The World Bank Group
in collaboration with
O’Hanlon Health Consulting, Tropical Health LLP,
University of California at San Francisco,
University of Edinburgh
DAY 3, SESSION 1
Using Contracts to Structure Markets

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The World Bank Group in collaboration with O’Hanlon Health Consulting, Tropical Health LLP, University of California at San Francisco and University of Edinburgh
Successful purchasing?

“An implicit assumption of the economic paradigm of market exchange is the presence of a government to define property rights and enforce contracts”

MARKETS FOR HEALTH

Definitions

Forces

Tools of Government

Benefits of Contracting

Drawbacks of Contracting

The Contracting Process

ISTC Case Study

Conclusion
Contracting is a purchasing mechanism used to acquire:

- from a specific provider
- a specified service
- for an explicit quantity
- of a known quality
- at an agreed-on price
- for a given period of time

In contrast to a one-off exchange, the term contracting implies an on-going relationship, supported by a contractual agreement.
Main Aspects of Contracting

• Nature of the contract
• Performance based contracting
• The role of the private sector
• Regulation and stewardship functions and contracting
<table>
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<th>Options</th>
<th>Common terms</th>
<th>Private sector responsibility</th>
<th>Public sector responsibility</th>
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<tbody>
<tr>
<td>Contracting non-clinical support services</td>
<td>Outsourcing</td>
<td>Provides nonclinical services (cleaning, catering, laundry, security, building maintenance) and employs staff for these services.</td>
<td>Provides all clinical services (and staff) and hospital management; manages contract and pays for support services.</td>
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<tr>
<td></td>
<td>Contracting</td>
<td>Provides clinical support services such as radiology or laboratory services.</td>
<td>Manages hospital and provides clinical services; manages contract and pays for services.</td>
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<tr>
<td>Contracting clinical support services</td>
<td>Outsourcing</td>
<td>Provides specific clinical services (such as lithotripsy; dialysis) or routine procedures (cataract removal).</td>
<td>Manages hospital and provides most clinical services; manages contract and pays for services.</td>
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<tr>
<td></td>
<td>PPP</td>
<td></td>
<td>Contracts with private hospitals, monitors, pays for services.</td>
</tr>
<tr>
<td>Contracting specific clinical services</td>
<td>Outsourcing</td>
<td>Contracted private hospitals provide services in accordance with contractual provisions</td>
<td>Finances, constructs, and owns new public hospital and leases it back to government.</td>
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<tr>
<td></td>
<td>PPP</td>
<td></td>
<td>Manages hospital and makes phased lease payments to private developer.</td>
</tr>
<tr>
<td>Buying hospital services</td>
<td>Contracting</td>
<td>Manages public hospital under contract with government or public insurance fund; provides clinical and nonclinical services. May employ all staff. May also be responsible for new capital investment, depending on terms of contract.</td>
<td>Contracts with private firm for provision of public hospital services, pays private operator for services provided, and monitors and regulates services and contract compliance.</td>
</tr>
<tr>
<td></td>
<td>Purchasing</td>
<td></td>
<td>Manages hospital and makes phased lease payments to private developer.</td>
</tr>
<tr>
<td>Private management of public hospital</td>
<td>Operating</td>
<td>Manages public hospital under contract with government or public insurance fund; provides clinical and nonclinical services. May employ all staff. May also be responsible for new capital investment, depending on terms of contract.</td>
<td>Contract with private hospitals, monitors, pays for services.</td>
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<tr>
<td></td>
<td>contract</td>
<td></td>
<td>Manages hospital and makes phased lease payments to private developer.</td>
</tr>
<tr>
<td>Private financing, construction, and leaseback of new public hospital</td>
<td>PFI</td>
<td>Finances, constructs, and owns new public hospital and leases it back to government.</td>
<td>Reimburse operator for capital costs and recurrent costs for services provided. Takes facility ownership at end.</td>
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<tr>
<td>Co-location of private wing or department within or beside public hospital</td>
<td>Services &amp;</td>
<td>Operates private wing or department (for private &amp; public (?) patients); fulfills payment and service access conditions agreed</td>
<td>Manages public hospital for public patients and contracts with private wing for sharing joint costs, staff, and equipment.; supervises fulfillment of patient access and other conditions.</td>
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<td></td>
<td>capital contract</td>
<td></td>
<td>Monitors conversion to ensure adherence to contractual obligations.</td>
</tr>
<tr>
<td>Sale of public hospital for alternative use</td>
<td>Co-location</td>
<td>Purchases facility and converts it for alternative use depending on sales agreement</td>
<td>Manages public hospital for public patients and contracts with private wing for sharing joint costs, staff, and equipment.; supervises fulfillment of patient access and other conditions.</td>
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<tr>
<td></td>
<td>Privatization</td>
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<td>Monitors conversion to ensure adherence to contractual obligations.</td>
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</table>
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ISTC Case Study

