

Contracting but not without caution: experience with outsourcing of health services in countries of the Eastern Mediterranean Region

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Abstract The public sector in developing countries is increasingly contracting with the non-state sector to improve access, efficiency and quality of health services. We conducted a multicountry study to assess the range of health services contracted out, the process of contracting and its influencing factors in ten countries of the Eastern Mediterranean Region: Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, Pakistan, the Syrian Arab Republic and Tunisia. Our results showed that Afghanistan, Egypt, Islamic Republic of Iran and Pakistan had experience with outsourcing of primary care services; Jordan, Lebanon and Tunisia extensively contracted out hospital and ambulatory care services; while Bahrain, Morocco and the Syrian Arab Republic outsourced mainly non-clinical services. The interest of the non-state sector in contracting was to secure a regular source of revenue and gain enhanced recognition and credibility. While most countries promoted contracting with the private sector, the legal and bureaucratic support in countries varied with the duration of experience with contracting. The inherent risks evident in the contracting process were reliance on donor funds, limited number of providers in rural areas, parties with vested interests gaining control over the contracting process, as well as poor monitoring and evaluation mechanisms. Contracting provides the opportunity to have greater control over private providers in countries with poor regulatory capacity, and if used judiciously can improve health system performance.

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يمكن الاطلاع على الملخص بالعربية في صفحة 873.

Introduction

Contracting is being increasingly used by the public sector in developing countries for the purchase of specified services from the private sector,¹⁻⁵ and in some developed countries through internal contracts with autonomous public providers.⁶⁻⁹ Contracting is an important element of health sector reform programmes in many countries because it provides governments with a management and regulatory tool that creates incentives for improved performance and increased accountability.^{1,10} Recent reviews have suggested that contracting can influence access, equity, quality and efficiency of health services; promote public health goals; and create an environment conducive to public-private collaboration.¹¹⁻¹³ The process is challenging and requires well designed contracts, transparent bidding, clear performance obligations and credible funding mechanisms. In addition, governments need to be able to monitor contracts and have the reputation of being a trustworthy partner.

We conducted a study on contracting out of publicly financed health services in ten countries of the Eastern Mediterranean Region (EMR) with the aim to (1) assess the rationale and capacity of the ministries of health (MOHs) and the private providers to enter into contractual arrangements; (2) review health interventions in which an outsourcing arrangement was implemented; and (3) identify factors that influence contracting.

Methods

We performed the study in 2004 in Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, Pakistan, the Syrian Arab Republic and Tunisia. These countries accounted for two-thirds of the 500 million population of the EMR and represented its diversity in terms of variation in income, population, size of the private sector and experience with contractual arrangements.

We developed an open-ended checklist (see Annex 1) to guide country investigators

in data collection. Although researchers were given some flexibility to adapt the checklist to their countries' needs, none of them modified it. This common checklist was the basis for ensuring comparability of data. Our study had two sections: (1) assessment of the overall status of contracting out of health services; and (2) review of interventions in which a contractual arrangement was the principal implementation strategy. We collected both quantitative and qualitative information by reviewing existing documents and studies and interviewing stakeholders including MOH staff and private providers. Our analysis, which was predominantly qualitative, was based on information provided by each country on different aspects of contracting as identified in the checklist. We asked the country investigators to review the studies for any major gaps in information. We monitored progress by establishing an electronic network with country investigators and occasionally through in-country visits. We shared the results in a regional consultative meeting with national policy-makers in April 2005.

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For the purpose of this study we defined “contracting” as a purchasing mechanism used to acquire a specified service, of a defined quantity and quality, at an agreed-on price, from a specific provider, for a specified period.¹⁴ “Contracting out” was defined as the development and implementation of a documented agreement by which one party (purchaser) provides compensation to another party (provider) in exchange for a definite set of services for a specific target population.¹⁵ We have used the terms contracting out and outsourcing interchangeably in this paper. “Internal contract” was defined as contracting among different tiers within the public sector.¹⁴

Results

Rationale and institutional capacity for outsourcing Rationale and interest

Our study revealed that most countries undertook contracting to improve access, efficiency and quality of health services (Table 1). In Bahrain and Lebanon, national policy to engage the private sector influenced the public health sector to outsource health services. In the Islamic Republic of Iran and Morocco the policy of decentralization was the underlying reason for contracting out. Afghanistan contracted out health services to rapidly expand basic health services disrupted due to years of conflict. In Tunisia contracting out to private providers was to help decrease the cost of treatment incurred on patients sent to foreign countries for treatment. While Pakistan contracted out to access the population at risk for HIV infection through nongovernmental organizations (NGOs), Jordan wanted to improve the use of private hospitals and save capital investment on public facilities. Egypt contracted out to improve coverage and quality of services and increase access to advanced medical technology available in private hospitals.

