

A GUIDE TO CONTRACTING FOR HEALTH SERVICES DURING THE COVID-19 PANDEMIC



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ACRONYMS

AFRO	Regional Office for Africa
EMRO	Regional Office for the Eastern Mediterranean
IFC	International Finance Corporation
LMIC	Low- and middle-income countries
RFP	Request for Proposal
PAHO	Pan American Health Organisation
PPD	Public-Private Dialogue
PSA	Private Sector Assessments
SEARO	South-East Asia Regional Office
WHO	World Health Organization
WPRO	Regional Office for the Western Pacific

EXECUTIVE SUMMARY

Government authorities seek to increase the capacity of health systems to respond to COVID-19 while maintaining access to essential health services. Drawing on private sector resources is critical as, in many countries, it is a dominant provider of health services, including for the poor. One important tool for increasing capacity in this way is *contracting*.

This primer offers a practical introduction to contracting the private sector in support of national COVID-19 responses. Its target audience is policymakers in low- and middle-income countries (LMICs) that have, at this time, limited experience of using contracts for health services but are expected to do so in the emergency conditions created by COVID-19.

The guidance does not advocate for contracting as a solution for all countries. Policymakers should use the manual to inform their own decisions about whether to use this tool. If policymakers decide not to use contracting, there are several other options for enhancing public-private sector coordination during the emergency.

If they do choose to use contracting to contain and mitigate the adverse health impacts of the pandemic, they often need to act quickly. They may not have time to develop organisational capacities, deploy 'normal' competitive procurement processes, or enter into fully comprehensive contracts. Nor can authorities always rely on the market to respond flexibly.

This guidance acknowledges these realities but seeks to ensure that, even in the emergency context, authorities can nonetheless (1) act lawfully, reasonably and with integrity (2) identify how the sub-optimal context gives rise to certain risks, and (3) formulate a comprehensive policy framework to mitigate these, and thus make a success of contracting in spite of the constraints they face.

The guidance outlines a step-by-step process to *contract in an emergency setting* organized according to four steps:

- 1) Define the purpose and structure of the contract;
- 2) Plan the procurement process;
- 3) Procure and sign the contract; and
- 4) Monitor the contractual relationship.

The guidance concludes by suggesting that, through this process, authorities can *institutionalise* new capacities, activities, and ways of working that will strengthen current response efforts and help them *build back better* - **strengthening core health system functions** so that future emergencies can be effectively tackled, and the momentum behind **long-term objectives, such as Universal Health Coverage (UHC), can be regained and accelerated.**

INTRODUCTION

Governments are seeking to increase the capacity of health systems to respond to COVID-19 while maintaining access to essential health services. Drawing on private sector resources is critical. In many countries, the private sector is the dominant provider of health services, including for the poor(1). It is estimated that the private sector provides 40 per cent of all health care in the PAHO, AFRO, and WPRO regions, 57 per cent in SEARO, and 62 per cent in EMRO(2).

This situation highlights the importance of effective governance of the private sector to optimize and coordinate the use of health system resources. One important tool for achieving this objective is contracting. Contracts for health services establish a legal agreement between a public authority and private sector entity, in which the latter undertakes to deliver an agreed set of tasks, in a given location (or for a specified population), over a defined period of time. Contracting can be used by public authorities to (a) purchase health services to increase a country's response capacity and (b) regulate private sector entities by determining their activities such as the quality and price of the services they provide.



What do we mean by “the private health sector”?

For this manual, “the private health sector” includes all individuals and organisations that are neither owned nor directly controlled by governments and are involved in the provision of health-related goods and services. This includes both for-profit and non-profit entities.

In the emergency conditions created by COVID-19, public authorities can use contracts with the private health sector to achieve important health system objectives. Examples of these objectives include:

- Expanding access to COVID-19 testing and treatment, including for the poor and other underserved groups;
- Relieving pressure on public health sector facilities by having the private sector deliver essential health services not related to COVID-19, such as urgent surgeries, maternity services, or cancer treatments;
- Leveraging additional capacity to fill public sector capacity gaps, e.g. providing access to technological solutions such as tele-medicine, providing extra quarantine facilities, and offering support services and ‘cold chain’ supply services for, and/or provision, of vaccination programmes; and
- Aligning the operations of the private health sector with national response strategies, including ensuring that the private health sector complies with all relevant clinical, infection control and reporting standards.

