Please cite this paper as:


Partnership for Democratic Governance

Contracting Out Government Functions and Services in Post-Conflict and Fragile States

EXAMPLES FROM THE HEALTH SECTOR IN LATIN AMERICA AND THE CARIBBEAN

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CONTRACTING OUT GOVERNMENT FUNCTIONS AND SERVICES IN POST-CONFLICT AND FRAGILE STATES

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Introduction and background

Contracting out is used as a means to deliver essential public services and perform public functions in a wide range of country environments including fragile states, post-conflict nations, countries hit by natural disasters, stable developing countries and industrialised nations. This paper serves to introduce the OECD Handbook on Contracting out Government Functions and Services published in 2010. The handbook, which was developed in collaboration with field practitioners from developing and developed countries, experts and donors, does not advocate a “contracting out model” but, rather, provides guidance that is adaptable to various situations and stresses the importance of longer-term sectoral and capacity development strategies. A useful starting point before taking any decision to contract out, this handbook also illustrates its main points through case studies taken from a number of countries and sectors.

Although this handbook was originally intended to address the specificities of contracting out in fragile states, the experiences and lessons as well as the guidance that this handbook provides are just as relevant for more stable developing nations.

The purpose of this paper is to highlight the relevance of the handbook’s guidance, lessons learned and country case studies not only for fragile states but also in the context of stable developing countries. In particular, the experiences of Colombia, Guatemala and Haiti in the health sector are summarised and key lessons and conclusions on contracting out are presented. These country cases represent three different modalities of contracting out and serve to illustrate the innovative ways that these countries have gone about delivering essential public health services to their populations.

Contracting out can be an excellent tool to achieve public sector goals and has successfully been implemented throughout the world. Its focus on accountability of public funds through contract management and oversight is one of the principal benefits of contracting.\(^1\) Although there are political risks that can have an impact on the success of contracting out, a thorough assessment of stakeholder interests and proper planning can mitigate these risks. Misunderstanding by the general public on the

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differences between contracting out and privatisation can create an environment of distrust and scepticism. Transparency in the contracting out process is essential in order to avoid any controversy about the use of public funds. By definition, the use of public funds to contract out to private providers requires the purchaser to ensure that those funds are used properly.

In order to contract successfully, the state — as purchaser — must be able to properly manage the contracting processes: that is, to define contract objectives, negotiate contract terms, prepare and implement contracts, and monitor and evaluate performance. In order to manage the contracting process, the public sector needs to clearly stand out as providing stewardship over the essential government functions and services and provide leadership in setting policy, contract oversight and monitoring, setting and enforcing regulation, and determining costs.

**What is the handbook?**

- A road map for pros and cons of contracting out;
- A guide for developing and formalising partnerships for use of contractual tools and modalities for delivery of services;
- An operational manual for informed decision-making; and,
- A reference tool for informed dialogue on contracting out.

**What is the handbook NOT?**

- A legal document; or,
- A technical manual or blueprint.

**How can it be used?**

- To strengthen performance of government;
- To provide necessary functions and services to the citizens of a nation;
- To formalise relationships for delivery of public goods, services and functions; and,
- To instil confidence and trust in the state.

**What does the handbook offer?**

- A step-by-step guide to:
  - Analyse types of contexts, sectors and variables that must be in place for contracting out;
  - Identify contract options (management, services, works and supplies);


− Analyse and understand incentives and risks;
− Assess environmental, political, institutional and individual capacity; understand and navigate the procurement process; and,
− Implement legal aspects and design, monitor and enforce contracts.

The handbook also contains annexes with resources including: glossary, professional and legal aide, contract templates and guidance, contract types, degrees of contract formality and case studies.

**When can the handbook be used and what is the rationale for contracting out?**

- When there are clear gaps in public services, goods and functions, for example in the delivery of public services (*e.g.* education, health, sanitation) or in performance of functions (*e.g.* financial, commercial, tax collection and customs, justice);
- When the capacity of government is weak due to, for example, underperformance, negligence, corruption;
- When loan conditionalities are placed on countries by international financing institutions;
- In emergency situations (*e.g.* natural disasters); and,
- When there is a lack of confidence in government, for example after war or civil unrest, in order to regain confidence in the state.