We found that the interests of the non-state health sector in contractual arrangements were the assurance of a regular source of revenue, enhanced recognition and credibility, increased volume of work and utilization of spare capacity. In Afghanistan, contracting out was a way of continuing the essential services being provided by NGOs during the post-conflict period.

Institutional capacity for outsourcing

We have summarized the overall capacity of the public and the non-state sector to engage in contracting (Table 2). Our study showed that all countries had some experience with contracting out of clinical services with the exception of Bahrain and the Syrian Arab Republic, where only non-clinical services were contracted out.

All countries, except the Syrian Arab Republic, had a policy that promoted contracting; Afghanistan had the most explicit policy. Bureaucratic support varied depending on the duration of contracting experience. Jordan, Lebanon and Tunisia had extensive experience, while the experience in Afghanistan, Egypt and Pakistan was relatively recent. We found that the legal framework and the necessary rules and procedures for outsourcing of health services required updating. Most ministries had limited capacity for cost and price analysis and transaction cost estimations were usually not done.

Most countries had some type of competitive bidding process for the award of contracts. However, many MOHs did not have independent contracting units, such as Pakistan, or lacked the institutional capacity to award contracts, such as Lebanon. In the Islamic Republic of Iran, although bidding procedures were in place, often, good local reputation and recommendations by experts and colleagues were the criteria for provider selection.

We observed that while NGOs were actively involved in the delivery of primary care services, especially in Afghanistan and Pakistan, the quality of services they provided, their lack of managerial capacity and the absence of a system for their accreditation were some of the associated key problems. In Egypt, Jordan, Lebanon, Morocco and Tunisia private providers had access to advanced medical technologies that made them attractive to contract with for secondary and tertiary care services.

With the exception of Egypt and Afghanistan, we did not find performance indicators included in the design of contracts. Moreover, since management information systems were inadequate to monitor the performance of private providers, such as in Afghanistan, performance was measured through third-party evaluations.

We observed that payment methods

for most contractual arrangements were either fee-for-service or block grants. Afghanistan had experience with payments based on capitation along with incentives for good performance. We observed that experience with capitation-based payment is accumulating in Egypt and the Islamic Republic of Iran, and that delayed payments were a problem in Jordan and Pakistan. We noticed risks with contracting out, such as differing interpretations of loosely worded contracts, limited number of providers in rural areas and parties with vested interests gaining control over the contracting process. Skeptics were also concerned about the lack of commitment among governments in low-income countries to contract once donor funds dry out.

We found that decentralization provided impetus for contracting out of health services in the Islamic Republic of Iran, Morocco and Pakistan so as to benefit from the synergy between decentralization and contracting that encourages institutions to improve management, optimize use of resources, be more accountable and improve overall performance.

Interventions with contractual arrangements

Primary care services

In Egypt, the Family Health Fund (FHF) was the main contracting agency to split financing from service provision, ensure competition among providers and act as a forerunner of the National Health Insurance Fund.¹⁶ The FHF is piloting the purchase of a package of primary care services for registered families through contracts with accredited private providers and NGOs, as well as internal contracts with the reformed public sector facilities. It has identified a set of 30 coverage, utilization and quality indicators for monitoring performance.

Our evaluation of contracting out of 103 primary health care (PHC) facilities in Rahim Yar Khan district in Pakistan showed that utilization, physical condition of facilities and patient satisfaction had improved and out-of-pocket expenditure had decreased. The quality of care, drug availability and accessibility to remote communities did not improve and there was little effect on the coverage of preventive health services.¹⁷ The Ministry of Health and Medical Education is piloting contracting out of primary care services in several provinces of the Islamic Republic of Iran. While it

Table 1. Rationale and interest of ministries of health and non-state sector in contracting out in countries of the World Health Organization Eastern Mediterranean Region

