Contracting out Health Services in Fragile States: Challenges and lessons learned

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Abstract

Governments engage with the private sector in several ways, one of which is through contractual agreements to provide services to the population on the governments' behalf (the process of 'contracting out'). The importance, feasibility and effectiveness of this contracting process in the health sector is disputed, particularly in states where the government is unable to adequately deliver fundamental services. This manuscript reviews the literature on contracting between governments and the private sector and analyses the basic principles and technical aspects of contracting, using experiences of countries worldwide. While there are stories of success with contracting for healthcare services in fragile states, this depends largely on individual properties of the countries in question, including levels of government backing and support, familiarity with engaging private providers and monitoring and evaluation schemes. Keeping this in mind is essential in benefiting the populations, governments and contractors in question.

Introduction

For decades now, governments in various parts of the world have delegated the provision of services such as education, healthcare and infrastructure to third parties, choosing to take on a more supervisory role in service provision[1]. In the healthcare sector, many reasons are attributed to taking such a decision. In states which are unable or unwilling to provide basic amenities to their populations, the adequate provision of services is of utmost priority. The technical and administrative aspects of this process of delegating services to private providers through contractual agreements vary widely by various factors – and no one method or pathway can be considered applicable to all states. Thus, this manuscript aims to assess and identify the essential elements of contracting out for health services, with particular emphasis on fragile states. Lessons learned from various states – both fragile and otherwise, will also be highlighted.

Fragile States

Definition

According to the Organisation for Economic Co-operation and Development (OECD), these are states which are ‘unable to meet (their) population’s expectations or manage changes in expectations and capacity through the political process’[2]. The UK’s Department for International Development (DFID) defines fragile states as: ‘those where the government cannot or will not deliver core functions to the majority of its people, including the poor’[3].

States are judged in this respect based on two criteria[4]:

1. Legitimacy: Government will and capacity to provide core services and basic security. It is their resolve to work in the interest of the public.
   (i) Willingness is the ‘explicit political commitment to policies supporting human welfare.’
   (ii) Capacity is ‘having core features that enable the state to mobilize resources for key objectives.’

2. Effectiveness in providing services and security

Reasons for fragility

Fragile states can be grouped into 4 categories[5]. States which are termed to be ‘in deterioration’ are countries where there is a rising risk of conflict, those in ‘arrested development’ have been through a prolonged conflict, political instability or turmoil. ‘Post-conflict’ states, where most fragile states lie in this categorization scheme are countries at high risk of relapse of violence – there is a 44% chance of experiencing a recurrence within 5 years[6]. The World Bank’s International Development Association (IDA) defines a post-conflict state as ‘A country that has suffered from a severe and long-lasting conflict, which has led to inactivity of the borrower for an extended period of, or at least a substantial decline in the level of external assistance, including from IDA; a country that has experienced a short, but highly intensive, conflict leading to a disruption of IDA involvement; and a newly sovereign state that has emerged through the violent break-up of a former sovereign entity.’ [7] States in ‘early recovery’ are those which show some reform in leadership and government, but change is difficult, slow and with setbacks.
It is important to distinguish whether the government is willing, but can't, provide basic services or is simply unwilling. Strong government will to provide such services is strongly linked to the success of the contracting process – through mobilization of resources, effective oversight and monitoring and producing a sustainable improvement in service provision through training of personnel.

Fragile states are neglected by the international community for various reasons including a lack of funding, interest and expertise in health systems research\(^6\)(it is worth noting that there is virtually no funding for health systems research in any of the fragile states), poor security and expensive lifestyle as well as lack of potential local partnerships. Thus, it has been estimated that once a state is classified as fragile, it will remain in this condition for an average of 50 years\(^8\) – with far-reaching consequences.

However, it has been argued that the international community should, for its own benefit, engage and help improve the situations of fragile states\(^5\). This is because these states tend to destabilize entire regions in which they lie, and may even be threats to security worldwide.

Figure 1 depicts how government ineffectiveness can lead to loss of confidence by the population, through poor quality of services provided.