**What should be kept in mind when contracting out government services and functions?**

- It is important for government to retain stewardship and oversight when contracting out to private providers as well as to provide leadership in setting policy and regulation over national functions and services.

**Who should use the handbook?**

- The handbook can be used by policy makers from national governments;
- Field practitioners and managers from national governments; and,
- The international community, including:
  - International organisations;
  - Multilateral and bi-lateral agencies;
  - World Bank, Inter-American Development Bank, and other international financial institutions;
− Diplomatic community; and,

− Private foundations.

**Definition of terms for contracting out**

The mechanisms or institutional arrangements for the procurement of essential services and functions are similar across all sectors. Funding can come directly from the state budget or it can be obtained through external loans or grants. It can be pooled through basket funding or swap funds. The leadership for contracting out may be something initiated and driven by national government or it may be part of a development package conceived of and driven by international donors. Contracting out can be something that is decided upon and designed through a highly participatory process involving a wide range of stakeholders in a country, or it can be simply mandated by law or as a condition or requirement by donors or banks. Contracting out can take a number of forms. In its most basic form, contracting out can be an informal verbal agreement (which is clearly less binding), written agreements or ‘contracts’ that define broad strokes and outputs based on agreed upon objectives, or performance-based contracts which specify outputs and targets, and link performance to payment.

The OECD handbook encompasses all of these types of arrangements and provides an overview and resources for a number of various other types of contractual arrangements such as leasing and longer-term arrangements.

Below are some of the key terms that are defined in the handbook and are important to understand for those who use the guide:

- **Contracting** is the purchasing mechanism used to acquire a specified service, of a defined quantity and quality, at an agreed-on price from a specific provider for a specified period.

- **Contracting out** is defined as the design and implementation of a documented agreement by which the government (purchaser) provides compensation to another party outside of the government (provider) in exchange for a definite set of services for a specific target population.

- **Contracting in** is where the national or central level of government contracts with the local level of government in a decentralised setting.

- **Performance-Based Contracting** (PBC) is a specific form of contracting and can be accomplished through either contracting out or contracting in. PBC can be defined as a transfer of competencies for a defined period of time based on the employment of a formal written agreement (contract) whereby payment is made by a government authority (the state) or a donor or donor-funded project to a contractor (provider) and based upon the attainment of predetermined results. In other words, the transfer of money or material goods is linked to a concrete and measurable action or achieving a predetermined target with rewards provided for reaching or surpassing targets.
Broadly defined, there are four categories of contracting out: \(^2\) (1) international donor agency to government;\(^3\) (2) within the public sector itself from one level of government to another;\(^4\) (3) international donor agency to non-state actor, e.g. private provider;\(^5\) and (4) government to private provider or health worker.\(^6\)

**Box 1. General types of contracts**

1. Partner government executes contract; funds from national budget (e.g. Bolivia, Colombia, Costa Rica, El Salvador, Nicaragua, Guatemala)
2. Partner government executes the contract; donor funding (e.g. Guatemala early on)
3. External funding entities (i.e. donors) executes, finances, and manages the contract for services, in close collaboration with the end users and/or partner government (e.g. Haiti)

**Contracting out in the health sector in Latin America and the Caribbean**\(^7\)

There are numerous experiences in contracting out in the health sector throughout the developing world as well as in post-conflict and fragile states. The health sector has provided leadership at the global level in contracting out to the private sector by government. Contracting out for health services serves as an excellent entry point for fragile states to consider as they begin to rebuild their infrastructure and workforce and regain the confidence of their citizens. Likewise, contracting out in the health sector in more politically stable countries is an effective way to quickly expand services to the most marginalised and underserved populations. Thus, there is increasing interest in developing countries to contract with NGOs and the for-profit private sector to deliver a wide range of health services, including: delivery of essential services, training, facilitation of stakeholder involvement in

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\(^3\) Based on a model of “conditionality” formally employed in the 1980s and early 1990s by the International Financing Institutions as requirements for loan disbursements as well as some of the present day modalities for paying for performance utilised by the Global Alliance for Vaccines and Immunizations and the Global Fund for Malaria, AIDS and Tuberculosis.