Countries – including some LMICs – already use contracts to address health system objectives. In LMICs, this work often focuses on informal agreements between the public sector and the private (e.g. Memoranda of Understanding or social contracting). The COVID-19 situation and contracting capacity gaps have generated significant demand from governments for guidance on how to make better use of contracts to support the COVID-19 response. The World Health Organization (WHO) and International Finance Corporation (IFC) have prepared this manual to meet this demand.

PURPOSE AND USE OF THE MANUAL

This manual provides a practical introduction to contracting the private health sector to support national COVID-19 responses. It is aimed at policymakers in LMICs that have limited 'expertise from experience' of using contracts for health services. However, the guidance has longer-term relevance and can be applied to the use of contracting in any emergency context – one in which public health authorities are required to act rapidly and flexibly.

The guidance does not advocate for contracting as a solution for all countries. Policymakers should use the manual to inform their own decisions about whether to enter into contracts, and to guide the effective use of contracts to meet their public health objectives. It should be noted that contracting is only one option for engaging with the private health sector (and other non-state actors) during the COVID-19 emergency. There are several other alternative 'Tools of Governance' that can be used to influence the behaviour of non-state actors (see box).



The private sector engagement 'toolkit'

Tools of Governance are instruments used by public authorities to influence the behaviour of individuals and organisations in the health sector. Other Tools of Governance(3) include Regulatory Tools (such as licensing, certification and accreditation); and Information Tools (focusing on information for both suppliers and consumers). The Contracting Tool – our focus in this manual – can be used in combination with all of these other instruments.

During public health emergencies, authorities are required to act rapidly to contain and mitigate adverse health impacts. They do not have the time to develop organisational capacities, run normal procurement processes, or enter into formal contracts, nor can they rely on the market to respond in a flexible way to the emergency.

This guidance acknowledges these realities but seeks to ensure that (1) authorities act lawfully, reasonably and with integrity in all aspects of the contracting process, (2) understand the risks of contracting in a sub-optimal context; and (3) formulate a comprehensive policy framework to mitigate the risks. Examples of risk include:

- Contracts that are not comprehensive enough, leading to gaps in service delivery;
- Delays in payments that can reduce the equity, quality and sustainability of services;
- Awarding contracts to the 'wrong' (e.g. to unqualified, or inefficient) providers;
- Poorly drafted contracts that are unenforceable;
- Corruption and theft; and
- Ineffective contract monitoring and dispute resolution mechanisms.

CONTRACTING FOR HEALTH SERVICES DURING THE COVID-19 PANDEMIC: A STEP-BY-STEP GUIDE

In this section, we provide a step-by-step guide to the process of contracting in an emergency context – one in which authorities need to act fast and flexibly in an environment in which experience with contracting is limited on both ‘sides’ of the market, public and private.

The contracting process is broken down into four steps:

1. Define the purpose and structure of the contract;
2. Plan the procurement process;
3. Procure and sign the contract; and
4. Monitor the contractual relationship.

For each step, we outline the main decisions to be taken, the risks inherent to these (especially in a health emergency context), and how they can be mitigated in practice.

STEP 1: DEFINE THE CONTRACT

Contracts can take several different forms and can be used to address a range of COVID-19 related objectives. In Step 1, critical decisions are needed about: (a) the service area(s) to be targeted through the contract; and (b) the type of contract to be used.

→ *Types of contracts*

There are three main types of contracts used to deliver health services: entry contracts, service contracts, and concessions. They are distinguished by three main features: how contractual partners are selected; how service volumes and performance standards are defined; and how services are paid for.