Country	Rationale for MOH ^a to enter into health service contracts	Interest of the NGOs ^b / private sector in contracting
Afghanistan	<ul style="list-style-type: none"> Disrupted public sector health services due to years of conflict 80% of health facilities operated by NGOs during conflict and in the early post-conflict period 	<ul style="list-style-type: none"> NGOs would continue to be actively engaged in provision of care NGOs would receive US\$ 4.5 per capita as cost of Basic Package of Health Services
Bahrain	<ul style="list-style-type: none"> Improved efficiency Economies of scale in private sector Government policy to involve private sector 	<ul style="list-style-type: none"> Increase scale of work Assurance of regular source of revenue
Egypt	<ul style="list-style-type: none"> Increase coverage of services Utilize advanced technology available with private sector Improve quality of care 	<ul style="list-style-type: none"> Assurance of regular source of revenue Guaranteed registration of families (increase clientele)
Islamic Republic of Iran	<ul style="list-style-type: none"> Decentralization of services MOH policy to provide services for segment of rural and deprived population 	<ul style="list-style-type: none"> Access to government resources for family physicians
Jordan	<ul style="list-style-type: none"> Optimize capital investments in public sector Improve accessibility and efficiency Decrease waiting lists at government hospitals 	<ul style="list-style-type: none"> Utilize spare capacity Assurance of regular source of revenue Increase credibility through affiliation with MOH
Lebanon	<ul style="list-style-type: none"> Access more elaborate infrastructure of hospitals in the private sector Avoid duplication of services already available in private sector 	<ul style="list-style-type: none"> Access to major insurers of population Utilize capacity in private sector
Morocco	<ul style="list-style-type: none"> Decentralization of services Improve access to services Overcome budget constraints for capital projects 	<ul style="list-style-type: none"> Enhanced recognition of private sector Opportunity for partnering with public sector
Pakistan	<ul style="list-style-type: none"> Improve access to services Expand service provision for culturally sensitive issues — HIV/AIDS^c 	<ul style="list-style-type: none"> Enhanced recognition of NGOs by the population Expansion of programme activities
Syrian Arab Republic	<ul style="list-style-type: none"> Public provision of services, clinical services not contracted out 	<ul style="list-style-type: none"> Access to government funds
Tunisia	<ul style="list-style-type: none"> Reduce cost of foreign treatment by contracting with national providers 	<ul style="list-style-type: none"> Most contracts between Ministry of Social Affairs and Solidarity or MOH and private facilities are adherents to these agreements

^a MOH = Ministry of Health.

^b NGOs = nongovernmental organizations.

^c HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome.

is difficult to give a verdict in the absence of a comprehensive evaluation, early evidence suggests that contracting out has helped improve access and quality, and decreased the cost of services.

We found that up to 80% of the health facilities in Afghanistan were operated by NGOs, which were directly contracted by the donors when peace was restored.¹⁸ Subsequently, the Ministry of Public Health espoused contracting out of a Basic Package of Health Services (BPHS) as the cornerstone of its National Health Policy. By early 2005, though the population coverage with the BPHS had extended to 16.5 million (70%), the actual extent of the service coverage remains unclear. The BPHS, which is funded by several donors, forms the core of service delivery with an

estimated cost of US\$ 4.5 per capita.¹⁹ A recent balanced score card assessment of health services demonstrated some improvement in health services.²⁰ We hypothesize that the major risk inherent in contracting out in Afghanistan is the decrease in external donor funds and their long-term sustainability.

Hospital services

Jordan, Lebanon and Tunisia have had extended experience with contracting out of hospital services. In Lebanon, the public sector outsourced a wide range of services in over 100 hospitals to cover its uninsured population. Some limitations were fragmentation of the contracting process between different agencies, the limited leverage of public over private sector, the inability to contain escalat-

ing health care costs and lack of public sector capacity to monitor performance. We found that the Jordanian MOH had internal contracts with the university hospital and military services for the provision of emergency and referral care with evidence that contracting improved efficiency. Tunisia outsourced haemodialysis services to private institutions, which were obliged to accept a flat rate determined by the MOH and not to charge co-payments. In these three countries, we found that payments were being made on a fee-for service basis and performance was not adequately monitored.