Conclusion
States act as *stewards* for much of the health system.
Performance pressures from contracts

Pressure on sellers …
- related to getting a contract or being included in a scheme or network
- to perform *under* a contract.

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples of Indicators</th>
<th>Weight</th>
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| Quality of Information    | - Medical records contain secondary diagnoses  
                            - Place of residence codes completed in patient records  
                            - Reason for caesarian sections provided                           | 0.10   |
| Efficiency                | - Also for specific services (without secondary diagnoses) remain within pre-defined ceilings | 0.10   |
| Quality                   | - Mortality, medical record and infection commissions are fully operational  
                            - % of deaths analyzed by mortality commission  
                            - % reduction in infection hospital rate                           | 0.70   |
| Patient Satisfaction      | - % percent of patient complaints addressed  
                            - Realization of patient satisfaction survey                         | 0.10   |
A common strategy to structure markets is to use either a) eligibility for contracts; and/or b) contract design to generate performance pressure on providers.
Tools of Government

Finance Tools
- LOANS
- CONTRACT
- GRANT
- VOUCHER
- TAX
- PUBLIC INFORMATION

Regulatory Tools
- ECONOMIC REGULATION
- SOCIAL REGULATION

Providers
Consumers

MARKETS FOR HEALTH
MARKETS FOR HEALTH

Contracting

Finance Tools
- VOUCHER
- TAX
- LOANS
- CONTRACT
- GRANT

Regulatory Tools
- SOCIAL REGULATION
- PUBLIC INFORMATION
- ECONOMIC REGULATION
- PUBLIC-PRIVATE DIALOG

Providers

Consumers

SOCIAL FUNDING
MARKET SIZE
MARKET CONSOLIDATION
MARKET SPECIALIZATION
CAPACITY

MARKETS FOR HEALTH
Social Health Insurance

- How large is the social or national health insurance (as % of THE)
- How well established and well functioning is SHI
- What percent of population is covered?
Market Size

**Multiple dimensions of ‘size’:**

- Are there potential bidders for contracts?
- Is the market large enough to have more than one contractor?
- Does the market lend itself to competition for the market, or competition within the market?
Market Consolidation

- Are there potential bidders for contracts?
- Are there barriers to entry or exit?
- Is the market a natural monopoly?

Are the services ‘measurable’?
Government Capacity

- How stable?
- Is there an established PPP unit or other locus of contracting expertise?
- Does the health sector have a track record of contract management?
- What politics pressures influence make/buy decisions within MOH?
Tools of Government

Finance Tools

CONTRACT

Providers S D Consumers

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Potential Benefits of Contracting

- **Competitive forces:**
  - Contracting can generate pressure on providers to improve performance in both price and quality (but this benefit hinges on the actual competitive forces at work).

- **Planning and policy development:**
  - Contracting requires and may promote better planning & policy development by improving the flow of information about volumes of goods, services, costs, quality, responsiveness, population served, health needs, and other issues.