1) Entry contracts. These are agreements that entitle the contractor to deliver a specified range of services to a specified group of beneficiaries, such as those enrolled in a social/ national health insurance scheme or voucher programme. The entry contract specifies

the terms the contractor must meet to become, and remain, eligible for reimbursement under the relevant scheme or programme. An example is a contract between a private laboratory and a national health insurance agency, public authority, or donor agency, which sets out the terms on which reimbursement will be provided (e.g. through the insurance scheme or voucher programme) for testing services to the specified beneficiaries (see India and the Philippines examples). Under contracts of this type, the contractor is subject to two important sources of performance pressure:

- The need to meet specified quality standards (under an accreditation and/or empanelment process), to become, and to remain, eligible for reimbursement; and
- The incentive to attract service users, who have choice over where to receive the services covered under the relevant scheme, and thereby receive reimbursement.

Because of these features of the contracting environment, the contract itself can be relatively ‘light touch’. It will focus on the prices the contractor can charge for its services to the authority and users (both of which are normally agreed through negotiations between the authority and a set of providers, and/or industry representatives, at the national or regional levels), outputs to be delivered, clinical and reporting standards to be observed, and arrangements for external monitoring.

Entry contracts are primarily used in countries in which the state of public-private relationships have reached a mature stage, usually because they are embedded in social/national health insurance structures (e.g., in India and the Philippines). For this reason, this manual does not aim to provide detailed guidance on contracts of this form – though we do draw from examples of such contracts where these provide insights across the different contracting models, including those more commonly used in LMIC contexts.



India

In India, the government used an established (checklist-based) process to empanel private laboratories to expand affordable access to COVID-19 testing under an entry contract model. Following empanelment, laboratories sign a contract with a public authority under which they conduct tests and analysis for beneficiaries of the AB PM-JAY health insurance scheme (which covers circa 40 per cent of the population). They are then reimbursed under the scheme on the basis of a national price list.



the Philippines

In the Philippines, the national health insurance program, PhilHealth, established reimbursement rates for COVID-19 testing based on procurement data of different consumables. Initially, PhilHealth procured COVID-19 tests internationally and set the price at \$8,000 pesos (~\$40/USD) per test based on international prices. The press reported, however, that individuals were paying out-of-pocket for a COVID-19 test in a private facility at \$4,000 pesos – half the price of the PhilHealth reimbursement. Subsequently, Philippine legislators demanded PhilHealth review their payment schedule to determine if they were over-paying. Eventually, PhilHealth reduced the reimbursement rate to \$4,000 pesos as the government introduced a locally manufactured test into the marketplace.

2) Service contracts. These are legal agreements in which the authority specifies the range of services to be provided by the contractor, to an identified group of people (or catchment area), for a specified period of time, at an agreed cost to the authority and/or service users. For example, a contract between a private hospital and the Ministry of Health, where the Ministry pays the private hospital to provide patients with treatment for COVID-19. Unlike entry contracts, service contracts normally operate on an exclusive basis whereby service users have to go to a specific provider – i.e., “users follow the money”, and do not allow for user choice over which facility to receive the service from.

The volume of outputs to be provided by the contractor (and paid for by the authority/users) can be determined by either (a) consumer demand or (b) the terms set out in the contract.

- In the former case, payment is volume-based, meaning it is determined by the level of use of the services (so that there is a need to ensure some constrain on total service provision – thereby placing downward pressure on supplier-induced demand and the associated risks to affordability and value for money for the authority).
- In the latter case, payment is availability-based, meaning it is fixed, according to the extent that services are being made available to users (so that it is important to define, upfront, the level of availability and take steps to ensure that private providers do not prioritise service delivery to those that can pay directly or via private health insurance – e.g. if these provide more lucrative revenue streams compared to government rates).

In either case, important aspects of service provision – such as the clinical quality of services, and how this will be measured – are defined in detail in the contract. This provides a powerful incentive for the contractor

to perform well with regard to service volumes and the quality of output. However, because there is no element of 'patient choice' in contracts of this type (unlike the typical case for an entry contract), the contract itself, and the arrangements for monitoring it, are the *only sources of performance pressure on the contractor*.