**Health statistics in fragile states**

Fragile states are the furthest countries from reaching the targets set by world leaders in 2000 in terms of poverty eradication, improving access to healthcare and education, promoting gender equality and environmental awareness (the Millennium Development Goals)\(^9\). Although they represent only about one-fifth of the world’s population, one third of maternal deaths and half of under-five deaths occur in them and a third of people living with HIV/AIDS live in fragile states\(^10\). A third of the people living in fragile states are malnourished and deaths from malaria are thirteen times greater in these countries than even other developing countries\(^11\). Moreover, they have the lowest levels of government health expenditure among the low-income states\(^12\). This highlights the need for an effective, extensive and most importantly, sustainable method of improving healthcare provision in fragile states.

**Issues with health systems in fragile states**

Health systems in fragile states can be deficient in a variety of ways. A lack of adequate infrastructure is an important contributing factor – poor oversight and monitoring, deficient policies (and lack of implementation of existing policies) and inequalities between urban and rural, as well as poor and rich populations exist\(^13\). One of the most significant shortages in the health systems of these states, however, is the lack of adequate information upon which policies are formed – information about disease endemicity and outbreaks, as well as health service coverage and utilization is lacking. Thus, gathering information is considered one of the most urgent interventions to be implemented in these states. Performing rapid assessments of a variety of different health indicators, demographic and epidemiologic characteristics of the population, and existing health service availability and needs, as has been achieved successfully in Liberia\(^52\), is integral to the efficiency of the health system. Effective management systems and human resources\(^14\)(with adequate capacity) are also deficient in the health systems of these states. Investment is lacking for health workers in fragile states\(^15\), and they often face unique challenges that hinder their performance\(^16\). Collectively, these issues lead to public systems of health services in most fragile states being highly inadequate\(^17\).

The World Bank in 2011 listed 33 fragile “situations”\(^18\). This list is updated annually, and thus is not considered a permanent classification. They include the following:

1. Afghanistan
2. Angola
3. Burundi
4. Central African Republic
5. Chad
6. Comoros
7. Democratic Republic of Congo
8. Republic of Congo
9. Cote d’Ivoire
10. Eritrea
11. Guinea
12. Guinea-Bissau
13. Haiti
14. Kosovo
15. Kiribati
16. Liberia
17. Myanmar
18. Nepal
19. Sao Tome and Principe
20. Sierra Leone
21. Solomon Islands  
22. Somalia  
23. Sudan  
24. Tajikistan  
25. Timor-Leste  
26. Togo  
27. Yemen  
28. West Bank & Gaza  
29. Western Sahara  
30. Bosnia & Herzegovina  
31. Georgia  
32. Zimbabwe  
33. Iraq

**Contracting**

**Definition**

Non-state providers can be involved in healthcare provision in a variety of ways, ranging from international organizations (such as the United Nations) sharing authority with the government to total privatization by which the government hands over all form of authority on a specific realm of service provision. However, some of these relationships exist as partnerships, while others are contractual agreements.

Contracting out refers specifically to the ‘transfer of competences and/or authority for a given period of time based on a contractual agreement between the delegating authority (government) and a third party (contractor)’. Contracting out in the health sector has been defined as the development and implementation of a documented agreement by which one party (the principle, purchaser, or contractor) provide compensation to another party (the agent, provider, or contractee) in exchange for a defined set of health services for a defined target population[19].

**Methodology**

The databases searched for relevant articles were MEDLINE (from 1946 to December, 2011), Scirus and Google Scholar. Search terms used were ‘contracting out’ and ‘health services’ and ‘fragile states’. Names of fragile states were also included as keywords to identify country-specific articles. The search terms were used in all possible combinations. The bibliographies of the articles found were also scanned for relevant articles possibly missed by the keyword search.

The complete articles found were retrieved and thoroughly assessed to determine if they met the review inclusion criteria, which were:

1. Articles discussing contracting out (as defined above by England et al[18]) for health care in terms of country experience, effects on the healthcare system, challenges and recommendations for the process.
2. Articles published in English
3. Articles dealing with other forms of partnerships, such as joint government-private sector projects were not excluded from the review.
4. Methodological quality was not used as an exclusion criterion, however the coherence and support provided for the arguments presented in the articles was used to evaluate their quality.

A narrative review was synthesized in order to provide a comprehensive summary of primary evidence concerning the contracting process, with particular emphasis on the unique aspects found in fragile states.

**Discussion**

**Reasons for Contracting**

The decisions to contract out healthcare services by governments depend on various individual country factors. Some, such as the countries of the Eastern Mediterranean region (which are not classified as fragile states) opt to engage provide providers in order to implement policies of decentralization and increase access to more modern medical technology[1]. In these countries, the option of contracting provides a very attractive option for the providers, due to guarantees of regular income and improved credibility[2]. Governments of these countries are considered to have the legitimacy and efficiency needed to successfully implement such policies.

