Its second objective was to contain public expenditures, although real constraints to expanding public sector care were more legal than financial.

The framework for contracts with cooperatives was created in 1971 in Costa Rica under Law 4750, which authorizes the Costa Rican Social Security Fund, as an independent agency, to sign contracts for projects to improve health services. In 1994, legislation was enacted to modernize the health sector. Loans from the World Bank and the Inter-American Development Bank were approved to support the allocation of resources to both public and private sector providers and the development of performance-based agreements with cooperatives, known as “*Compromisos de Gestión*.” These agreements have the status of legal contracts between a public and a private agency. In addition, the Ministry of Health and the CCSS established a model for primary care. The model clearly identifies priority health services—curative and preventive care and health promotion—to be delivered by both public and private providers. Since 1997, the *compromisos* have guided provider cooperatives in implementing the model.

The Costa Rican Ministry of Health and CCSS are institutions that traditionally have both provided and financed public sector health care. Through these contracts with cooperatives, the CCSS is separating its purchasing and provision functions. Through contracting, the provision of health care services will instead fall to different public and private providers.

As in Colombia, though for different reasons, the Costa Rican government has decided to strengthen its health care oversight and regulatory roles. This oversight includes assessing and ensuring the quality of health care provided under *compromisos*. Supervision takes place at the national level: the Ministry of Health regulates the health sector in general, and the CCSS ensures compliance with the terms of contracts to which it is a party.

Since 1987, the Costa Rican government has purchased health care services from COOPESALUD. The contract goes through the CCSS. Since 1998, the contract has taken the form of a *compromiso de gestión*. Because of the newness of the contract, it is too soon to evaluate its effectiveness; results of the first evaluation were not available at the time this study was researched.

Of the five NGOs studied, COOPESALUD demonstrates the most notable example of quality assurance mechanisms. In fact, the CCSS–COOPESALUD contract is the only one that specifies and defines the promotion of continuous improvement of the quality of care. For example, Article 6.1

of the contract stipulates that in order to ensure quality of care the provider will: “guarantee the scientific and technical quality of the services provided; incorporate clinical management; and systematically incorporate internal management controls as framework actions in the promotion of excellence in providing care; and promoting satisfaction for hospitalized clients.” And in order to “...gear services toward achieving outpatient satisfaction, the provider must conduct information and educational programs that respond to the needs and problems expressed by its clientele.” The CCSS monitors quality assurance by performing six-month assessments of COOPESALUD’s contract performance.

This case illustrates the record-keeping and information demands of public sector contracting. The CCSS stipulates in its contracts that providers will maintain their own accounting records and meet all requirements for clinical, financial, and administrative information. The formats for these systems are not defined in the body of the contract or its attachments. COOPESALUD keeps its own records on the services it provides, its financial accounts, and other information, although in a format compatible with reporting requirements of the CCSS.

Despite these information demands on the provider, in Costa Rica, it is the purchaser that bears a greater administrative burden. The purchaser must develop oversight mechanisms to accurately measure performance and progress towards contract goals. The purchaser must monitor the service volume and linkages between payment services provided. And the purchaser must withhold disbursements if it finds that contractor does not follow established protocols or meet performance targets.

The CCSS responded to these demands by creating in 1996 a new procurement unit, shifting resources from other units in the CCSS. The procurement unit is responsible for preparing, negotiating, and assessing contracts and for contracting policies to obtain services. It handles technical and administrative information used for contract management. The technical design corresponded to a new model for allocating financial resources that was put into place using credits from the World Bank.

It is this linkage between contract performance and payment that distinguishes performance-based contracts. The linkage is measured against predetermined indicators. From the cases that were reviewed, the CCSS contract with COOPESALUD contained the most detailed and fully developed indicators for gauging performance. Contract clause 7.3 states that an overall result from a six-month evaluation inferior to 90 percent of agreement targets will have a direct and proportional impact of up to a 2.5 percent reduction in the budget for the following semester.

COOPESALUD has to meet several benchmark indicators for integrated primary care provided to five population groups: children, adolescents, women, adults, and the elderly. Three kinds of indicators are defined: organizational, service provision, and quality of care. The first are set by CCSS and are compulsory and standard. The others are subject to discussion during contract negotiations. Each indicator is defined in the contract.

Of the five countries reviewed, only COOPESALUD in Costa Rica and PROFAMILIA in Colombia estimated the costs of services prior to executing a contract. COOPESALUD used an internal cost analysis to negotiate the price it would charge the government for services and to demonstrate the benefits of contracting with the cooperative. The CCSS did not do a cost-benefit comparison of COOPESALUD and other cooperatives' costs. The CCSS bases its budget on averages, and these are used to set a ceiling for per capita costs of the service contracts.

The payment mechanism used by the CCSS and COOPESALUD is based on a predetermined global sum, disbursed monthly. The cost of service to the target population is estimated on the basis of a standardized volume of the unit costs of primary care. This amount is multiplied by total target population and a global figure is obtained. To determine how much to pay its providers, COOPESALUD uses a provisional method combining elements of budgeting by historical costs and costing a package of services in order. However, size of the beneficiary population is estimated by the provider, with all the variability and potential for bias that the direct economic incentive for overestimation may introduce.

The method by which the CCSS pays COOPESALUD leads to a series of indirect effects on the market environment and the level of consumer choice among primary health care providers. The CCSS pays COOPESALUD a global amount for providing a defined package of services to an estimated population within a given geographical area. The preferences of the population are not considered at the time the estimates of service volume are made. Since in many areas the CCSS has no other service provider, the target population has little provider alternative other than the COOPESALUD provider and the for-profit private sector.

4.3 GUATEMALA

The central government and Ministry of Health in Guatemala adopted contracting to expand access to and improve the quality of health services for rural and indigenous populations, many in remote areas. The action responded to commitments in a series of peace agreements that ended Guatemala's decades-long civil war, ratified by Guatemala and four other Central American countries. Specific commitments included reducing maternal and infant mortality by half, eradicating polio, eliminating measles, and allocating 50 percent of public health expenditure to disease prevention. Because the Guatemalan Ministry of Health does not have the physical infrastructure or human resources to provide care for uncovered populations, it turned to civil society, including existing community-based NGOs, to extend coverage to the poorest sectors of society and to provide a defined package of basic health services. Currently, the Ministry of Health has 103 contracts with 67 NGOs.

The Guatemalan situation differs from those of Colombia and Costa Rica in several respects. First, in accordance with their social mission, the community-based NGOs in Guatemala have a long history of providing social services, including health services, to low-income indigenous communities. These NGOs were interested in expanding access to these populations and therefore

reacted favorably to the government proposal to use NGOs to strengthen alliances between the Ministry of Health and the community.

Second, the Ministry of Health was receptive to this approach because it was permitted under the existing legal framework; Article 24 of the 1997 Guatemalan Health Code and the Public Administration Law authorizes the Ministry to sign agreements with health sector NGOs. (The Health Code was passed as a condition for disbursement of an Inter-American Development Bank [IDB] loan.)