Service contracts require carefully specified outputs, quality standards, performance indicators, and the means of verifying that these are being met. Therefore, service contracts can be long and detailed, and costly and complex to procure and monitor. These requirements vary depending on the type of



England

In England, service contracts with private hospitals, based on the average costs of production (this is in effect a cost-based contract), have covered: (1) inpatient respiratory care to COVID-19 patients; (2) urgent elective care services during the 'surge'; (3) diagnostic capacity to maintain priority elective and cancer pathways; (4) inpatient non-elective care supplement bed capacity; and (5) staffing for redeployment in public sector facilities.

service. For example, a contract for specific laboratory tests would typically be far easier to specify than one for hospital services. Where dedicated human and financial resources are insufficient to perform these contracting activities effectively, this creates a number of risks for authorities, which need to be identified and mitigated, as explained in subsequent sections.

3) Concession contracts. These are formal agreements in which the authority gives authorisation to a specific contractor to deliver a defined set of services to an identified group of users, for a specified period of time. An example is a contract between a private laboratory and a public hospital where the laboratory company provides tests to patients in the

hospital, and the patients themselves pay the private laboratory out of their own pockets.

Concessions are different to service and entry contracts because, in this case, payment is made by service users directly, and not by government. The amount of payment can be regulated – but in many cases the regulation is informal (and may in practice give contractors significant 'price-setting' power). As no public funds are provided, this form of contract is not well-placed to lower financial barriers to health care access. Instead, the focus is on increasing availability of services that were previously absent, or insufficient, to meet the identified requirements of the COVID-19 response.

Negotiation with bidders will tend to focus on considerations such as:

- *The size of the fee* (which the authority should seek to minimise to reduce the financial impact on the targeted population(s));
- *The volume of output* (which the authority should seek to optimise in line with the identified requirements of the response); and
- *The quality of output* (which the authority should ensure is compliant with national clinical and reporting standards).



Ethiopia

In Ethiopia, the Federal Ministry of Health pre-selected (based on facility inspections) a subset of licensed laboratories for contracting. Initial concession contracts focused on COVID-19 screening and referral, but these have been expanded to include more complex services – such as sample collection, analysis, and reporting. This is a 'user pays' model.

Table 1 outlines the key features, and the advantages and disadvantages (pros and cons), of the three types of contracts discussed in this section.

TABLE 1: TYPES OF CONTRACTS USED TO DELIVER HEALTH SERVICES

	ENTRY CONTRACTS	SERVICE CONTRACTS	CONCESSIONS
 <p>METHOD FOR SELECTING CONTRACTORS</p>	<p>Contracts are entered into with providers that have been accredited and/ or empanelled, due to their attributes/ capacities, to serve a defined group of patients (e.g. those enrolled in a specific social/national insurance scheme or are in receipt of vouchers).</p>	<p>Contracts are allocated through a competitive process - or, in an emergency context, a pre-qualification process focused on attributes/ capacities of bidders. [This may harness a pre-existing accreditation or empanelment process where one is in place.]</p>	<p>Contracts are allocated through competitive procurements - or, in an emergency context, a pre-qualification process focused on attributes/ capacities of bidders. [This may harness a pre-existing accreditation or empanelment process where one is in place.]</p>
 <p>DEFINITION OF THE CONTRACT</p>	<p>Specification of the range of services to be delivered (defined by benefits covered under the insurance scheme and/ or the target of the voucher programme), clinical and reporting standards, and the amount and structure of the fees to be paid.</p>	<p>Specification of the range of services to be delivered, service volumes, clinical and reporting standards to be observed, and the prices to be paid by government (either on the basis of 'usage' or 'availability').</p>	<p>Specification of the range of services to be delivered, clinical and reporting standards to be observed, and the restrictions, if any, applied to the user fees (i.e. they may be regulated or based on market prices).</p>
 <p>SOURCE OF FINANCING</p>	<p>Government authority/ social health insurance agency (with user co-payments in some cases).</p>	<p>Government authority (with user co-payments in some cases).</p>	<p>Service users (in form of 'out of pocket' payments).</p>
 <p>PROS</p>	<p>Contract can be 'light touch' (as accreditation / empanelment places a floor on providers' capacities).</p> <p>Strong incentives to 'perform' - i.e., to attract and sustain demand from users.</p> <p>Services made available to patients free at the point of use (or at low prices).</p>	<p>Strong focus on performance due to detailed contract (high level of certainty with regard to service volumes and quality of outputs).</p> <p>Services made available to patients free at the point of use (or at low prices).</p>	<p>Comparatively simpler to contract from government perspective than service contracts e.g., contract specification and pricing.</p> <p>Limited public funding is needed; and, therefore, lower financial costs and financial risks for the public authority.</p>
 <p>CONS</p>	<p>Lack of detailed performance criteria may lead to gaps or weaknesses in delivery.</p> <p>Quality relies on conditions of 'entry', alongside service user choices - where these are inadequate, performance pressure on provider(s) is limited/ inadequate.</p> <p>Public/social insurance funding is required.</p>	<p>Contracts tend to be lengthy and detailed - i.e. include volumes and performance levels, to safeguard the interests of authorities and service users. Hence, they are costly and complex to procure and negotiate.</p> <p>Public funding is required - with both costs and risks for the authority.</p>	<p>Contracts may lack the detail to ensure they safeguard the interests of authorities and service users - therefore requiring strong monitoring and evaluation capacity.</p> <p>Higher costs and risks for service users.</p>