\(^4\) Examples include the Costa Rican Social Security Institute’s model of contracting between levels of care and the model implemented in Brazil with budget transfers from central government to municipal level.

\(^5\) This is the more common model seen in Afghanistan, Democratic Republic of the Congo, Haiti, Liberia and during the pilot phase in Rwanda, among others.

\(^6\) Examples include Guatemala, El Salvador, Honduras, Liberia, Nicaragua and Peru, among others.

\(^7\) Information for the cases presented in this paper are derived from a number of sources including: Abramson, Wendy. Partnerships between the Public Sector and Non-Governmental Organizations: Contracting for Primary Healthcare Services: A State of the Practice Paper, Latin America and Caribbean Health Sector Reform Initiative, Abt Associates, Inc., 1999; Contracting Out Government Functions and Services: Emerging lessons from post-conflict and fragile situations. Chapter 1: Lessons from Cambodia, Guatemala and Liberia: OECD, PDG. November 2009.
health reform policy development, delivery of key public health goods or services such as supply chain management; and procurement of medicines or medical supplies.

Governments in Latin America and the Caribbean (LAC) have acknowledged over the years that they face difficulties in their attempts to meet the basic health needs of their populations. They approach contracting out to non-governmental organisations (NGOs) and to for-profit companies as a strategy to meet the needs of underserved populations. Most countries in the LAC region are utilising contracting out as a tool to provide basic public functions and services to their populations. Across the region, countries have been gradually shifting their focus from government provision of essential goods and services to contracting out with private commercial and non-profit providers to meet the needs of their populations. In the health sector, some of the more studied cases include those of Bolivia, Brazil, Colombia, Costa Rica, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and Peru.

What follows is a brief overview of three countries with a relatively long history of contracting out for health services in the LAC region: Colombia, Guatemala and Haiti.
COLOMBIA

Rationale

The Colombian government has multiple motivations for contracting out, including efficient use of public funds, expanded coverage and improved quality of care.

Institutional arrangements

Colombia stands out as an example of a country whose legal framework supports the public sector contracting of private agencies. As a result, a broad range of contracts between state agencies and providers — among them NGOs — can be found in the Colombian health sector.

Until the early 1990s, the government social security health system in Colombia exerted a virtual monopoly over the management and provision of health services. In 1993, two key pieces of legislation were passed that laid the foundation for radical public health reform: Law 80, known as the Public Administration General Statute on Government Contracting; and Law 100, whose goals included universal coverage, improved efficiency in healthcare service provision and the assurance of an adequate level of quality. These laws provided for administrative and political government restructuring (including decentralisation) which affected the delivery of health services. The restructuring strengthened the role of the Ministry of Health as a purchaser of healthcare and its role in the oversight and regulation of care at the national level. The laws explicitly allowed for public agencies in Departments and Municipalities to contract out to the private sector 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.

Effect on statebuilding

Colombia’s experience is unique in the LAC region in terms of its open and intentional support for an open market and a culture of contracting. The administrative and political system reforms were carried out gradually. In addition, the new insurance scheme and reforms of the health system were gradually transitioned to become one of demand-driven subsidies.

Although there was initial opposition from trade unions and labour groups which viewed contracting out as a threat to job security, this was in great part a natural consequence of any radical change to the system. Through public information campaigns, this new culture of contracting out for healthcare services with private providers through an open market system was eventually accepted.
Capacity building versus service delivery

Colombia has had a robust private healthcare market, which made it relatively easy for an open and competitive environment for contracting out to be put into place. Colombia’s innovative approach, based on ‘regulated competition’, required little focus on the capacity building of private contractors. This model, which allows free choice and encourages private sector and community participation in healthcare, effectively moved the Colombian funding scheme from one of supply subsidies to one based on demand. By radically reforming the country’s healthcare model, important incentives structures were created to facilitate efficiency and improve quality of services delivered.