Finally, support from the government of Guatemala was critical to the contracting approach, especially because certain sectors, particularly medical syndicates, opposed the change.

The government pays Talita Kumi via a global budget, a fixed amount paid prospectively and based on the population in the geographic area that the NGO serves. Payments are made quarterly. To handle the NGO contracts and monitor funds, the Integrated Health Care System (*Sistema Integral de Atención en Salud*, SIAS) was created as a special unit within the Ministry of Health. SIAS receives technical and administrative support from the IDB and the United Nations Development Programme. Still, the unfamiliarity of this new contracting method and the large number of NGO contracts have made it difficult for the Ministry to make advance payments as stipulated by the contracts. Furthermore, disbursements can be withheld in the event of irregularities in the use of resources or poor productivity on the part of the NGO. Delay in payment is a problem for many NGOs, because they are small and lack a strong financial bases. Any disbursement delay impedes their operations and ability to deliver health services.

This study examined the contract between the NGO Talita Kumi Foundation and the Ministry of Health. The contract does not address delays in payments. Talita Kumi reports that in the three years it has been under contract, delays in government payments have occurred, albeit only rarely. The administrative capability of Talita Kumi has allowed it to fulfill prerequisites for payment. When there have been delays in payments, the organization has resorted to other funding sources, such as bank credits, to continue operations. Fortunately, Talita Kumi has immediate access to overdraft protection credits on its bank accounts. NGOs that do not have such financial capacity are affected more adversely; lack of funds for medical supplies and general operations could prevent them from providing services to the community.

4.4 PERU

In part because of its fiscal crisis in the 1980s and its battle against narcoterrorism, basic Peru's health statistics in the early 1990s indicated problems in health status and access to care. For example, in 1990, infant and maternal mortality rates were among the highest in the LAC region. In 1993, the government decided to confront health problems in a way similar to the one in Guatemala: with social investment to improve basic health services for the most needy population groups and to expand access to health services by underserved populations, particularly in rural areas.

There is no legal framework in Peru that enables public–private contracting. However, an executive decree authorized the Ministry of Health to create Local Health Administration Committees to co-manage local health programs with major funding from the government. CLASs resemble NGOs in their organizational structure and commitment and links to the community. Each CLAS consists of a five-to-seven-person team, half of whose membership is chosen by the community and half by the Ministry of Health. Some 530 CLAS now exist nationwide. They operate 855 primary

health establishments in 26 of the country's 34 district health offices and cover a target population of 4 million.

4.5 DOMINICAN REPUBLIC

The final contracting case studies was between the Dominican Republic's Secretariat of Public Health and Welfare and the PROFAMILIA affiliate in that country. SESPAS has identified improvement in the quality of care and extension of reproductive service coverage as its major motivation for contracting.

PROFAMILIA's reasons for seeking a formal relationship with the government are similar to those seen in Colombia and Guatemala, to diversify its resource base as a way to ensure its future financial sustainability and to increase and improve health care for the population. As in Colombia, reproductive health and family planning services in the Dominican Republic are not offered by the public sector; rather, they are offered by NGOs, including PROFAMILIA. There is a growing need for access to such services.

Much like Peru, the Dominican Republic has no legal framework to support health sector reform or contracting. SESPAS makes allocations from its annual budget in order to fund NGOs.

The Dominican Republic is now attempting to strengthen and credential health-providing NGOs. This process is part of SESPAS's supervisory role over the health system as it determines norms and regulations for health service provision. This accreditation process will address issues such as human resources, technology, infrastructure, institutional capacity, and management and will encourage steady improvement in the quality of care, efficiency, and effectiveness of NGO service providers. Through accreditation, the NGO service providers receive support to strengthen their levels of quality and efficiency. As a result they are better able to participate in competitive bidding for service contracts from SESPAS and the Dominican Social Security Institute.

5. DEVELOPING A CONTRACT: ISSUES TO CONSIDER

Before entering into a contract, both the purchaser and the provider should contemplate questions such as the following:

- ? What objectives does each party have in seeking a contract?
- ? Are the political environment and the legal framework conducive to contracting?
- ? How able is each party to meet its responsibilities, especially in terms of the complexity of the contract, be it a block grant, service contract, or performance-based contract?
- ? What is the level of risk for each party?
- ? Once decided to proceed with a contract, how do the parties go about it?

As the five contracting cases reviewed in the preceding section demonstrate, contracting is not necessarily the outcome of an orderly process, nor is there a “recipe” for government and NGO officials to follow. Rather, contracting responds to the particular needs of a country at a particular time. Nevertheless there are issues that a country’s policymakers, health authorities and providers, and NGOs should consider before negotiating and implementing a contract.

This section reviews why governments and NGOs choose to use contracts, political environments and legal frameworks that favor or hinder contracting, facilities and skills needed to succeed at contracting, and ways to go about designing a contract.

5.1 WHY COUNTRIES CHOOSE TO CONTRACT

The contracts described in this report were rooted in the national initiatives of each country’s government and civil society. The contracts were developed primarily to extend health services to underserved populations, oftentimes the socially and economically disadvantaged. More specifically, the contracts offered alternative ways to provide health services that were not being supplied by the public sector for political reasons, lack of financing, or lack of technical skills.

5.1.1 Why the Public Sector Contracts with NGOs

Governments have many reasons for contracting with NGOs: the need to extend basic services to underserved sectors of the population, improve the quality of care, control costs, improve the efficiency of the public health system, and reduce public expenditure. Contracting allows the public sector to avoid problems encountered with traditional public service arrangements, often faulted for inflexible human resource management and rarely amenable to performance-based incentives. Contracting can be used to link new incentives to the performance of the purchaser and the provider in order to ensure that health services are provided to the greatest population in the most cost-effective way possible.

When the public sector considers its options for health service delivery, including the option of contracting out to the private sector (for-profit or not-for-profit), ideally it will compare the costs of each option. It should also compare the quality of the services offered by each provider and the ability of each to reach the target populations. As a cost cutting strategy, some health systems are shifting from single providers to free markets, which foster competition among providers and increase efficiency in the use of resources.

Peru and Guatemala have large native indigenous populations who are culturally and ethnically diverse and who live in remote areas with little access to health care. The respective governments thus contracted CLASs and NGOs primarily to expand access and improve the quality of care. In Costa Rica, the government contracts out to cooperatives to extend coverage and to contain public sector costs. The Colombian government has multiple motivations: efficient use of public funds, expanded coverage, and improved quality of care. However, unlike in Costa Rica, the government in Colombia introduced consumer choice and free competition among providers in order to achieve the same goals. Other governments in the LAC region may wish to use the examples of Costa Rica and Colombia as they consider contracting as a means to cut health care costs. A later section of this report, on incentives, will further explore the issues of free competition and consumer choice.

5.1.2 Why NGOs Contract with the Public Sector

This study found that NGOs enter into contracts for three reasons: to fulfill a social mission, to sustain themselves financially, and to gain recognition from the government. An individual contract may allow an NGO to realize one or more of these motivations.