- **Price stability:**
  - Contracting provides government with a mechanism for purchasing needed health services at an agreed-on and, therefore, predicable price.

- **Improve equity:**
  - Contracting can focus on delivering services to targeted population groups.
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Potential Drawbacks of Contracting

- Transaction costs
- Government capacity
- Provider capacity
- Setting the price right is difficult
- Monitoring and evaluation
- Quality may be a casualty of Contracting
The Contracting Process

1. Determine needs and review services
2. Identify stakeholders and their roles
3. Develop an implementation plan
4. Develop a marketing and promotion plan
5. Conduct procurement
6. Implement with monitoring & evaluation systems

Source: ADB, 2013
Emergence of PPP Units in Africa

- Markets for Health

Source: O’Hanlon
<table>
<thead>
<tr>
<th>Function</th>
<th>Tasks</th>
<th>COUNTRY</th>
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<tr>
<td>Broker Knowledge</td>
<td>Information clearinghouse on private health sector and PPPs</td>
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<td>ZA</td>
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<td>Resource Center: Tools, methodologies, lessons learnt</td>
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<tr>
<td>Strategic Advise</td>
<td>Sector analysis; scoping PPP opportunities; strategies to improve PP interface</td>
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<tr>
<td>Implementation Support</td>
<td>Expertise in specific skills capacity building/ skills transfer</td>
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<td>Project (PPP) implementation support</td>
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<td>Project (PPP) oversight</td>
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<td>Monitoring and evaluation</td>
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Source: O’Hanlon
Health PPP Process

**Phase 1: Analysis and Prioritization**
- Diagnose health sector needs
- Agree on health priorities and system gaps
- Develop a PPP Strategy for Health

**Phase 2: Preparation**
- Conduct feasibility/sustainability study
- Review legal/policy framework
- Assess MOH institutional capacity
- Identify MOH PPP Team

**Phase 3: Design and Award**
- Structure a Health PPP
- Market it to the private sector
- Prepare PPP arrangement
- Conduct offer process

**Phase 4: Implementation and Evaluation**
- Put financing in place
- Initiate PPP activities
- Regularly monitor progress
- Close PPP and Evaluate
- Share lessons learned from PPP/H

Stakeholder Consultation: Private Sector, Consumers

Source: O’Hanlon
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</table>
Britain in 1990s

- Long waits for non-critical services
- A large number of capacity gaps across Britain, particularly in specialties such as cataract removal and orthopedic procedures.
- Modernization of hospital infrastructure however hospital focused and infrastructure/infrastructure related services focused
- Increasing government experimentation with privatization (trains, airports) or quasi-privatization (subways, hospital PFIs)
What are ISTCs?

- The private sector was intended to provide up to ½ million procedures per year at a cost of over £5 billion in total to run Independent Sector Treatment Centres (ISTCs) for the NHS in England.

- Independent Sector – meaning not public

- Treatment Centre – elective-focused with separation from emergency care

- Government aims to help reduce waiting times & support NHS in meeting targets by both:
  - provide additional capacity
  - introducing choice & competition
Size & Scope

Phase one = £1.7 billion

Phase two contracts = £2.75-3.75 billion

Initial expected cost of programme = £5 billion

Time-line
• Phase 1 announced in Oct 2002
• First contracts signed in Sept 2003
• First ISTC commenced service in Oct 2003
• Phase 2 announced in March 2005
Background to Private Sector Contracting

• The Market at the Time of Launch of the Program:
  – Private medical providers provided services primarily to the privately insured
  – NHS purchasing on an ad hoc manner to the incumbent providers (average price was in excess of the UK tariff) under short-term contracts

• The gov’t had considerable experience with private sector contracting via the Infrastructure Program (PFIs)

• However, until the launch of the ISTC program, contracting for clinical services had not been done in a strategic manner under a long term contract
Though the ISTC’s represented less than 1% of total NHS spending, it garnered a disproportionate amount of attention.