The place where capacity needed to be built was in local government’s capacity to purchase healthcare services. Difficulties arose in navigating the extreme complexity of healthcare decentralisation coupled with the rapidity at which the contracting out programme was implemented. The main area of difficulty was with the information systems associated with contracts. At the time, the Ministry of Health revised the standardised formats for recording clinical histories, but because the contracts were executed by numerous agencies at different levels of government, discrepancies occurred between facility records and central statistical information systems. Under decentralisation, Colombia has delegated responsibility to departments and municipalities not only for providing healthcare services but also for collecting and maintaining certain statistical data at those levels. Before a purchaser can pay for contracted services, the healthcare provider must supply that purchaser with the information specified in the contract.
GUATEMALA

Rationale

The original impetus for contracting out in Guatemala was the commitment in a series of peace agreements that ended Guatemala’s three-decade-long civil war. To meet the coverage extension mandates of the 1996 Peace Accords, the Guatemalan Ministry of Health (hereafter ‘the Ministry’) needed to rapidly extend coverage to the most underserved people — the poor, rural, indigenous populations. There were huge disparities between the Spanish-speaking urban and peri-urban populations and the native non-Spanish-speaking indigenous rural populations. This latter group was to be the primary focus of the Government’s efforts.

Since the Ministry did not have adequate infrastructure and health units from which to provide services, the Government considered building up public sector health infrastructure by creating more vacancies and hiring additional personnel in the Ministry. However, this would be a lengthy process over the medium to long term. In addition, because the term from one government to the next was relatively short, it would be impossible to guarantee the implementation of such a strategy. The Government therefore 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. The NGOs and Community-Based Organisations (CBOs) provided basic survival services as part of the relief and emergency efforts during the civil war in isolated conditions and in a sporadic and, at best, disjointed manner. The armed conflict precluded any co-ordination or collaboration with the Government. Clearly, a more traditional model of pure public sector health service delivery would not have been feasible due to the community’s inherent lack of trust in the state after the war, and the need to reach populations which were both geographically and culturally difficult to access.

Box 2. Central American Peace Accords – Guatemalan Health Sector Commitments

In the Central American Peace Accords, the Government of Guatemala committed to: a) Increase public spending on health as a percentage of GDP by 50% compared with spending in 1995; b) Budget at least 50% of government spending for preventive care; c) Reduce infant and maternal mortality to 50% of the 19% rate; d) Encourage social participation in health; and, e) Maintain the certification of the eradication of poliomyelitis and achieve the certification of the eradication of measles.

Although Spanish is Guatemala’s official language, there are 22 departments with 25 languages spoken throughout the country.
Institutional arrangement

The Ministry decided to formalise its relationship with NGOs to expand access to, and improve the quality of health services for, rural and indigenous populations. In 1997, with initial funding from an Inter-American Development Bank (IDB) loan\(^9\), the *Program to Extend Coverage of Basic Health Services* was adopted, whereby informal agreements were made in three pilot departments by signing seven agreements with four NGOs.\(^{10}\) The original agreement was specified in a credit agreement with the IDB and called for a three-year pilot project that would be evaluated and subsequently expanded.

The pilot was a success. The Government saw a dramatic increase in the extension of health services to the underserved and decided to officially institutionalise and formalise the extension programme. The new model was brought to scale and applied nationwide. Around the same time that the pilot project was brought to scale, elections took place (1999), and a newly elected government entered office. The new government saw that the extension programme was functioning well and opted to further solidify it by aligning the Ministry ‘agreements’ with the Guatemalan Public Contracting Law. There was no need to align these contracts with a particular health plan or policy, since this public contracting law enabled the new government to provide the Ministry with the ability to utilise national budget line items for contracts with NGOs. This provided further institutionalisation and further legitimised the newly elected government and contracting as a tool to extend coverage through NGOs. Thus, the original ‘agreements’ were transformed into specified and formalised performance-based contracts under the national legal framework.