Non-clinical services

In Bahrain, Morocco and the Syrian Arab Republic, the MOHs contracted out services for the maintenance of medical

Table 2. Capacity of the public and private sectors to contract out health services in countries of the WHO Eastern Mediterranean Region

Country	Political environment, bureaucratic support, legal framework	Purchaser characteristics: strengths and weaknesses	Provider characteristics: strengths and weaknesses	Risks of the process	Mechanisms for monitoring performance
Afghanistan	<ul style="list-style-type: none"> Weak political, bureaucratic and legal framework External donor influence to push for contracting 	<ul style="list-style-type: none"> MOPH^a lacked experience with purchasing of health services, contracting unit established for managing donor funds 	<ul style="list-style-type: none"> NGOs^b had past experience of contracting with donors as the main provider of health services 	<ul style="list-style-type: none"> Reduction in donor funds for contracting out; rising expectations in population; long-term sustainability 	<ul style="list-style-type: none"> Balanced scorecard assessment for monitoring performance
Bahrain	<ul style="list-style-type: none"> Government policy supports private sector development Supportive bureaucratic process, strong legal framework 	<ul style="list-style-type: none"> Clearly defined rules and procedures Dedicated section in Finance Ministry 	<ul style="list-style-type: none"> Limited capacity of local companies for most contracts Opportunities for regional/international companies 	<ul style="list-style-type: none"> MOH^c has to have a back-up option in case of failure of contractor to provide services 	<ul style="list-style-type: none"> MOH approves hiring of personnel by the contractor Users report performance Previous record taken into account
Egypt	<ul style="list-style-type: none"> Contracting is part of reform programme Legal framework for contracting present 	<ul style="list-style-type: none"> Four technical units established in Family Health Fund which support contracting process 	<ul style="list-style-type: none"> Private sector provides most ambulatory care Majority of facilities not accredited by MOH 	<ul style="list-style-type: none"> Fee for service and capitation being tested System of facility accreditation needs improvements 	<ul style="list-style-type: none"> 30 weighted performance indicators (encompassing coverage, quality and utilization)
Islamic Republic of Iran	<ul style="list-style-type: none"> Political and legal support through 3rd Socioeconomic Development Plan passed in 1999 	<ul style="list-style-type: none"> Improve access, quality and efficiency of PHC^d services, especially to the deprived and vulnerable population 	<ul style="list-style-type: none"> Private sector mainly involved with urban hospitals Lack of experience with PHC services 	<ul style="list-style-type: none"> Public and private managers lack skills of contracting Private sector demonstrates opportunistic behaviour 	<ul style="list-style-type: none"> Performance-based service contracting with measurable standards and negative incentives for non-performance
Jordan	<ul style="list-style-type: none"> Political environment and legal framework is present Bureaucratic framework is not flexible 	<ul style="list-style-type: none"> Experience of contracting for the past three decades Cost and price analysis for some projects 	<ul style="list-style-type: none"> Lack of skilled and professional managers Some experience exists in negotiating contracts 	<ul style="list-style-type: none"> Delay in payments from the MOH Concerns regarding quality of care in private sector 	<ul style="list-style-type: none"> Weak monitoring mechanisms are a challenge, new systems being piloted
Lebanon	<ul style="list-style-type: none"> Legal framework is adequate; lack of political will for improving contracting process 	<ul style="list-style-type: none"> MOH has experience in contracting Contracting is highly fragmented Does not limit cost of health care 	<ul style="list-style-type: none"> Major provider of services Oversupply of specialists and services 	<ul style="list-style-type: none"> Number of providers is above requirement Contracts are not performance-based 	<ul style="list-style-type: none"> Political environment affects monitoring of contracts Capacity to monitor contracts is poor at MOH
Morocco	<ul style="list-style-type: none"> Decentralization has been an impetus for contracting No clear policy on contracting of clinical services 	<ul style="list-style-type: none"> MOH has experience in contracting Loose partnership arrangements with public sector 	<ul style="list-style-type: none"> Advanced diagnostic and therapeutic services Limited experience in clinical contracting 	<ul style="list-style-type: none"> Difficulty in ensuring quality of services 	<ul style="list-style-type: none"> Monitoring indicators not well defined Adequate information system not in place
Pakistan	<ul style="list-style-type: none"> Political commitment exists; bureaucratic support is ambivalent; legal framework being adapted 	<ul style="list-style-type: none"> No dedicated contracting unit in MOH Experience limited to specific national programmes 	<ul style="list-style-type: none"> Different providers (NGOs, government-supported NGOs, private practitioners) Technical, financial capacities vary widely 	<ul style="list-style-type: none"> Delay in release of payments adversely affects contracts Block payments made, concerned only with quantity 	<ul style="list-style-type: none"> Information system has limited capacity, most programmes unable to monitor quality of services
Syrian Arab Republic	<ul style="list-style-type: none"> No bureaucratic or political support for contracting Only non-clinical contracts 	<ul style="list-style-type: none"> Major provider of care Expanding service infrastructure 	<ul style="list-style-type: none"> Advanced diagnostic and therapeutic services 	<ul style="list-style-type: none"> Difficulty in ensuring quality of services 	<ul style="list-style-type: none"> Information system has limited capacity to assist in monitoring contracts
Tunisia	<ul style="list-style-type: none"> Political and legal framework supportive 	<ul style="list-style-type: none"> Social Security Fund has long experience; contracts not given directly to private facilities 	<ul style="list-style-type: none"> Advanced diagnostic and therapeutic services 	<ul style="list-style-type: none"> Reimbursements made on flat rate determined by MOH and no co-payment charged 	<ul style="list-style-type: none"> Medical inspection for assessing hospitals and treatment facilities

