



Performance-Based Contracting for Health Services in Developing Countries: A Toolkit

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This book was written to help bridge the yawning gap between many developing countries and the Development Goals for health. Right now, that gap looks daunting. But we can narrow the gap significantly by contracting, especially using non-state providers. The status quo, in which millions are denied basic health services, is not acceptable. Contracting is an effective way to improve the daily lives of the most vulnerable.

Contracting is the means by which a funder buys specific services from those non-state providers. This practical “how to” guide is aimed at staff of government agencies, insurance companies, social insurance funds, nongovernmental organizations, faith-based organizations, private health care providers, and international development partners.

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Summary of Performance-Based Contracting

SUMMARY BY MICHAEL H. C. MCDOWELL

Contracting is when a financing agency or “purchaser” (government agency, parastatal body, insurance entity, development partner) supplies resources to a nonstate provider (NSP) or “contractor” – a non-governmental organization (NGO) such as a faith-based organization (FBO) or community-based organization (CBO) or private for-profit company or individual(s) – to deliver specific services in a specific place over a defined time.

Performance-based contracting (PBC) is a type of contracting which explicitly contains three elements:

- *Definition* of a series of objectives and indicators which measure performance
- Collection of *data* on performance, indicating how well contractors have successfully implemented the defined services
- Where performance has been poor or worse, this leads to *consequences* for the contractor, i.e., rewards (bonuses, public recognition), or sanctions (termination of the contract, financial penalties, public criticism, and debarment from receiving future contracts).

There are many different types of PBC:

- Primary health care (PHC) in rural or urban areas
- HIV prevention services among high risk groups
- Providing HIV/AIDS treatment services to people living with HIV
- Setting up health insurance systems
- Establishing and operating a voucher project
- Acting as an intermediary with many for-profit providers to bolster the management of TB patients
- Offering behavior change communication activities and information, education, and communication
- Providing equipment, maintenance, security, food preparation, waste management and cleaning services in a hospital
- Operating an ambulance system, managing a hospital

- Operating diagnostic services within health facilities
- Providing social marketing of health products, e.g., contraceptives, and
- Working as an “umbrella” agency overseeing the work of many smaller NGOs and CBOs.

PBC is different from the provision of grants. With contracts, it is the purchaser, not the NSP, who decides which services will be delivered, where, and how performance will be measured. Contracting also is often a form of “pay for performance” (P4P) and sometimes has been used to introduce P4P for individual health workers. P4P is attractive because it compels providers to focus on important objectives and uses financial rewards to reinforce good performance.

Like all contracts, contracts for health services are *voluntary*, meaning both parties enter into the agreement freely. Another useful term for contractor is “partner.”

Grants are quite different from contracts. Grants are usually given to organizations which submit a proposal to a funding agency such as governments or donors. With grants, it is generally the NSP which decides what kinds of services will be delivered, and when, where, and how they will be delivered and evaluated. Contracts are much more precisely defined than grants. Only if a funding agency defines precisely what kinds of services are to be delivered, does the distinction between grants and contracts blur.

How to Contract

PBC must be done systematically. It has been tested and has worked well in many countries with different and often difficult circumstances. There are seven basic steps.

1. Consult closely with stakeholders, i.e., government health workers and officials, local politicians, NSPs, development partners, and the community. After the initial talks, draft a contracting plan and go back to the stakeholders with concrete proposals to discuss and identify “champions” among them to support contracting efforts and to overcome resistance.
2. Define the services in five basic ways: a) define the objectives of the contract and select no more than 10 indicators for success; b) make sure you have addressed equity and quality of care; c) ensure contractors and purchasers focus on achieving the objectives, possibly through P4P; d) define the size and location of each contract “lot”; e) define the scope of services to be delivered.
3. Design the monitoring and evaluation system, especially how to collect data.
4. Decide how to select the contractors through an open competitive selection process with clear criteria, and a transparent and independent evaluation process, possibly using World Bank Guidelines.
5. Arrange for contract management and develop a contracting plan. Use a clearly defined, reasonably sized, properly financed team with explicit responsibilities and authority, who have a variety of skills. When contracts are large, be sure to use contract management software.
6. Draft the contract and bidding documents. Maximize managerial autonomy and accountability; protect the interest of both parties; establish reporting procedures and terms of reference; and formulate a Request for Proposals (RFP).
7. Carry out the bidding process and manage the contract, ideally within six months.

Whether to Contract

Contracting has the following advantages:

- It ensures a greater focus on achieving measurable results
- It taps the private sector’s greater flexibility and avoids bureaucratic “red tape” and unhelpful political interference
- It reduces corruption, e.g., absenteeism, selling of jobs, and stealing of drugs
- It uses constructive competition to increase effectiveness and efficiency
- It overcomes “absorptive capacity” constraints which often plague government health systems
- It improves the availability and distribution of health workers
- It broadens the autonomy of managers on the ground, and
- It allows governments to focus on their strengths, such as planning, standard setting, financing, and regulation.