As seen above, Talita Kumi entered into a contract with the Guatemalan Ministry of Health primarily to strengthen its ties with indigenous communities and fulfill its social mission of providing services to underserved populations. In contrast, the primary motivation of PROFAMILIA in Colombia was to diversify its funding base and thus ensure its financial sustainability in light of reduced donor funding. All the NGOs benefited from the formal government recognition that a contract bestowed upon their organization.

5.2 THE POLITICAL ENVIRONMENT AND THE LEGAL FRAMEWORK

With the exception of Colombia, the countries in this study face political and legal barriers to contracting and have had to develop plans and find alternative ways to carry them out. In most LAC countries, the legal framework is not geared to public contracts, and in some cases it appears to be obsolete and does not lend itself well to responding to health problems.

5.3 CONTRACTING CAPABILITIES

5.3.1 Government

Ministries of health in Latin America and the Caribbean are beginning to reorient their functions, from one of direct health care provision to one of financing, purchasing, and regulating care in order to increase coverage, quality, and efficiency of care. To carry out these new responsibilities, the public

sector needs to develop internal structures that will formally separate financing, purchasing, and service provision functions.

It is important not to lose sight of the pressure created for both contracting parties when these functions are separated and responsibility for purchasing services is added. This is why strengthening the management skills (health, administration, and finance) and health information systems of both purchasers and alternative providers is indispensable (Bennett 1997, Mills 1997, Sojo 1999).

Regulation and Quality Assurance

The evolution in the role of ministries of health makes health sector regulation a major public sector responsibility. Three areas are key to this regulatory function: accreditation, enforcement of national treatment standards for health care providers, and quality assurance activities to ensure a certain level of care.

Establishing a process of accreditation for health care facilities is one of the first steps that governments take after deciding to contract services. Accreditation specifies the basic requirements that a health care provider (in this case, an NGO) must meet in order to be considered for a contract. Requirements may vary depending on the type of contract. For example, a performance-based contract may require that the NGO have a specific type of financial system, that it follow certain clinical protocols for the health services planned, that it maintain a given ratio of physicians to nurses or nurse's aides, or that it have certain basic equipment or infrastructure.

Regulation also implies the oversight or supervisory function that the public sector takes in enforcing provider compliance with national health care standards and treatment protocols.

The third component is quality assurance. Quality assurance consists of several activities intended to set requirements for service provider performance and to supervise compliance thereof, in order to make the care given the most effective and safest possible (Bouchet and Abramson 1998).

In the contracting process, once the government has determined the requirements that the NGO must meet to qualify for consideration as a contractor, it will evaluate which areas of the health care to be provided it needs to regulate and how it will do so. As the governments in Latin America and the Caribbean begin to accord greater importance to their regulatory roles in the health sector, they will better appreciate their ability to supervise contracts as a regulatory function.

Participants at the May 1999 LAC regional workshop stressed the need for their countries to develop policies for quality assurance in relation to monitoring national standards and improving performance of service providers. However, with the exception of Costa Rica, none of the contracts analyzed here address these three types of regulation or the definition used in this paper for quality assurance. They specify neither mechanisms to enforce quality standards nor indicators to measure compliance. Given that improved quality is one of the major reasons for contracting out, an in-depth examination of the experience in Costa Rica is recommended in order to appreciate how to incorporate quality assurance measures in the body of a contract.

Information Systems and Record Keeping

Appropriate information systems are critical to the success of an integrated contracting process. On the purchasing side, they reinforce to the purchaser that it must first have in order its own administrative structures, procedures, and mechanisms that are needed for contracting. In the case of health care contracting, relevant information would include the public health services provided, the quality of those services, the personnel and materials used in providing the services, as well as the costs of public and private health care. By demonstrating to the government the cost and quality of public health services, information systems allow it to decide which services to contract out. Once a contract is in place, information systems enable flexible and appropriate contract supervision. For example, they provide the patient records that help the purchaser to review the quality of care delivered; they also review and process contractor invoices. Bennett and Mills (1998) describe the essential requirements for an information system that will assist in decision making on awarding contracts and the supervision thereof.

Both public sector and NGO participants in the LAC regional meeting identified the use of information systems in monitoring and evaluation as an area for improvement. Whereas ministries of health keep records on epidemiological and administrative information, few countries have created the formats and records needed to monitor NGO contract compliance. This is an area that warrants further investigation and is recommended for future technical assistance or training.

Payment

The ability of the public sector to purchase services and pay bills must be considered in the contracting process. This is important for both the public agency that is choosing NGOs for government contracts and for the NGOs that are committing themselves to a contract.

Many NGOs with government contracts depend on timely payment for their financial survival. While many health care NGOs charge a user fee to patients, others do not, and, in any case, the fees alone are not sufficient to support an NGO for an extended period of time. Thus, a significant delay in payment from the government can have a deleterious effect on an NGO's cash flow and prevent it from carrying out the services to which it is committed by contract. An important consideration when deciding on a public sector contract is the degree to which the contracts and the contractors will be affected should the government fail to do its part to ensure proper handling of payments (Smith and Lipsky 1993).

The case studies in the preceding section discussed two instances of delayed payment: The large PROFAMILIA in Colombia has survived several delays in payment thanks to its diversified revenue sources. Most NGOs, particularly the smaller ones in terms of human and financial resources such as Guatemala's Talita Kumi, lack the financial reserves that come from diversified funding, but they survive thanks to relationships with the financial community, that allow, for instance, bank credits.

5.3.2 NGO Contracting Capabilities

As mentioned earlier in this paper and in the individual case study discussions, contracting often requires an NGO to professionalize or in some specific respect change its management, financial, and monitoring systems. This often requires an NGO to upgrade its information system. While a detailed

examination of this issue was not in the scope of this study, the issue is certainly relevant and thus given additional treatment in Annex B.

5.4 NEGOTIATING A CONTRACT

Once the public sector and NGOs decide that they indeed have the interest in and the capabilities to pursue contracting, they must consider the ways to go about designing a contract.

5.4.1 The Range of Contract Types

There are many types of contracts and contract elements, including budget subsidies and block grants, for the consideration of purchasers and providers. Along a continuum of contracting options, the British system would be situated at one extreme and the U.S. system at the other. In Great Britain, the public sector contracts internally, within the public health system. The British National Health Service contracts general practitioners who act as “gatekeepers” to the health system on behalf of beneficiaries (patients). In the United States, the government purchases a large portion of “public” health services from private sector providers, both for-profit and not-for-profit; the two largest programs for are Medicaid and Medicare.

5.4.2 Interests of the Purchaser and Provider

Specific goals and objectives of both parties, purchaser and provider, are discussed during contract negotiations. The discussion can become complicated given that, as noted by Brinkerhoff (1999), a broad range of interests exists among many actors, including national governments, international donors, international NGOs, and local NGOs, all of which have different agendas. Another factor to be considered in negotiations is the total unit cost of services to be contracted. Both parties need to determine for themselves the costs of these services prior to discussing them in order to consider whether from an economic standpoint it makes sense to contract for them and, if so, at what price.