^a MOPH = Ministry of Public Health.^b NGOs = nongovernmental organizations.^c MOH = Ministry of Health.^d PHC = Primary health care.

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equipment and hospital building, as well as support services such as cleaning, catering, gardening and security. Contracts were being awarded through competitive bidding, with monitoring mechanisms varying among countries and payments being made as block grants on a quarterly or annual basis. In Bahrain, a third party — the Tender Board in the Ministry of Finance — was ensuring transparency in the selection process.

What compels contracting out of health services in the Eastern Mediterranean Region?

We found that disillusionment of the general public with directly provided services; the concern of the public sector to improve access, efficiency and quality of services; optimization of hospital bed occupancy; and better targeting of vulnerable populations were the main reasons for contracting out in the EMR. The increasing trend in engaging the private sector in service delivery led many governments to promote health services outsourcing policies, which countries such as Bahrain are now actively following. These policies have influenced social sector ministries to outsource health services despite good public sector health services. While in Afghanistan the principal reason for contracting out has been the multilateral and bilateral donor agencies, contracting in Pakistan and the Islamic Republic of Iran was an indigenous initiative.

Discussion

Contracting out of health services is receiving increasing attention among low- and middle-income countries but, while evidence relating to the benefits and risks of this approach is accumulating,^{11,12} it is far from conclusive. Careful consideration and a thorough analysis of the local context are essential before deciding on outsourcing versus direct provision.² Contracting takes place more frequently in the EMR than presumed and there is a wide variation in the kinds of contractual arrangements and the range of services outsourced.

We hypothesize that contracting out of health services is an evolutionary process and that all countries, developed and developing, pass through a learning phase before contracting is recognized as an effective management and regulatory tool. We would like to mention two important cautionary notes: (1) contracting

is complex and cannot be a solution for all problems of the health-care system; and (2) not everything can or should be contracted out. Jordan, Lebanon and Tunisia, despite decades of experience with contracting, need time before the capacities among purchasers and providers are adequately developed and procedures streamlined. In Afghanistan, Egypt, Islamic Republic of Iran and Pakistan, experience with outsourcing is relatively recent and the long-term sustainability of this approach has yet to be ascertained.

Our study had a few limitations: (1) coordinating collaborative research across ten countries given the diverse environments, though our checklist as a guide to undertaking studies, the e-network of country researchers and on-site monitoring allowed a fair comparison; (2) comparing the wide range of services contracted out from clinical to non-clinical, although these had been considered together in an earlier study,² but the existence of several types of contracting mechanisms within each country made comparisons easier; and (3) the focus of the study being the process of contracting and not the outcome.

We believe that several issues regarding assessment of the contracting process in countries of the EMR need to be considered before contracting out becomes accepted as a viable alternative to direct provision. There needs to be a supportive public policy in favour of engaging with the non-state sector. The policies on private sector contracting have seen a substantial change over the past decade in the EMR. The legal and administrative framework for contracting out health services needs updating in many countries. Many MOHs lacked a dedicated unit for contracting. Afghanistan and Egypt were two examples where donor-financed projects have supported the establishment of contracting units. We believe that the limited capacity of the public sector to design, negotiate and award contracts; undertake a cost, price and volume analysis; optimize payment methods; and effectively monitor contract performance are among the remaining problems.

We hypothesize that unless such capacities are enhanced the value of contracted out services will always be questioned. Moreover, the capacity of private providers to successfully meet the requirements of the contractual arrangement in terms of an effective process

and successful outcome should also be considered. The purchaser–provider relationship is an important determinant of the success of the contracting process. We need to consider whether providers find purchasers intimidating because they have greater negotiating power or is there a mutual trust and cooperation in their relationship?¹⁰ A perception that needs to be dispelled among public sector managers about NGOs is their apparent actions as profit-making entities.