Broadening consumer choice was a key reason why contracting for health services was started in New Zealand in the early 1990s. In this case, it was one of many social and economic reforms being made by the government – focusing on corporatization and privatization of the public sector[3]. Over the years in New Zealand, an interesting shift occurred from individual negotiation of contracts with each provider (which was meticulous, yet time-consuming and expensive), to eventually developing a standard set of terms – a much more cost-effective approach. Around
the same time, the state of Colombia began a shift from a completely state-run social security health system to a competitive contracting process involving private providers and Non-governmental organizations (NGOs)[iv].

In most cases, post-conflict non-fragile states opt for contracting as a means to providing rapid health services to those at most need – occasionally, as in the case of Guatemala, this may refer to a specific part of the population55 (in this case, the mostly rural, non-Spanish-speaking Guatemalans). This is generally considered the most prevalent indication for contracting out in post-conflict situations.

There is often a dilemma in fragile states between the need for urgent provision of basic health services and the need to build the capacity of the state[v]. States which opt for contracting out health services usually do so because they lack the capacity or will to do so independently. It is recommended that governments who can’t (or won’t) provide basic services play an indirect role in health service delivery[vi],[vii]. That is to say, they assume responsibility for setting policies and recruiting and monitoring the activities of non-state providers. Therefore, they seek NGOs, private sector firms and communities to provide these services on their behalf1.

However, the ability of fragile states to undertake even these indirect roles is disputed[viii]. Lack of basic legitimacy and capacity, with absent strong leadership and motivation seems to be the reason for this.

One reason why fragile states choose contracting is due to indirect pressure from international donors. Fragile states are frequently underfunded with international aid[ix], receiving up to 40% less aid than predicted[x]. In the point of view of aid donors, a fragile state which cannot provide services26 (even when provided with the resources), is not a feasible partner and thus alternatives are sought. Some have argued that aid can only be effective and properly utilized when legitimate policies (and hence legitimate governments) are in place[xi]. This means that the donors seek less involvement with the government, and rely mainly on non-state providers[xii]. The government, in an attempt to maintain its authority and standing, chooses to instead regulate a contracting process by which the aid received is utilized by non-state providers. Such contractual relationships can be successful, with proper implementation – however this is only true between governments and providers. It has been recommended that the relationships between donors are governments be partnerships, rather than contracts with enforced conditions[xiii].

These donors and service providers however often face the challenge of a swift transition from provision of emergency services (such as is needed during times of conflict) to providing stable, equitable and adequate quality healthcare services[xiv],[xv].

Barriers to Contracting

Barriers to successful contracting must be addressed on an individual country basis, and cannot be generalized.

Sometimes, the providers themselves pose a threat to the success of the process, by being hesitant in accepting terms that required them to deliver results that even the public sector could not achieve, by having low confidence in government in terms of payment punctuality55 (both of which occurred in Guatemala) and by delays in relocation to a newly established country, such as in South Sudan[xvi].

On the other hand, the government often has a hand in posing barriers to contracting success. In South Sudan, capacity building was not given due priority from the start and no clear exit strategy was established for contracts38. This has led to delays in following World Bank procedures and vast delays in negotiations – setting the process back at least three years. It can be argued that this has defeated the very purpose of the project - which is to provide immediate health services to those in need. The costs of these kind of mistakes is high - in 2007, two years after the peace agreement which triggered the contracting process, only 30% of the population had access to minimal healthcare and infant and maternal mortality rates were still among the highest in the world. Another issue is that of sustainability, it is unlikely that funding will be available for long, and the cost of the process is high – about $4 million per state per year38.

In the case of Colombia, one major pitfall was the lack of adequate information systems, in terms of record keeping and centralized statistics[xvii]. Information collection in this case was uncoordinated from the start, leading to unnecessary duplications and lack of availability of data at times of need. Most markedly, the community itself had a lack of knowledge of how the system worked, particularly the poor – which has greatly affected the utilization and success of the project.
The competitive basis upon which most countries base the process of bidding for contracts also has some flaws. It has been reported to lead to underestimation of costs by providers in an effort to win the contracts[xviii]. On the other hand, overestimated proposed costs by providers (exceeding available funds) may hinder and delay the negotiation process[xix]. In Afghanistan, competitive bidding resulted in accessible, secure regions having an abundance of bids, while more remote areas (where it can be argued that health services are needed the most) had low competition, or sometimes none[xx].