5.4.3 Contract Negotiations and the Level of Decentralization

Even though contracting under a decentralized health system is not the subject of this study, the degree to which and the way in which a country and, in particular, its health system is decentralized (e.g., delegation of authority, decentralized functions, devolution of assets) affect both the contract process and outcomes.

Will contract negotiations take place at the central or federal level of government, or is negotiating authority delegated even further down to the local level? Are there rigid national rules under which contracts must negotiated?; a flexible national framework that allows for some local adaptation?; or are contracts negotiated purely on the basis of the local needs and setting? Complete decentralization—with no standard format determined at the central level but rather all responsibility and authority over human resources and funds under local control—would lead to disparate kinds of contracts and create a situation under which the national health system would be difficult to monitor.

On the other hand, some local authority input is valuable. Partnerships can be formed more easily and operate more efficiently if decentralized relations support and promote local autonomy and decision making (Brinkerhoff 1999). Ideally, under a federal framework, the contract negotiations will take place at the local level, rather than have the local level simply implement a federal level agreement, a process that may impose a rigid work style. The special features of each locality and provider should be taken into account so that the formal contract agreement can be as successful as possible.

5.4.4 Analytic Framework

Many other issues need to be studied before reaching a contractual agreement. They include issues such as how results-oriented the contract is, what gains in health outcomes are expected, how flexible the purchaser is, what kinds of incentives are in place, and how well integrated those incentives are into the contract. Still other issues to consider are accounting and invoicing procedures; determination of costs, including administrative costs; and information systems.

The purchaser's decisions to open a public bidding process, to contract a non-profit or for-profit company, or a public or private group, will shape the negotiation process. The proposals for most competitive contracts will include performance goals. In the Latin America and Caribbean region, relatively few NGO health service contracts have been subject to competitive bidding. None of the contracts in the five cases examined here were awarded through such a process.

The following issues should be considered prior to negotiations: administrative costs; monitoring and evaluation; performance-based costs, as well as related payment mechanisms and incentives; and costing and pricing of services.

Administrative or Transaction Costs

Administrative or transaction costs are the costs of contract management and supervision. In order to improve efficiency, often an objective of contracting, each side must make sure that each contract component offers maximum added value; thus, every attempt should be made to minimize administrative costs. Equilibrium must be sought between greater added value in service and cost control in administration. Contracts in which payments are closely linked to contractor performance tend to incur higher administrative costs than outright subsidies or block grants; however, they contain mechanisms that ensure greater efficiency and higher quality in the long term. Likewise, appropriate record-keeping systems may necessitate start-up expenditures, but in the long term they will facilitate contract management that will benefit both parties to the contract.

It is helpful to structure contracts so that the provider must assume all unjustified administrative expenses. This means that not all administrative costs are not automatically reimbursed; rather, contract negotiations allocate a fixed amount, or ceiling, for administration. Containing total costs below the ceiling results in net savings for the provider; conversely, should these costs exceed the ceiling, the provider must cover them out of pocket. This offers the provider a powerful incentive to control costs.

This study does not cover this issue in depth, because none of the five contracts investigated specified the provider's administrative costs; nor did any reflect administrative costs under a budget

category.

Monitoring and Evaluation Systems

The complexity of the monitoring and evaluation systems of both parties to the contract is an important factor to consider when discussing what type of contract is best suited to the circumstances. Performance indicators included under the terms and conditions of the contract act to ensure the providers' responsibilities to the purchaser. Ideally, the indicators will be straightforward and easy to draft.

In order for the purchaser to adequately supervise a performance-based contract, it is important that the contract require the provider to have an information system that generates administrative and financial as well as health care data. Cost data is essential to the financial side, and health care data should include information on coverage and quality of services, so that the purchaser can monitor service provision.

In performance-based contracts, the provider should complete medical forms to record case data for nationally regulated clinical protocols and for the indicators used to determine contractor performance. Generally, certain standards are agreed to, along with indicators for procedures and outcomes, as well as incentives to encourage the supply of appropriate information to the purchaser. The inclusion in a contract of regular NGO performance evaluations will help to set performance goals and measure them against national standards. As a rule of thumb, the more demanding the monitoring requirements are the greater the administrative costs will be.

The cases studied show a broad range of experiences in supervision and evaluation among public sector purchasers and NGO providers. The Colombian and Costa Rican contracts demonstrated that both the public sector purchaser and the care provider had made efforts to adopt consistent information systems.

Performance-based Contracts

As relations between the public and private sectors become more formally structured, there is a greater need to link health service expenditures to performance objectives. Performance-based contracts define specific results that, ideally, will reflect the health objectives of the public sector. In order to gauge results, these contracts should include a variety of indicators to measure areas such as coverage, quality, and efficiency.

BOX 2. ILLUSTRATIVE PERFORMANCE INDICATORS

- ◆ Volume of services: availability of services, coverage
- ◆ Quality of services: end-user surveys to gauge customer satisfaction, medication errors, staff rotation, absenteeism, waiting time for patient admission, percentage of cases referred to higher-level health facilities
- ◆ Financial measurements: cash flow, expenses versus revenues

Indicators intended to measure performance are set out under the terms of the contract itself. Box 2 lists performance indicators that can be used to supervise the performance of primary health care units and hospital outpatient services.

This type of contract places the greater degree of risk on the provider, which is held accountable for its own performance, with payments linked directly to results. The provider assumes the greater administrative

burden, because it must monitor and maintain all the information that it receives on the services provided, the quality of those services, and the cost of the services.

After deciding whether to contract for health services, public sector decision makers will have to determine which contract option to employ and the type of payment structure that will work best in the specific circumstances. It is essential for the sake of the contract that its design, management requirements, and payment methods be defined before an agreement is reached, so that appropriate incentives for good performance can be included.

Costing and Pricing Services

It is in the purchaser's interest to know the costs of service delivery in order to determine the benefits from contracting services out to the private sector. It is in both the purchaser's and the provider's interests to know these costs, so that the costs are appropriately priced in the contract.

*Determining costs*³: Before agreeing on the price of services that the provider will charge the purchaser, each party should estimate the unit cost of each service to be provided under the contract. The government should estimate the number of services to be offered on the basis of an analysis of demand and of the needs of the population covered under the contract. In determining the unit costs for the services to be provided under contract, the NGO should determine whether these services would receive a cross subsidy.

The provider needs to ensure that it can cover its costs under the contract. It has no obligation to share its cost estimates with the purchaser. In fact, this information can be a useful negotiation tool if used discreetly. Sharing contractor costs with the purchaser only serves to inform the purchaser of what the provider's margins of return will be.