Though our study could not document it, there may be substantial transaction costs involved in creating and maintaining the contracts, which is a reflection of the capacities of public sector institutions. Thus, it is equally important to compare the transaction costs of contracting with the explicit and hidden costs of directly managed public systems that incur large costs in monitoring staff and output quality. There may also be significant costs involved in bureaucratic and administrative mechanisms as well as political interference.²¹

Assessing whether providers are actually providing services on the ground relies on the following: (1) whether monitoring indicators will be included in the contract; (2) whether this information will be reported by the providers or collected independently; (3) does the public sector have the means for assessing the reliability and validity of the information? (4) how will the information be used? The monitoring and evaluation aspects of the contractual arrangement seem to be deficient in most EMR countries. A study from Costa Rica has shown that the data gathered do not provide the purchaser with information directly related to all of the contract objectives nor of the contract performance.²²

In the EMR, PHC services are mostly contracted out to NGOs, which is similar to the experience of contracting primary health services in other WHO regions.^{3,23,24} Population coverage indicators, though easier to measure, provide little information on actual service coverage, as in Afghanistan. Thus, it is important that indicators, such as effectiveness and quality of treatment or efficient resource use, are considered while preparing contracts.²²

Donor agencies have promoted contracting out of health services in many EMR countries, during or post-conflict, because health systems were disrupted and MOHs were weak, and NGOs took over as providers of health care as donor funds became available. There is always

the risk of the donors influencing the process in the short term, raising the question of sustainability over the long term when donor funds begin to dry up. We believe that sustainable health improvement cannot be achieved unless physical infrastructure and human resources are rehabilitated by the public sector for the poor and vulnerable.

Lebanon, which experienced a civil war in the 1970s, provides lessons on the long-term consequences of contracting out. During and following the civil war, there was rapid expansion of the private sector at the cost of the public sector, the MOH had a limited role in service provision and contracted out most services, which resulted in high cost of health care. Though Lebanon spends more than US\$ 500 per capita on health, its health system is arguably the least efficient in the region. While contracting with NGOs may be the only means to improve the system in post-conflict situations, the risk of missing the opportunity for long-term health system development projects the need for future research and debate.²⁵

Conclusions

We conclude that contracting as a purchasing tool, when applied judiciously,

could contribute to the improvement of health system performance. Contracting does not mean privatization of health services. While the state cannot divest itself from the responsibility of ensuring essential health functions, contracting out may provide an opportunity to obtain greater control over private providers in developing countries with poor regulatory capacity. Five supporting elements have been proposed for effective contractual arrangements: a few clearly defined deliverables; supportive stakeholders; trust between contractor and agency contracted to deliver services; independent source of monitoring information; and a legal system and political environment which convinces both sides that the contract will actually be enforced.²⁴

While effective contracting requires MOHs to have the capacity to design, award, manage and monitor contracts, enhanced capacity of the private sector to implement contracts is equally important. We suggest that contracting be used primarily to promote public health objectives. At the same time, more research is required to evaluate the impact of contracting on health outcomes in the region. ■

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Résumé

Externaliser, mais avec prudence : expérience acquise dans le domaine des prestations de santé dans certains pays de la Région Méditerranée orientale

Le secteur public des pays en développement passe un nombre croissant de contrats avec le secteur non public afin d'améliorer l'accès, l'efficacité et la qualité des services de santé. Nous avons mené une étude multi-pays pour évaluer la gamme des services de santé externalisés, le processus de passation des contrats et les facteurs influant sur ce processus dans dix pays appartenant à la Région Méditerranée orientale : Afghanistan, Bahreïn, Égypte, République Islamique d'Iran, Jordanie, Liban, Maroc, Pakistan, République arabe syrienne et Tunisie. D'après les résultats de cette étude, l'Afghanistan, l'Égypte, la République Islamique d'Iran et le Pakistan ont fait l'expérience d'une externalisation des services de santé primaire; la Jordanie, le Liban et la Tunisie ont externalisé très largement leurs services de soins hospitaliers et ambulatoires; tandis que le Bahreïn, le Maroc et la République arabe syrienne n'avaient externalisé pour l'essentiel que des services non cliniques. L'objectif de la passation de contrats avec le secteur non public