“The private drain on the NHS”
Services are being shunted off to the independent sector, robbing us of a true picture of healthcare in Britain
- the Guardian (October 15, 2009)

“English treatment centres are treating less complex patients than hospitals”.
ISTC cherry pick easier cases, obviously enough
- BMJ 2009;339:b4540
Creating a Market to Act as a Change Agent

- why a market driven approach rather than just purchasing additional capacity
  - Allow/Encourage new market entrants
  - Increase competition
  - Bring down costs for hospital services

- if capacity was the only issue, it is likely that the gov’t could have provided additional funds to Trust Hospitals or even the incumbent private hospitals

- The long run question was what type of market did the NHS want to create?
Governance Regimes: Characterizing the State’s Role

Implement

CUSTOMER COMPETITION: 0%
PRICE INFLUENCE: Administered
ENTRY BARRIERS: Very High
SOCIAL FUNDING: No contracts
CONTRACT CONDITIONALITY: No contracts

Steward

CUSTOMER COMPETITION: 100%
PRICE INFLUENCE: Market
ENTRY BARRIERS: 0
SOCIAL FUNDING: 0
CONTRACT CONDITIONALITY: No conditionality

Passive

CUSTOMER COMPETITION: 100%
PRICE INFLUENCE: Market
ENTRY BARRIERS: 0
SOCIAL FUNDING: 0
CONTRACT CONDITIONALITY: No conditionality

Principal changes of ISTC

0% to 100%
0% to 100%
0 to 0
0 to 0
0 to 0

No contracts to No contracts
No conditionality to No conditionality
Risks for a Market Going Wrong

• Risk of Destabilizing the NHS – Staffing, training and from a financial standpoint.

• Quality of Clinical Staff – Not just in medical qualifications but also skill level and how health care is practiced if using foreign doctors.

• Cherry Picking/Cream Skimming – Taking healthy patients and/or profitable services, thus potentially restricting access and increasing inequality

• NHS Tariff/Reimbursement level – Per patient contracted amount was 11% higher than NHS reimbursement in Wave 1.
Risks for a Market Going Wrong

- Guaranteed Contracts – Actual per patient reimbursement was higher given the low volumes in early phase
- Incumbent Providers – Increase of volumes at NHS would likely reduce volumes/revenues in the private hospital market.
- Impact on Private Health Insurance Market – Potentially less need for private insurance
Overall Benefits to Gov’t/Health System

The core objectives of the ISTC Programme were to:

• assist the NHS in reducing waiting times;

• support the shift from capital intensive/expensive hospital-based care;

• expand plurality of provision;

• promote innovative service models; and

• contribute to the long-term development of relationships between the IS and the NHS in the attainment of local NHS targets.
Key Questions for Creating a Market

• How many competitors does one need for competition or to create a contestable market?

• How is the market defined? Scope of services? Geography (Local, regional or national)?

• What is the size of the market needed to create true competition?

• What proportion of a market needs to be open to competition to affect overall prices/volumes?
Key Questions for Creating a Market

• What needs to be done to attract and retain new market entrants?

• How do doctor referrals play an important role in ISTCs? How may these referrals be more difficult/easier in markets with a weaker gatekeeping system such as in emerging markets?

• How should services be contracted
  – Price – fixed price? Or variable price?
  – Volumes – minimum volume floors? Volume caps?
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Conclusion
Contracting can be a powerful tool...

- **If The Environment Is Suitable**
- **If The Market Is Appropriate**

  - Contracting provides a somewhat coercive, highly targeted and relatively predictive way of **changing health commodity/service availability and provision**.

  - **Contracting can effect competitors;** health seeking behavior, quality and efficiency in both **positive and negative ways**.

  - Large, complex, contracts will have few potential providers, decreasing the power of the purchaser.

  - Contracting requires high government capacity to initiate and, importantly, to manage.