Setting prices: Unless some sort of block grant arrangement is chosen, provider prices will be specified under the terms of the contract. Pricing options could include payment exemptions for the target population(s), setting user fees according to a sliding scale, and other types of subsidies. Under an insurance system or a subsidized arrangement for public sector employees who are not charged for services, pricing will vary. There is a gamut of pricing options, ranging from free market supply and demand (using cost recovery mechanisms) to exemption policies whereby services are provided free of charge.

³ The terms "cost," "price," "payment," "rate," and "charge," which appear in this section are defined in Annex C.

In the cases examined in this study, providers do not estimate in a systematic way the costs and prices used to determine what they are paid under the contract. COOPESALUD in Costa Rica did conduct cost estimates as an input to its contract negotiations. Additionally, COOPESALUD and PROFAMILIA in Colombia used cost estimates to determine the payment level required to provide health services at feasible rates. But the estimates were not arrived at systematically. The research in this particular area and the discussion held with representatives of governments and NGOs show a clear need by the purchaser and provider to consider costs and their role in determining payment under the contract.

Incentives

All contracts contain financial and non-financial incentives. In contracting services, the government/purchaser is distributing risk and responsibility between itself and the contractor/provider (Walsh 1995). The contract terms, the price levels set, administrative costs, and the costs of supervision determine the risk distribution. The higher the risk, the higher the compensation that the provider will, presumably, seek.

Non-financial risk for the purchaser refers to whether the results sought, contracted, and paid for are actually obtained; that is, whether the provider supplies the goods and services agreed upon in the contract.

The distribution of financial risk between the purchaser and the provider will determine how costs of services will be covered. Financial risk involves the prospect that the actual cost of services provided will exceed the amount of funds available. Such risk can be mitigated in several ways, such as through copayments or by limiting coverage to a defined package of services with ceilings on expenditures or the number of visits. Should a provider underestimate the cost of services, financial risk will result, in that the provider may not be reimbursed for all costs it incurs; conversely, if the cost of services provided does not reach the level estimated, the provider's risk will decrease, in that the payment it receives under the contract may exceed its costs. Each payment mechanism has a varying distribution of risk between the purchaser and contractor.

The following section briefly covers some of the payment mechanisms available to both parties and their corresponding incentives. For example, a fee-for-service scheme charges set rates for different services; providers receive this rate for each service rendered, and it is the purchaser who assumes the greater share of financial risk. Under a prospective payment system such as capitation, which pays the provider a set amount per person enrolled in the health plan—regardless of the number of services rendered—financial risk is transferred to the provider. Risk can be shared by the provider and purchaser, such as with case-based payment, which pays a fixed payment for all services related a specified case or illness. The section considers the Costa Rican and Colombian cases in particular, and how their payment schemes could affect behavior by presenting specific positive and negative incentives.

Funding and Payment Mechanisms

Many economists and managers contend that health system performance is linked more closely to the method of resource allocation (how health care providers are paid) than to the overall budget. Purchasers can pay for services in a variety of ways, individually or in combination: by case, day, person, year, or type of service (Wouters 1998). Each payment mechanism has a corresponding set of

positive and negative incentives resulting in specific behavior by the provider in terms of the type, quality, and quantity of service provided. With health sector reforms and innovations that diversify the care provided, reformers in the public health sector will need to consider carefully the incentives that influence providers (Wouters 1998, Bennett 1998).

Annex D describes four of the main payment methods for health services. In defining these methods, it is important to identify when the payment terms are determined. When the price of a package of services is negotiated before service is rendered, the method is called “prospective payment.” One prospective payment method is capitation, another is global budgeting. Prospective payments act as an incentive to the provider, who assumes greater financial risk, to employ greater efficiency. When payment is determined during or after the time in which the service is provided, it is considered a “retrospective payment” or “cost-based reimbursement.” Fee for service is one the most common kinds of retrospective payments (Maceira 1998). Additional information on payment mechanisms and incentives is found in the Partnerships for Health Reform primer for policymakers, *Alternative Provider Payment Methods: Incentives for Improving Health Care Delivery* (Wouters 1999).

This section looks at the payment mechanisms employed in the Costa Rican and Colombian contracts, the positive and negative incentives inherent in each, and the theoretical effects of these mechanisms on efficiency, quality of care, and access to services. The payment mechanism used in the COOPESALUD contract in Costa Rica is a global budget; the PROFAMILIA contract in Colombia uses case-based payment. Neither case study was able to compare theoretical incentives and risks to actual experience; to date no evaluation of the linkage between a particular payment mechanism and actual efficiency and quality of care has been carried out.

In the case of Costa Rica, global payments based on population estimates for a geographical area may promote two kinds of incentives. The first concerns efficiency. Because such payments are not linked to volume or level of care actually provided, they encourage efficiency—services provided at the least possible cost, with the least possible waste of resources—assuming the provider can keep any savings realized. A second, related incentive is encouragement to conduct health promotion and disease prevention activities associated with primary care. This allows a provider to treat illnesses at an earlier, minimally appropriate level of care, thus preventing complications and need for referrals to higher levels of care—and thereby controlling costs.

However, a global payment mechanism may undermine the quality of care. First, because the provider receives payment regardless of the number or level of services delivered, there is an incentive to undertreat patients. And, perceiving a lack of quality, the population may cease to solicit needed health care.

In order to mitigate some of these negative incentives, the purchaser could concentrate its contract monitoring and evaluation on the volume of services provided (i.e., service coverage), the population that actually requests services as opposed to the target population, the quantity of primary level care or services provided in conjunction with health promotion, the reduction of negative risks, and the quality of care itself.

In the case of the PROFAMILIA contract in Colombia, the NGO is advanced a fixed amount per person covered or reimbursed a fixed amount for each case attended. As in the case of global budgeting, both positive and negative incentives may result from case-based payment, though the incentives are not necessarily the same as in global budgeting. Because the provider is paid per person or per case treated, it is in the provider’s interest to compete for clients, in part by offering high

quality services that attract as many patients as possible. These patients may come from another provider or from among the previously underserved, thus expanding access to health services and broadening coverage for the population.

Because case-based payment is fixed per case, this mechanism, similar to global budgeting, encourages efficient use of resources. However, here too the incentive to minimize costs runs the risk of less-than-effective treatment of a given case, because the providers may fail to provide all the procedures associated with a particular diagnosis. Obviously, such an incentive can have a negative impact on the care that the patient receives.

Overall, case-based payment incentives for quality and efficiency encourage a provider to emphasize health promotion, reproductive health, and disease prevention activities. The case-based disincentive to provide follow-up care for certain conditions, such as postoperative care, may be anticipated and a contract provision made for including follow-up care at no additional cost to the patient. Higher-risk—and thus more costly—cases are more likely to be identified and referred to a higher level of care in a timely manner. Ultimately, long-term costs are better contained.