Potential Disadvantages of Contracting

There are certain inadvertent consequences of contracting in fragile states. The operational standards of private providers may be unsustainable, thus the long-term feasibility of contracting is a potential limitation to the process. Lack of accountability of service providers is also an issue - without adequate penalties for falling short on service provision goals, motivation may be lacking on the contractor’s side. The sustained improvement of local capacity may be neglected in a contractual agreement, further questioning the long-term feasibility of the process. With contracting out, there is sometimes an unintended political role which may turn into hostility between state and provider[xxi]. This can manifest in many ways, including the fact that international contractors are sometimes unaware of local politics, suggesting unfeasible reforms and policies that damage state-contractor relationships. In March 2009, the government of Sudan expelled 13 national and international NGOs from the country, accusing them of aiding the International Criminal Court in indicting the country’s president over alleged war crimes[xxii]. Before this, conflict-ridden Darfur was the site of the largest humanitarian operation in the world[xxiii]. As a result, 4.7 million people (including 2.7 million internally displaced persons) in the Darfur region were left with a severe shortage of aid. More than 1 million people were directly affected with reduced access to healthcare, safe water and sanitation, and food due to the expulsions. Dozens of immunization and feeding camps had to be closed (in Darfur and elsewhere) and IDP camps were left vulnerable due to decreased protection measures. The expulsions lead to outbreaks of illnesses such as meningitis in remote areas, where some of the expelled organizations were the sole providers of healthcare. The government was unable to fill in the gaps left by the departing organizations, and UN agencies only managed to cover an estimated 30% of the deficit. This provides a typical example of how politics can interfere with healthcare provision in fragile states. In Afghanistan, NGOs were initially welcomed and maintained good relationships with the government early in the reconstruction phase. It has, however now been reported that tensions run high between the government and NGOs[xxiv] due to the questionable neutrality of some NGOs. NGOs criticizing the government[xxv] and governmental authorities lacking the resources to influence NGOs. In some cases, NGO activities have been restricted while in others, relationships between them have been completely severed[xxvi]. The question of why tensions have risen now, when NGOs have been working in Afghanistan for a long time, prior to the reconstruction and during Taliban rule is not an easy one to answer. It may be that now, NGOs see that they do not have as much space to work – the government regards service provision as a top priority and thus becomes heavily involved in the planning and implementation of NGO activities[xxvii]. It is sometimes difficult to build an exit strategy in the contracting process, and concerns over loss of state sovereignty over health services can cause it to fall out of favour.

Potential Advantages of Contracting

It is relatively well established that contracting out for health services can be beneficial for service delivery by improving patient outcomes and service utilization[xxviii]. However, it has been argued that it may be detrimental to state building – though this is a rather simplistic view. Various factors come into play here and the success of contracting processes in building capacity and strengthening health systems can be appreciated when appropriate measures are taken, as exemplified by certain countries.

It has been argued that contracting allows governments to focus on their core duties, while maintaining service provision through contractual agreements[xxix]. Studies have noted successful implementation of short- and long-term goals through contracting for health services[xxx]. These include widespread access to healthcare, improved quality, lower costs, adherence to policies and targets, improved accountability and strengthening capacity of both the private sector and the government[xxxi],[xxxii].

Maximizing the benefits of contracting

Since the problems with the contracting process are unique to each country, it is logical that the potential solutions to these issues be specific to each situation. Two countries which particularly stood out in the success of their contracting process have been Afghanistan and Guatemala. In general, it seems that
the more exposure a country has had to providers (such as NGOs) prior to beginning a contracting process the more likely the process is to succeed.

Preliminary studies have been shown to be useful before deciding on whether or not to opt for the contracting method, or what technical aspects of the process fit the country best. In the case of Guatemala this was in the form of a pilot program, limited to 4 NGOs. This served the purpose of gradually introducing the highly reluctant communities to the change, to build trust between the government and providers and to tweak the terms of the contracts. In Liberia, a rapid assessment of the healthcare system was done and found deficiencies in areas such as management, drug supply and clinical workforce capacity[xxxiii] (there were only 0.97 healthcare workers per 1000 population – 0.57 if nurses are excluded). The survey showed that the priorities of donors and the needs of the population were largely mismatched. Prior to this survey, the $80 million of international aid flowing into the Liberian health sector and delivered by NGOs was distributed without matching the priority needs of the population – only 40% of Liberians had adequate access to healthcare. The results were utilized to establish priorities for stakeholder activities[xxxiv].