The Ministry’s role is that of oversight and the development of norms and protocols for service delivery. The NGOs are responsible for delivering health services in accordance with the pre-established performance indicators. Performance measures are stipulated in the contract by service, activity, quality, and productivity. The requisite level of effort in management and administration is low, since data collection and monitoring is already provided. Monitoring takes place every two months and a contract evaluation on a yearly basis. Ministry payments were made to NGOs as budgetary transfers from two Ministry budget line items.

Under agreement with the central government, all donations and loans towards the new coverage programme were to be put into a single basket of funding with Ministry of Health national funds. The only exception to this was the U.S. Agency for International Development (USAID), where funds were administered by the United Nations Development Programme (UNDP) and short-term funding by Plan International.

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\(^9\) This approach fell under the existing legal framework Article 24 of the 1997 Guatemalan Health Code and the Public Administration Law and authorizes the Ministry to sign agreements with NGOs. (The Health Code was originally passed as a condition for disbursement under an Inter-American Development Bank loan.)

\(^{10}\) NGOs under the “agreements” were responsible for delivering a basic package of primary healthcare services to a geographically targeted population of approximately 10,000 each. Under agreements made between 1997 and 2004, NGOs were paid prospectively, through a global payment mechanism, a fixed amount through capitated payments each quarter for a total of four yearly instalments. The only requisite for payment was proof of expenditures of at least 75%. The payment covered the direct cost of the basic package plus administrative expenses as well as expenditures related to institutional strengthening.
The effect of contracting out on statebuilding

Initially, the NGOs in Guatemala were sceptical of formalising relationships with the Government. When the programme was initiated, NGOs for the most part felt that they provided higher quality services to the community than the public sector. In addition, there was huge mistrust on the part of civil society, and of the NGOs which represented civil society. The NGOs’ primary concern was that contracts could not and would not be transparent, and that the Ministry would not be able to make timely payments to the organisations. To help ease their financial situation and mitigate the latter concern, the NGOs were able to negotiate advanced payments, including start-up costs.

To manage these perceptions and promote partnerships between communities and the Government, the Ministry decided to implement an intensive targeted promotional campaign. The campaign was designed to support NGO autonomy in this process. In addition, the Ministry invited organisations with experience in health to attend meetings on the new model. Advertisements on regional radio stations and written and oral invitations were among the communication channels used. The Government intentionally did not advertise the new model in national newspapers in order to mitigate potential fallout from the labour unions, which were already wary of using NGOs under this new mechanism.

It is widely recognised that the Government still does not have the capacity to accomplish what the NGOs are carrying out in Guatemala in terms of extending coverage in the short to medium term. Although contracting with NGOs has been underway for over a decade and has survived three different administrations, some actors in the health sector still refer to it as ‘privatisation’ or other negative terms. In order to institutionalize obtaining of internal stakeholder buy-in for this programme in light of misperceptions about agreements or contracts as a form of privatisation, particularly medical unions, it was necessary to create an accountability mechanism at the local level. In order to ensure accountability to the community as well as transparency over the use of Government funds, a new mechanism called auditoría social or ‘social audit’ was devised. This social audit was put into place in order to ensure community participation in healthcare services, but mainly to provide a type of community oversight to the use of Government funds to the health sector through contracting with NGOs.

Long-term capacity building versus service delivery

The original IDB loan funds included a line item for capacity building at all levels of the public healthcare system — central and regional Ministry staff, as well as NGOs. Other donor agencies, including the United Nations Children’s Fund (UNICEF) and USAID, also provided funding to support capacity building for this model. In 2007-2008, IDB provided additional funding for monitoring by assigning personnel at the central and regional levels to be charged with contract negotiations, monitoring and strengthening of information systems. This funding ended in 2008, and there remains a gap in human resource capacity for this function, highlighting the importance of an exit strategy.