As in the case of the global budget example of Costa Rica's COOPESALUD, the Colombian Ministry of Health could mitigate risks and, under a performance-based contract, reward good performance through the design and implementation of a monitoring and evaluation system. Under the per-case payment contract, the purchaser would monitor observance of the treatment protocols stipulated in the contract in order to ensure quality of care and referrals to more complex care levels. In contrast to Costa Rica's global payment method, Colombia would have no need to compare caseload to the targeted case volume because the per-case payments encourage a larger volume of patients to be seen. Another measure the purchaser should be encouraged to consider for its contracts is a requirement that the patient sign a document after receiving each service under the treatment protocol. For example, after a hysterectomy, the patient would sign a document a week after the surgery indicating that she had received the complete range of care, from preoperative planning to postoperative control.

In summary, although these case studies were not able to explore and confirm certain assumptions about human behavior in relation to payment mechanisms and corresponding risks and incentives, it is safe to infer that negative risks decline when the provider is a non-profit organization, such as an NGO (see Annex A). An NGO's mission embraces the provision of high-quality care and minimizes the profit incentive. Conversely, when the contractor is a for-profit organization, the risks increase, particularly in relation to the quality of care and access to services.

In Costa Rica, several types of incentives could be promoted in relation to the global payment method based on an estimated population in a given geographical area. Incentives exist to use resources efficiently and to provide the most appropriate level of treatment, encourage health promotion, and contain costs. However, there may exist an incentive to economize resources to the detriment of treatment appropriate or necessary to resolve a particular case; in other words, the quality of care is at risk. The Colombian contract would, in theory, tend to provide more positive incentives for efficiency and effectiveness in treatment.

6. LESSONS LEARNED AND CONCLUSIONS

This case study has described and analyzed government–NGO contracts for health care provision in five Latin America and Caribbean region countries. The study selected the cases based on the willingness of contracting parties to collaborate on this project and on their experiences in contracting. As such, the study is an initial attempt to consolidate the experiences in the region. It does not pretend to exhaust the range of contracting experiences of health care NGOs in the LAC region.

Nor does it pretend to prescribe strict guidelines for contracting of health care in the region. Although the NGOs share certain experiences—especially identification of projects as a complement to national legislation and difficulties in the monitoring and evaluation of performance under a contract—there are also several points at which their experiences diverge. Even though contracts are in place, purchaser and provider continue in a learning process as they transition to a more sophisticated level of contracting. Therefore, comparisons between one country’s contract and another must be carried out with caution. The cases should not be considered as models that can be reproduced in their entirety under other social and political conditions. Rather, they offer an opportunity to study various aspects of the contracts currently in existence, and the countries themselves can learn much about the achievements and challenges they may soon be facing.

For example, this study looked at reasons for contracting. In some cases, namely Guatemala and Peru, problems in access and quality of care for low-income and underserved populations motivated the governments to contract out service provision; contracting allowed the NGOs to fulfill their social service mission. In Colombia, the government responded to the need to expand access to services and to restructure the health system as dictated by new legislation; the main motivation for PROFAMILIA was to ensure its financial sustainability by diversifying its sources of income.

As the cases show, many contract variables, alone and in combination, directly affect contract implementation and outcomes. The variables include regularity of payment, amount of payment (determined by costing and pricing of services), method of payment and its corresponding incentives for performance, focus on performance and complexity of the monitoring and evaluation system, administrative requirements such as the burden of invoicing, and the range of services provided. Before a contract can begin implementation, each party may have to adopt for itself new organizational systems: administrative and management systems, supervision and evaluation systems, financial systems, and information systems.

The cases also show how a country’s political environment and legal framework, especially contract law, are among the most influential factors in the success of contract negotiations and execution. In countries such as Colombia, where the legal framework allows public–private contracting, such arrangements have been undertaken with relative ease. In countries where the policy environment hinders contracting, the parties have had to find more creative means to design and execute projects under contract-like arrangements.

Related to the broader political and legal environment is the more specific health care reform environment in which contracting is occurring. As noted in the case studies, ministries of health in some countries are shifting from their traditional focus on health care provision to one of care purchasing and regulation; in some countries traditional central level authority is decentralizing to

district and subdistrict levels. These shifting responsibilities and relationships are changing the types of contracts being executed.

The effect of efforts to decentralize health systems were seen to influence several contracts in this study: In Guatemala and Costa Rica, an official of a federal agency signed the contracts, whereas in Peru and Colombia purchasing took place at the departmental or regional levels. The effect of contract negotiation, implementation, and monitoring by decentralized government agencies is an important topic for future investigation.

None of the cases examined used competitive bidding to award contracts. However, the Dominican Republic is in the process of designing a contracting process that would provide for competitive public bidding.

Nor are any of the contracts studied true performance-based contracts, whereby the provider is rewarded for excellent performance and exceeding contract goals, or penalized (usually by withholding payment) for failure to comply with the agreement. Colombia's contract with PROFAMILIA and Costa Rica's with COOPESALUD come closest to this type of arrangement. However, actual contract payments that were examined by this study did not find them linked to provider performance. (At the time of this study, Costa Rica had not yet released the results of the *compromiso de gestion* that took effect in 1998.)

The scope of work for this study did not include gathering information that would indicate what portion of public expenditure is budgeted for contracting. However, based upon study research, conversations with government representatives, and the relatively short experience working with contracts, it is possible to say that NGO contracts for health services at this time represent a very small portion of overall public expenditure. If, however, the substantial level of interest in contracting that the governments of the LAC region have demonstrated is any indication of future trends, one could well expect the level and volume of these contracts to increase.

Study research and particularly the government officials and NGO representatives who attended the LAC regional meeting identified three skills that they need to improve in order to facilitate the expected increase in contracting: cost estimation and price setting; integrating monitoring and evaluation systems (particularly for performance measurement) into contracts; and analysis of the incentives and risks corresponding to each payment mechanism.

It is important for each contracting party to estimate as accurately as possible the costs of providing services, so that contracts will be financially sustainable and yield the maximum possible benefit to both sides.

Meeting participants were unanimous in identifying their need for knowledge about creating new information systems and strengthening existing systems in order to monitor and evaluate financial performance and other contract activities. Specific questions asked by participants included: What information systems are needed in order to execute the contracts? What monitoring and evaluation systems do the countries have in place and what challenges are present in relation to their effective use? Of all the cases examined, only the COOPESALUD contract in Costa Rica specifies performance indicators and is monitored and evaluated against those indicators. The five countries all deserve acknowledgment for their keen interest in development of information systems as input into decision making.

Little information exists on the risks and incentives related to contracting, yet it is essential to understand which contracting party bears the greater risk, the degree of risk, and the incentives

inherent in each type of contract. To do this, payment methods and their related incentives and risks must be understood prior to entering into a contract. Risk analysis may focus on incentives for an organization (government agency or NGO) as a whole or on incentives for individual staff members within the organization, and on financial or non-financial incentives. Although this study looked at the incentives inherent in the Costa Rican and Colombian contracts, no empirical data on risks and incentives were gathered. Further research in this area would act to test the hypotheses and assumptions presented around this issue.