→ **What to contract for**

In optimising the health system response to COVID-19, a range of service areas are important. Services areas in which there are often existing private health sector capacity, and are therefore potential candidates for contracting, include the following:



- **Testing** (diagnostic services including pathology and radiology);
- **Treatment** (primary care, hospitals, ICU care, tele-medicine, ambulance services);
- **Isolation** (e.g., quarantine centres/ private hostelling);
- **Support services** (e.g., warehousing and logistics for medicines/ supplies/ personal protection equipment (PPE), logistics for collection and transportation of testing samples; call centres, contact tracing, and quarantine/ isolation follow-up services); and
- **Vaccination** (e.g., ‘cold chain’ supply services, distribution, and vaccination provision).

Key questions to answer in relation to ‘what to buy’ are:

- What range and volume of COVID-19 services and essential health services are needed?(4)
- Who are the intended service beneficiaries/ users, and where are they located?
- How will a contract complement the public sector’s role in this service area/ locality?
- Do we have sufficient data to address the questions above? If not, how will such data be (rapidly) sourced and analysed?

Table 2 provides more detail of the services that can be targeted through contracting of the private health sector, and provides examples for the contract types outlined above.

TABLE 2. CRITICAL COVID-19 RELATED SERVICES AND CONTRACTING PROCESSES

 SERVICE AREAS	 EXAMPLES (PER CONTRACT TYPE)
<p>Diagnostics</p> <ul style="list-style-type: none"> • Testing services – fixed/ mobile facilities • Generic pathology laboratory services • Radio-imaging/ ultrasonography 	<p>Entry contracts: Patients access testing (taking and analysis of samples) from private facilities, and they, or providers, are reimbursed by the relevant social health insurance fund.</p> <p>Concessions: Patients access testing facilities and services providers are paid on a fixed fee per test basis.</p> <p>Service contracts: An authority pays a private laboratory to perform radio-imaging/ ultrasonography for a public patient.</p>

Primary care

- Home care services – monitoring, supply of kits, vaccines, medicines, follow-up
- Mobile services

Service contracts: : An authority pays for home care services to be offered to specified recipients at low-cost.

Concessions: Patients access standard care management services in certain locations or at home from pre-selected/ pre-qualified providers at government-approved rates.

Hospital care

- Inpatient respiratory care
- ICU and critical care
- Urgent elective and cancer care during ‘surge’
- Staffing for re-deployment in public facilities

Entry contracts: Patients access hospital care services from empanelled private hospitals, and they (or providers) are reimbursed by the relevant social health insurance fund.

Service contracts: An authority provides funding to private hospitals, who agree that defined inpatient and critical care is offered to referred patients for free or at low cost. *...for HR services:* An authority provides funding to private hospitals/ physician provider networks/ HR agencies, who agree to provide skilled doctors, nurses and paramedical staff on a fixed rate or lump-sum basis for a defined period of time *...and for operations management of hospitals:* An authority contracts with private hospitals or other healthcare providers to operate and manage field hospitals/ government hospitals for a fixed fee or revenue share basis.