The Ministry of Health needed to simultaneously continue to deliver basic health services to the population and also work to build both NGO and Ministry capacity to execute, manage, administer,
finance, monitor and evaluate contracts. It was determined early on that a number of NGOs might not be willing to accept agreements that committed them to delivering measurable results. NGOs were particularly uncomfortable with being asked to deliver concrete results that even the public sector was unable to deliver, for example, increasing immunisation coverage or prenatal visits. So, in the first round of negotiations, the Ministry did not belabour the point of performance indicators in the agreements; rather, the agreements stipulated that the NGOs would comply with processes and schedules and “deliver health services”. In addition, during the initial round of contracts in 1997, all seven of the proposals submitted were accepted. The Ministry then worked diligently to distribute guidelines to all NGOs and provided them technical assistance to help them prepare future proposals. The following year, a similar mechanism, called an ‘open contract’, was applied and essentially allowed for any acceptable NGO proposal to result in an “agreement”. That year, 117 “agreements” were signed.

At the time, although there were not many indigenous health service delivery NGOs in Guatemala, there were several grassroots organisations in the indigenous communities. Part of the Ministry’s strategy was to use international NGOs to help build the capacity of local NGOs to provide health services. It was thought that this would create a multiplier effect, whereby government agreements would be able to be expanded to include local Guatemalan community groups.

As of 2010, there is one contract per jurisdiction of 10,000 people, totalling 424 contracts. Each contract contains a set of indicators and targets, and performance is measured both in terms of financial expenditures and results. The process of monitoring and supervising the performance of 424 jurisdictions has been challenging, and the capacity of the Ministry at the department and central levels could benefit from strengthening. The contracting strategy/model had always been designed to be implemented and monitored at the departmental level, but it was not until 2007 — a full ten years after this process was initiated — that each department in Guatemala had authority over the provider selection process, contract management and supervision, monitoring and evaluation, and funds disbursements. This process presents many bottlenecks and difficulties, but is clearly part of the vision of the Guatemalan Health Ministry.

Since 1997, recurrent costs have been covered by the Ministry. In 2008, IDB budget support ceased, and World Bank funding was added. There is now a full-scale automated monitoring and evaluation system in place for contracting, and the Guatemalan model is fully sustainable and part of Ministry system funded through the national budget of the Government of Guatemala.


12 Further information can be located on the ministry website: www.mspas-sias.gob.gt
HAITI

Rationale

Haiti is the poorest country in the LAC region, and access to basic healthcare services in Haiti has been a huge problem for many years. According to the Pan American Health Organization (PAHO), in 1995 Haitian infant mortality rates hovered around 80 per 1,000 live births and maternal mortality at 523 per 100,000 live births. In addition, government health services were historically fragmented and weak due to poor infrastructure and human resource pools, and the majority of healthcare services were delivered by NGOs. Based on these alarming figures, in 1999 as part of its overall strategy to improve access to key maternal and child health services in Haiti, USAID, under a bilateral project, introduced a performance-based contracting pilot project as a way to systematically improve the NGOs’ effectiveness and provide greater access to services, particularly for mothers and children.

Institutional arrangement

USAID’s original arrangement for contracting was through a pilot project, whereby a United States consulting firm was contracted by USAID to contract directly with NGOs for a few key services, namely immunisation and prenatal and maternal care.

The USAID-funded pilot was done in three phases: 1995-99, 2000-04 and 2006-07. The long-term goal of the project was to pay NGOs by services provided (outputs). The NGO providers operated under a payment system that reimbursed their expenses within a ceiling. The new system set performance targets and withheld a portion of their historical budget, allowing them to earn back the withheld amount plus a bonus if they met the targets. After a year, the initial pilot project showed good results in increasing coverage to pregnant women and babies and the project was expanded to include other basic healthcare services.