A first step toward addressing these knowledge gaps would be to promote exchanges of information among the countries. Participants at the LAC regional meeting lauded that opportunity to discuss and learn about their respective contracting processes. Along these lines, it may be beneficial for LAC officials to meet with counterparts from other regions to learn about the tools and techniques being used with a view toward adapting them to their own needs.

Finally, one cannot emphasize enough the importance of examining in advance the range of contracting responsibilities and the abilities of the private sector and NGOs to enter into a contract. One should not assume that health policies favorable to contracting will automatically yield good results. During the regional meeting, it was notable that the representatives of the government agencies and the NGOs joined in asserting the need for both parties to have many years of preparation and institutional strengthening in order to ensure the prospects for a successful contracting experience.

ANNEX A. TYPES OF NGOS

The NGOs in Latin America and the Caribbean differ from those in the United States or other “developed” countries given the considerable dependence of Latin American NGOs on international assistance. Of the five cases studied, all receive some type of funding or direct support, perhaps technical assistance, from international or foreign agencies for their operations.

The purchaser of health services should become familiar with the sources and types of funding (both international and local) that their potential NGO contractor receives, as well as the NGO’s mission. For example, an organization whose funding is from an international source, whether in the form of grants or contracts, will have to maintain special accounting systems to use its funds and meet its activities’ reporting requirements. An organization that does not receive those funds may have greater autonomy to execute tasks and report on them.

The following NGOs or NGO-like entities were studied for this report.

- ? The Local Health Management Committees in **Peru** function much like an NGO, whereby management is shared between the community and the Ministry of Health providers, but the financing comes from the government.
- ? Cooperatives, such as COOPESALUD in **Costa Rica**, are established to act as an NGO, but are the property of the employees and are employee-managed. Cooperatives are very common in the region of Latin America and the Caribbean.
- ? Communities or churches generally fund community-based NGOs, such as those seen in **Guatemala**. The Talita Kumi Foundation is an NGO that generates revenues through production. A broad range of NGOs also receives funding (or grants) from international agencies in order to fulfill their social mission.
- ? PROFAMILIA in **Colombia** and PROFAMILIA in the **Dominican Republic**, both IPPF affiliates, are NGOs whose major funding has traditionally been from international grants. These two NGOs are at different stages along the road to financial sustainability. Today only 5 percent of the funding for PROFAMILIA in Colombia comes from the IPPF.

ANNEX B. NGO CONTRACTING CAPABILITIES

Many non-governmental organizations are seeking out contracts with in-country public agencies in an effort to diversify their funding bases and thus ensure financial sustainability. NGOs that enter into health service contracts with a government purchaser generally face a number of challenges in responding to the demands of the new client. In order to judge an NGO's ability to successfully implement a contract, both parties should consider an NGO's existing organizational structure, operational systems, and internal culture.

The organizational structure of most NGOs is quite distinct from that of most government bureaucracies. They often use different accounting, financial, and technical systems. It is likely that an NGO will have to modify and/or strengthen some of its management systems and institutional capabilities in order to succeed in a contract. Information systems and monitoring mechanisms are usually good places to start.

The NGO may be faced with a need to expand the range of services it offers and even alter its service delivery protocols and cultural patterns in order to meet government norms and standards. In addition, the NGO may have to adjust or create from scratch reliable management information and record-keeping systems, including cost accounting systems and the mechanisms they entail. The NGO will have to determine the internal costs of services that it will provide under government contract, breaking out fixed and variable costs. In many situations, an NGO may not have sophisticated cost estimates and cost recovery mechanisms in place. It may fail to take into account depreciation of vehicles and equipment, staff incentives, inflationary factors, or the need to prorate administrative and other costs under their program operations.

Many NGOs in the United States have shifted toward results-oriented performance, whereas NGOs in developing countries continue to struggle with the organizational changes and combination of new skills and techniques required to operate under government contract. Many NGOs are not accustomed to a donor imposing conditions upon them. An NGO that is working for the first time under a performance-based contract faces the challenge of having to fulfill conditions in order to receive payment, all the while continuing to function as an organization using the systems and patterns traditionally in place.

Developing an appreciation of market-oriented funding plays a major role in an NGO's transition toward more diversified sources of funding. As its resource base grows, the organization will frequently find that a greater share of its resources depend directly on its performance; thus, it is charging for services that at one time it may have offered free of charge.

In the worst of cases, the NGO's social mission may be compromised by its shift toward a market-oriented financial structure. J. Gregory Dees has observed that as an NGO takes a more market-driven approach to its finances, its commercialization may place its social mission at risk (1998). This situation is most likely to occur when an organization that has long depended on philanthropic contributions, international grants, or charitable institutions for its funding enters into a formal contract with either a private sector company or a government agency. Once the NGO has committed itself to the terms and conditions of such a contract, its funding will be conditioned on compliance with these terms. However, as long as the ultimate beneficiaries under a government service contract are the same population toward whom the NGO's social mission is geared, then notwithstanding changes in work style, the organization can successfully sustain its mission while

receiving government funding. The challenge for the organization is to find a diversity of funding sources that favor both its mission and its financial sustainability.

Whatever other interests the public sector and an NGO have, a health service contract makes them parties to a relationship in which one agency is the purchaser and the other is the contractor. In studying this kind of arrangement, it is important to appreciate both points of view and be aware of areas of convergence as well as areas of divergence. Both the government agency and the NGO want to: 1) improve the quality of care available to a population that is underserved; and 2) increase the availability of the care—coverage—in the target population. These two points form the basis of the relationship between the two parties. In most cases, the public sector will seek to reduce the costs of providing health care, whereas the NGO will seek to fulfill its social mission and build a solid financial base in search of financial sustainability.

ANNEX C. DEFINITIONS AND USE OF TERMS

TERM	PURCHASER	PROVIDER	CONSUMER/END USER
Cost	The value of an input; generally used to determine the level of investment required to produce a service or treat a case.	The value of an input; generally used to determine the level of investment required to produce a service or treat a case.	What is paid or disbursed in order to receive a service or treatment.
Price	What the provider asks to be paid in exchange for service or treatment.	What the purchaser is asked to pay in exchange for service or treatment.	What is paid for a service.
Payment	What is disbursed to the provider in exchange for service or treatment.	What the purchaser disburses for service or treatment.	What is disbursed in exchange for service or treatment.
Rate	Similar to price, what the purchaser pays the provider in exchange for service or treatment.	Similar to price, what the purchaser is asked to pay in exchange for service or treatment.	Consumers generally do not use this term.
Charge	The amount that the provider requests from the purchaser in exchange for service or treatment.	The amount that the consumer is asked to pay or that the provider asks of the purchaser for a service or treatment.	What is paid for service or treatment.

ANNEX D. PAYMENT MECHANISMS

Payment Mechanisms

Global amount/ block grant (prospective)

Under a global amount or block grant payment, the purchaser pays to a provider an agreed-upon fixed amount on a regular basis (month, quarter, year) (Wouters 1998). In this study, this type of payment involves the transfer of funds from the government to an NGO to fund a budget line item, to cover high priority health services, or to finance the general operations of the organization.