était de garantir une source régulière de revenus et d'obtenir davantage de reconnaissance et de crédibilité. Si la plupart des pays concernés favorisaient la passation de contrats avec le secteur privé, la présence du dispositif juridique et administratif nécessaire dépendait de la durée de l'expérience acquise en matière d'externalisation. Les risques inhérents à l'évidence au processus de passation de contrats étaient la fiabilité des bailleurs de fonds, le nombre limité des prestataires en zone rurale, l'intervention de parties ayant des intérêts dans la mainmise sur le processus de passation de marchés, ainsi que l'insuffisance des mécanismes de surveillance et d'évaluation. L'externalisation offre la possibilité d'exercer un plus grand contrôle sur les prestataires privés des pays dont le dispositif réglementaire est limité et, si elle est utilisée à bon escient, d'améliorer les performances du système de santé.

Resumen

Contratar, pero con prudencia: experiencia de externalización de servicios de salud en países de la Región del Mediterráneo Oriental

El sector público de los países en desarrollo está contratando cada vez más servicios con el sector no público para mejorar la accesibilidad, la eficiencia y la calidad de los servicios de salud. Realizamos un estudio multipaíses para evaluar la variedad de servicios de salud subcontratados, el proceso de contratación y los factores que influyen en ellos en diez países de la Región del Mediterráneo Oriental: Afganistán, Bahrein, Egipto, República Islámica del Irán, Jordania, Líbano, Marruecos, Pakistán, República Árabe Siria y Túnez. Nuestros resultados muestran que el Afganistán, Egipto, la República Islámica del Irán y el Pakistán tenían experiencia de contratación externa de servicios de atención primaria; Jordania, Líbano y Túnez subcontrataban gran parte de sus servicios de atención hospitalaria y ambulatoria; y Bahrein, Marruecos y la República Árabe Siria externalizaban sobre todo servicios no clínicos. El interés del sector no estatal por conseguir

contratos se debía a su deseo de asegurarse una fuente regular de ingresos y lograr un mayor reconocimiento y credibilidad. Aunque la mayoría de los países promovían la contratación con el sector privado, el apoyo jurídico y burocrático en cada país dependía de la duración de la experiencia de contratación. Los riesgos inherentes al proceso de contratación eran la dependencia de los fondos de donantes, el número limitado de proveedores en las zonas rurales, la posibilidad de que partes con intereses creados llegaran a controlar el proceso de contratación, y unos mecanismos de seguimiento y evaluación deficientes. La contratación brinda la oportunidad de ejercer un mayor control sobre los proveedores privados en los países con escasa capacidad normativa, y si se usa de forma juiciosa puede mejorar el desempeño del sistema de salud.

ملخص

التعاقد دون التخلي عن الحذر: تجربة التعاقدات الخارجية للخدمات الصحية في بلدان إقليم شرق المتوسط

الخدمات غير السريرية (غير الإكلينيكية). وقد انصب اهتمام القطاع غير الحكومي في التعاقد على ضمان مصدر منظم للعوائد واكتساب وتعزيز الاعتراف به ومصداقيته. وقد عززت معظم البلدان التعاقد مع القطاع الخاص، وكان الدعم القانوني وتعقيد العمل المكتبي في البلدان متفاوتاً وفقاً لمدة التجربة ومدى التعاقد، فيما كانت الأخطار المحدقة بعملية التعاقد تتمثل بالاتكال على تمويل المانحين، وقلة عدد القائمين على العمل في المناطق الريفية، وسيطرة أطراف من أصحاب المصالح على عملية التعاقد، وضعف آليات المراقبة والتقييم. إن التعاقد يقدم فرصة للاعتماد على القائمين على العمل في القطاع الخاص في البلدان ذات القدرات التنظيمية الضعيفة، ويمكن للاستخدام الحكيم للتعاقد أن يحسّن من أداء النظام الصحي.