Capacity building, long-term sustainability and service delivery expansion

Historically, those paying for healthcare services in developing countries have not required the providers to guarantee their performance. Public payers tend to fund public institutions to maintain capacity (paying salaries and recurrent costs) rather than to ensure that consumers receive high-quality services. Any contracts with private providers generally have not held them accountable for performance. Donors have tended to adopt similar practices, providing lump sum grants or

reimbursing public providers and NGOs for documented expenditures. As a result, providers have tended to focus on securing funds instead of improving efficiency, productivity or the quality of care.

_Paying for Performance in Haiti_ is part of a package of interventions geared towards strengthening NGO capacity to deliver quality health services to the Haitian population. Rather than dealing with the burden of submitting their expenditures every month, NGOs receive a monthly sum with a ceiling figure. At the end of a defined period, performance relative to indicators is measured and the size of the bonus is determined. This form of payment enables NGOs to use resources efficiently while focusing on implementing systems of management and staff motivation that are effective in achieving results. The payer must establish contracting, monitoring and evaluation systems and therefore assumes the role of an active purchaser. The new system set performance targets and withheld a portion of their historical budget, allowing them to earn back the withheld amount plus a bonus if they met the targets. The contract stipulated that NGOs could receive bonuses based on performance that could equal as much as 10% of historically established budgets. Indicators to measure performance are included in each contract and NGOs received technical assistance in data collection and reporting.\(^\text{14}\)

Bonus payments are made to NGOs if they meet or surpass their targets. These payments can be used in a variety of ways including payment to individual workers, to make infrastructure improvements to their facility, or procure other items for the health facilities. The contracting out model in Haiti was designed specifically to address issues of efficiency, quality of care and performance under contracts with service delivery NGOs. To date, this model has helped to improve key health outcomes in Haiti as it was brought to scale. The services provided under contract were in addition to those already being provided by the Ministry of Health of Haiti.

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\(^{14}\) Taken from Center for Global Development: Performance Incentives for Global Health: Potential and Pitfalls. 2009
LESSONS LEARNED AND CONCLUSIONS

In choosing whether to contract out for service delivery, the purchaser must consider the national legal framework and political environment, the capacities of the public sector to manage the contracting process, as well as the goals and objectives of contracting. The decision to contract is not a straightforward process, nor is there a ‘recipe’ to follow. Rather, contracting out responds to a country’s particular needs at a particular time. Nevertheless, there are issues that policymakers, health authorities and providers should consider before negotiating and implementing a contract (Abramson 1999).

Box 3. Essential functions and services are procured because of...

- Weak infrastructure (facilities and workforce);
- Gaps in capacity of Government;
- High out of pocket health expenditures;
- Low socio-economic status of general population;
- Lack of confidence in Government;
- High levels of social and economic inequity;
- Gaps in access to essential services;
- Disparities between the haves and the have-nots;
- Transition from emergency or relief model to development model (during war or natural disaster); and,
- Definition and division of state functions (steering, oversight, regulation, policy, financing) versus service delivery.

Experience from other sectors, including the health sector in industrialised nations, developing countries, and fragile states suggests that services delivered through contracts can be more effective than publicly provided health services, which are oftentimes both inefficient and lacking in quality. Government has a much greater need to link expenditures to performance objectives. Contracting out defines specific results that, ideally, will reflect the public sector’s policy and objectives. To gauge results, these contracts should include a variety of indicators to measure
performance. In the health sector, for example, performance is generally measured based upon indicators of coverage, quality and efficiency.\textsuperscript{15}

**The reasons for contracting in fragile, post-conflict situations and in more politically stable countries are not dissimilar.** A number of institutional issues on the part of the government need to be considered when making the determination whether to contract for services or products. The decision to contract out for a service generally stems from a public agency’s weakened capacity to perform a select function or the ability of a contractor to provide the service or function more efficiently or effectively then the public entity. The decision as to whether to contract out depends on several considerations, including political preferences and an analysis of efficiencies in service production by non-government contractors as compared to government.\textsuperscript{16}

All three of the country examples examined in this paper initially chose contracting out for similar reasons, including the following:

- Rapidly extend coverage to underserved sectors of the population and provide priority services to targeted groups.