In 1999, the poorest nation in Latin America and the Caribbean, Haiti, also started a pilot contracting program which was highly successful. Contracting seems to work best when capacity building and long-term sustainability of the health system is placed foremost on the agenda. In Liberia, while donors funded basic service provision to the population[xxxv], the government focused on developing healthcare training programs and accrediting healthcare facilities. This was especially important after the survey conducted showed massive deficiencies in the health workforce. In Afghanistan, the Ministry of Public Health formed a Grants and Contracts Management Unit (GCMU) to manage contracts. In this way, building local capacity provides a cheaper, more sustainable substitute to recruiting expatriates.

Contracting cannot be successful without engaging the communities in question. The successful relationships between providers, state and communities has been attributed to a full-scale promotional campaign launched in Guatemala. The aforementioned pilot programme itself helped engage communities and prepare them for more large-scale interventions. Accountability and monitoring are both aspects of the process that cannot be neglected. This is particularly true of post-conflict or fragile states, where corruption can be particularly prevalent. To overcome this, Afghanistan has implemented a strict performance monitoring policy, through the Ministry of Public Health’s Grants and Contracts Management Unit (GCMU) and independently via a third party. So far, the contract of at least one NGO has been terminated for failure to perform. Statistics show that quality of care increased by 32%, and improvements in maternal and child health indicators have improved significantly in the country. A different approach has been taken in Guatemala following decades of civil war - confidence in government was very low, and corruption was widespread. The government decided to implement a system of social audit to ensure accountability and transparency, as well as promote community contribution and supervision to the use of funds.

Compensation mechanisms must be well established for contracting to be effective. In certain countries providers have explicitly demanded assurance that payment will be timely and complete, and some have used advance payments (with start-up costs) to solve this problem, while implementing performance-based reimbursement strategies[xxxvi]. In some countries, mixed mechanisms based on donor choice have been implemented. These include fixed payments in addition to performance-based bonuses (such as the World Bank in Afghanistan – which offers incentives of up to 10%), while others in the same country reimburse expenditures with no incentives[xxxvii].

There is no fixed generalized model for countries to follow when contracting out, due to the unique nature of each fragile state’s needs, abilities and characteristics[xxxvii]. It is therefore essential for a government to consider various aspects of contracting out before making a decision to do so[xxxix]. Identifying the potential contractors should start the contracting process, as well as agreeing upon the extent and nature of the delegation of health service provision to the potential contractor. An initial plan on accountability, including how the contractors will be monitored, evaluated and held responsible for their respective service provision tasks is also advisable – scrutiny in terms of the contractor’s impact on health service as a whole should be a priority. The extent of government and community engagement, and how the contract fits into national healthcare strategies may help prevent future conflicts or misunderstandings between the state and the providers. The duties and obligations of the contractor should be clearly and
concisely stated, particularly in terms of the potential extension beyond simple service delivery to capacity building and policy development.

Fragile and non-fragile states: common ground

Despite the differences, some similarities do exist between non-fragile countries and fragile states – evidence shows that in both situations the duration of experience in contracting and the degree of government support seem to correlate with the success of such projects. Also, most of these states provide an open, competitive bidding process for providers to win contracts.

The services most commonly contracted out in both types of states are usually primary care services, or customized basic health packages.

Conclusion

The topic of contracting out is of utmost importance in fragile states due to their lack of adequate services, poor government will or ability and domestic or international insecurity. Contracting out for health services in fragile states has prerequisites for success – any or all of which may be problematic to achieve in an unstable country. The issue is further complicated by the fact that these prerequisites vary from state to state and the lack of basic information systems in these countries makes trial-and-error a necessary yet time-consuming option. However, some countries can be considered success stories to be learnt from. These countries prove that contracting out can be beneficial in achieving both short and long-term goals, including empowering communities and building local capacity.

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Illustrations

Illustration 1

Figure 1

The figure above shows the vicious cycle of healthcare service inadequacy and its effects on government function and the wellbeing of the population.
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