تزايد وتيرة تعاقد القطاع العام في البلدان النامية مع القطاع غير الحكومي لتحسين إتاحة الخدمات الصحية وكفاءتها وجودتها. وقد قمنا بدراسة متعدّدة البلدان لتقييم مدى التعاقدات الخارجية لتقديم الخدمات الصحية، وعملية التعاقد والعوامل المؤثرة عليها في عشرة من بلدان إقليم شرق المتوسط، وهي أفغانستان والبحرين ومصر وجمهورية إيران الإسلامية والأردن ولبنان والمغرب وباكستان والجمهورية العربية السورية وتونس. وقد أظهرت النتائج التي توصلنا إليها أن لدى كل من أفغانستان ومصر وجمهورية إيران الإسلامية وباكستان خبرة في التعاقد الخارجي لتقديم خدمات الرعاية الصحية، فيما اقتصر التعاقد الخارجي في كل من تونس والأردن ولبنان على المستشفيات وخدمات الرعاية الجوّالة، أما التعاقد الخارجي في كلٍّ من البحرين والمغرب والجمهورية العربية السورية فقد تركز بشكل رئيسي على

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Annex 1. Checklist for assessing the role of contractual arrangements in improving health sector performance in countries of the WHO Eastern Mediterranean Region

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

1. What is the rationale for Ministries of Health to enter into health services contracts with nongovernmental organizations (NGOs) or the private sector?
2. What is the interest of the NGOs/private sector in receiving public sector financing?
3. Is the political environment enabling/disabling for the execution of contractual arrangements in the health sector? Does the political environment influence the negotiation and execution of contracts?
4. Does the bureaucratic set-up support contracting out of services to the private sector?
5. Is the legal framework robust enough to facilitate contracting between the public and private sectors?
6. Are there efficient mechanisms to recourse in the event of a dispute between the two contracting partners?
7. What are the capabilities of the purchaser (Ministry of Health) to successfully enter into a contract in terms of: (i) competitive bidding; (ii) awarding contracts; (iii) monitoring and supervision; (iv) regulation; (v) payment mechanisms; (vi) performance evaluation; (vii) other aspects?
8. What are the capabilities and experiences of the providers (private sector organizations) in terms of: (i) developing a proposal; (ii) technical capacity to implement; (iii) financial management capacity to fulfill the terms of the contracts?
9. What are the strengths and weaknesses of the purchaser (public sector) that should be taken into consideration when entering into a contractual agreement?
10. What are the strengths and weaknesses of the provider (NGOs/private-sector) that should be taken into consideration when entering into a contractual agreement?
11. What risks and incentives does each party incur when entering into a contract?
12. What are the prevalent payment mechanisms of each contract? To what extent do they promote efficiency, equity, and quality? How transparent are these?
13. Is there capacity among the public and private sector to undertake a cost and price analysis before negotiations?
14. What information systems/sources exist in the Ministries of Health to successfully carry out the contract and assess performance of the contracting private sector agency?
15. What monitoring mechanisms and evaluation systems are in place in the public sector and what challenges exist in this area?

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(Annex 1, continued)

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

1. Who is the purchaser and who is the provider? When was the contract signed? What is the duration of the contract?
2. What is the type of the private sector/civil society organization (CSO)? When was it established/registered? What are the sources of its funding? What percentage of its revenue comes from the public sector? What is the major type of service it provides? What relationship does it have with the community if any?
3. What is the nature of the public-sector organization/agency that is outsourcing its services? Is the financing source direct government funds or out of a donor-financed project?
4. How was the CSO/NGO selected? How transparent was the entire selection process with respect to announcement of the contractual agreement, competitive bidding, award of contract and negotiation between the purchaser and the provider?
5. How are the issues of expected service outputs, monitoring and evaluation, performance assessment, transfer of funds, settlement of disputes, etc. addressed in the contractual agreement?
6. What are the types of services being given by the provider (CSO/NGO)? Has a package of services been agreed upon? Is it targeted to a specific population, vulnerable group or a geographical area?
7. How does the public sector agency monitor and/or evaluate the performance of the agency? What are the indicators agreed upon? How is information collected and to what extent is the information source independent of the provider?
8. Are there any financial or other risks/incentives built in the contract for the purchaser or the provider? How are these distributed across the purchaser and provider with respect to the terms of contract, price levels set, administrative costs, and the cost of supervision?
9. What are the administrative and transaction costs of the contract for the purchaser and the provider? Are 100% of administrative and transaction costs being reimbursed?
10. What is the payment mechanism between the purchaser and the provider? Is it prospective, such as subsidy, block grant, or based on performance or population coverage, or is it retrospective such as fee-for-service? Are there delays in the release of payments? What are the reasons for delay and how does the provider cope with it?
11. What are the means of financial audit of the provider and the mechanisms for addressing fiduciary issues? Have there been any such disputes between the purchaser and the provider, and how were these settled?