- Provide services that the government does not have the infrastructure (human or technical capacity) to provide.

- Encourage competition among healthcare providers.

- Improve government’s ability to focus on health policy, planning, financing and oversight.

**Experience in LAC region has shown how a country’s political environment and legal framework, especially laws on procurement and contracting, 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 or regulatory environment hinders contracting, the parties have had to find more creative means to design and execute donor-funded projects under contract-like arrangements or by careful attention to legal language and concepts. This was the case of Costa Rica, where the National Social Security Institute was able to initiate contracting under the auspices of an international donor-supported project in spite of national legislation non-conducive to contracting and likewise in Guatemala.

**Leadership from the highest levels of government and stakeholder involvement are essential for ownership and sustainability of contracting out to the private sector.** Both Guatemala and Colombia had a clear vision of how they wished to partner with community-based NGOs from both the Presidential and Ministerial levels of government. Likewise, the Guatemala experience is an example of what can be mobilised quickly when there is a sense of political urgency as was the case

\textsuperscript{15} Abramson, W. 1999.

\textsuperscript{16} OECD DAC Fragile States Group (2008). *Service Delivery in Fragile Situations: Key concepts, Findings and Lessons*
after the Central American Peace Accords were signed. In the case of Haiti, contracting out was successful in that the efforts of the donor community managed to pilot and create a model that will bring basic health services to those in dire need in an environment low public sector capacity.

If stakeholders are not managed well and information is not shared in a transparent manner, contracting out could be misconstrued and cause unrest amongst labour and professional unions and other stakeholders. Since it is prudent to prevent political misunderstandings before entering into contractual arrangements, it is important to thoroughly assess the incentives of all key actors involved including the private for-profit and not-for-profit sector, trade and labour unions, the government and the general population. Stakeholder interests will need to be continuously reassessed and monitored along the way to mitigate political risk. When political risk is evident either before or during the contracting out process, the government can reduce negative incentives and create positives one through policy dialogue, information sharing, efforts that target particular incentives and reduce resistance, use of pilots, thoughtful and well communicated contract design and co-financing of contracts by national governments and donors. (OECD 2010 p. 54-55)

A model that would bear further examination is that of the “social audit” in Guatemala, a country with a long history of corruption, particularly during the war period. This model would serve to provide civil society oversight to use of government funds for contracting out of NGO and fortify transparency as well as ensure accountability to the community. This model could very well be adapted to other sectors beyond the health sector.

Contracting out has created a culture of change in the countries where it is being utilised. Each of these cases reflect a different model for contracting out: In Guatemala contracting is done directly between the Ministry of Health and private sector; in Haiti financing for contracts flows from a donor directly to a USAID contractor and contracts are made between the U.S. Government contractor and NGOs; in Colombia contracting takes place under National Health Reform directly between the departments and municipalities. In addition to being examples of public agencies in the health sector, contracting NGOs or private for-profit companies, the cases described in this paper also serve as examples from which countries in the LAC region may draw lessons.

Contracting out and, in particular, performance-based contracting is an iterative process, and as a country gains in its experience, it moves towards strengthening its contracting model. In the cases of Guatemala and Haiti, the model has expanded greatly to include more service providers and more service delivery functions. After an initial pilot phase, agreements were gradually formalised and contracts included performance measures. Contracting out, and in particular performance-based contracting of public health services by definition should be a true partnership between the state and the private sector. For instance, in the cases of Guatemala, Haiti and Colombia performance was measured through careful monitoring of key performance indicators, and sub-standard performance under contract led to sanctions and non-renewal of contracts. This performance incentive strongly motivates the contractor to target its efforts towards meeting the contract’s performance goals.