Capitation payment (prospective)

Under capitation, the provider is paid an amount in exchange for a predetermined set of services for the population targeted. The size of the population and the geographic area of coverage determine the volume; the two parties will agree to a contract on the basis of their coverage target in relation to the two variables for volume. Under this type of payment mechanism the provider will receive per capita payments each month, quarter, or year, regardless of the volume of demand originally projected. Prospective payment mechanisms increase the incentives for efficiency because the service provider assumes a greater financial risk (Wouters 1998). This payment mechanism offers strong incentives to control costs. However, providers in their efforts to economize may undercut the quality of care.

Case-based payment (prospective)

Under case-based payment, the provider is paid a fixed amount for each case. The cost per case is based on diagnosis and procedure classifications and determined before the contract is reached. One problem with this type of payment is that the procedures expected to be performed for a given case may be minimized in an effort to contain costs. This incentive to increase efficiency may undercut the quality of care, so this method requires a system of monitoring and evaluation that allows the purchaser to closely review the output and quality of the services provided.

Reimbursements for services provided (retrospective)

Under fee-for-service reimbursement, payments are made only for services provided. This method encourages providers to increase the volume of services provided, including to the point of providing unneeded services. Therefore a system of supervision and evaluation is recommended to enable the purchaser to collect information on the volume of services claimed and compare the result with the volume of services from other providers (public, private, or NGO). These comparisons should be used to develop national projections of service volume for given targeted populations or areas, and ultimately to control costs.

ANNEX E. BIBLIOGRAPHY

- Bennett, Sara. 1997. *Private Health Providers in Developing Countries: Serving the Public Interest?* London: Zed Books
- Bennett, Sara and Mills, Anne. 1998. *Government Capacity to Contract: Health Sector Experience and Lessons*. Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine. John Wiley and Sons, Ltd.
- Bitrán, Ricardo and Yip, Winnie. September 1998. *A Review of Health Care Provider Payment Reform in Selected Countries in Asia and Latin America*. Major Applied Research 2, Working Paper 1. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.
- Bouchet, Bruno and Abramson, Wendy. May 1998. *Health Sector Reforms in Developing Countries: How Quality Assurance Methods Can Make a Difference*. Manuscript. Bethesda MD: Partnerships for Health Reform/University Research Co., LLC.
- Brinkerhoff, Derick W. 1999. *Exploring State-Civil Society Collaboration: Policy Partnerships in Developing Countries*. The Implementing Policy Change Project, Phase II. Bethesda, MD: Abt Associates Inc.
- Dees, J. Gregory. 1998. "What Do You Do When Traditional Sources of Funding Fall Short? Enterprising Nonprofits." *Harvard Business Review* (January-February): 58-67.
- Harrington, H. James. 1991. *Business Process Improvement: The Breakthrough Strategy for Total Quality, Productivity, and Competitiveness*. The American Society for Quality Control. McGraw Hill Inc.
- Hammack, David C. 1993. *Nonprofit Organizations in a Market Economy*. San Francisco: Jossey-Bass.
- Maceira, Daniel. 1998. *Provider Payment Mechanisms in Health Care: Incentives, Outcomes and Organizational Impact in Developing Countries*. Major Applied Research 2, Working Paper 2. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.
- Smith, S.R. and Lipsky, M. 1993. *Nonprofits for Hire: the Welfare State in the Age of Contracting*. Cambridge, MA: Harvard University Press.
- Sojo, A. January 1999. *Los Compromisos de Gestión en Salud de Costa Rica: Algunas Lecciones de un Cuasímercado* Germinal.
- Walsh, K. 1995. *Public Services and Market Mechanisms: Competition, Contracts and the New Public Management*. Basingstoke: Macmillan.
- World Bank. 1998. *Flagship Module 6: Separating Public Finance from Provision*. Washington, DC: The Economic Development Institute of the World Bank.

Wouters, Annemarie. June 1998. *Alternative Provider Payment Methods: Incentives for Improving Health Care Delivery (Métodos alternativos de pago a proveedores: incentivos para mejorar la prestación de los servicios de salud)*. Primer for Policymakers. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

PUBLICATIONS OF THE REGIONAL INITIATIVE OF HEALTH SECTOR REFORM FOR LATIN AMERICA AND THE CARIBBEAN

1. Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean (English/Spanish)
2. Base Line for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean (English/Spanish)
3. Análisis del Sector Salud en Paraguay (Preliminary Version)
4. Clearinghouse on Health Sector Reform (English/Spanish)
5. Final Report – Regional Forum On Provider Payment Mechanisms (Lima, Peru, 16-17 November, 1998) (English/Spanish)
6. Indicadores de Medición del desempeño del Sistema de Salud
7. Mecanismos de Pago a Prestadores en el Sistema de Salud: Incentivos, Resultados e Impacto Organizacional en Países en desarrollo
8. Cuentas Nacionales de Salud: Bolivia
9. Cuentas Nacionales de Salud: Ecuador
10. Cuentas Nacionales de Salud: Guatemala
11. Cuentas Nacionales de Salud: México
12. Cuentas Nacionales de Salud: Perú
13. Cuentas Nacionales de Salud: República Dominicana (Preliminary Version)
14. Cuentas Nacionales de Salud: Nicaragua
15. Cuentas Nacionales de Salud: el Salvador (Preliminary Version)
16. Health Care Financing in Eight Latin American and Caribbean Nations: The First Regional National Health Accounts Network
17. Decentralization of Health Systems: Decision Space, Innovation, and Performance
18. Comparative Analysis of Policy Processes: Enhancing the Political Feasibility of Health Reform
19. Lineamientos para la Realización de Análisis Estratégicos de los Actores de la Reforma Sectorial en Salud
20. Strengthening Ngo Capacity to Support Health Sector Reform: Sharing Tools and Methodologies
21. Foro Subregional andino Sobre Reforma Sectorial en Salud. Informe de Relatoría. (Santa Cruz, Bolivia, 5 a 6 de Julio de 1999)

22. State of the Practice: Public -Ngo Partnerships in Response To decentralization
23. State of the Practice: Public -Ngo Partnerships for Quality Assurance
24. Using National Health Accounts to Whom It May Concern: Make Health Sector Policy: Finding of Latin America/Caribbean Regional Workshop (English/Spanish)
25. Partnerships between the Public Sector and Non-Governmental Organizations Contracting for Primary Health Care Services. A State of the Practice Paper. (English/Spanish)
26. Partnerships Between the Public Sector and Non-Governmental Organizations: The Ngo Role in Health Sector Reform (English/Spanish)

Special Edition

1. Cuentas Nacionales de Salud: Resúmenes de Ocho Estudios Nacionales en América Latina y el Caribe
2. Guía Básica de Política: Toma de Decisiones para la Equidad en la Reforma del Sector Salud

1.

To view or download any LAC/HSR Initiative publication, please visit our website at:

<http://www.americas.health-sector-reform.org/>
and select “LAC/HSR Initiative Product Inventory.”