Concessions: An authority empanels private hospitals, which agree that defined inpatient and critical care will be offered to referred patients for free (or at low cost) and to private patients at pre-determined prices.

Technology-enabled services

- Tele-ICU services
- Tele-medicine/ teleconsultation
- Tele-radiology
- Mobile services

Service contracts: An authority provides funding to tele-health service providers, who agree to offer a defined care package to specified patient groups for free or at low cost. *...for tele-ICU services:* An authority contracts with private hospitals or healthcare providers to provide tele-ICU services to a certain number of beds in government hospitals for a fixed per bed fee or revenue share basis.

Concessions: An authority empanels private mobile health providers who agree to provide defined out-patient services to select patients for free or at low cost and are reimbursed the by the government. Private patients may be provided services at pre-determined rates or at market rates.

Isolation capacity

- Hotelling/ quarantine centres in hotels/ community centres
- Testing and handling services in airports/ ports/ border areas

Service contracts: *...for hotelling / quarantine facilities:* An authority contracts with private service providers or hotels to manage quarantine facilities on a per capita or per bed basis. This may also include provision of space including hotels or setting up of temporary quarantine facilities in public buildings, etc.

Concessions: An authority contracts with private diagnostic service providers to offer testing services at borders, airports, railway stations, bus terminals on a fixed fee per test basis.

Support services

- Logistics and warehousing services for testing/vaccine supplies and other medical equipment and supplies
- Transportation and distribution of COVID related supplies
- Local production of COVID related supplies
- Call centres, contact tracing, and quarantine follow-up

Service contracts: *...for logistics/ support services:* An authority contracts with a private provider to provide transportation, warehousing and distribution services for critical COVID-19-related medical supplies, medical oxygen, PPE, blood supplies, vaccines, and/or consumables. Other services such as procurement, transportation of test samples, and specialised cold-chain services, may also be included. Payment may be based on per unit, value, consignment or weight or a combination of these. Similar contracts may occur for area sterilisation.

...for institutional support services: An authority contracts with multiple private providers or consulting firms to provide a variety of services, such as data analytics, technical human resources, development and operation of command centres including staffing and information technology backbone; technical and transaction and legal advisory services to facilitate contracting, training of government staff, etc. Payment may be based on a retainer or lump-sum basis.

...for local manufacturing of COVID-19 related supplies: An authority contracts a local manufacturing company to produce critical medical supplies (e.g., PPEs, gloves, etc.) and equipment (e.g. ventilators). Payment can be per unit and/or specified volume.

Vaccination

- Logistics, cold-chain, distribution and vaccination services for vaccination

Service Contracts: An authority contracts (a) a logistics company to provide cold-chain logistics and distribution services for vaccines, (b) a specialised cold-chain services company to use its dry ice-based logistics to distribute vaccines, (c) with private healthcare providers to provide vaccination services to a specified population, (d) with an operations research and data analytics company to create a database of, and enable prioritisation among, individuals eligible to receive the vaccine.

→ Mitigating risks during Step 1

Step 1 has focused on selecting the 'right' contracting approach and targeting the 'right' service area(s). The decisions made during this step include the following:

- Determine the legal basis for contracting with the private sector;
- Select the appropriate contracting mechanism;
- Establish the basis under which the contract will pay for services; and
- Estimate how much the contract will cost and assess affordability.

As Table 1 makes clear, different contract types offer a different balance of 'pros' and 'cons'. Ultimately, however, the appropriate type of contract depends on the core objectives set for it. For example, if the objective is to address an *absence or inadequacy of a specific set of appropriate quality services* – e.g., a lack of COVID-19 testing and/or treatment services, in general or in a given locality - then a concession contract may be appropriate. In contrast, if policymakers wish to ensure that financial barriers to testing or treatment do not lead to underutilisation of critical services, then an entry contract or service contract may address the requirement.

However, the authority will also need a careful analysis of its technical and financial capacities, and whether these are adequate to manage a more complex contracting mechanism. In most LMICs, **technical capacity** to enter into more sophisticated contracts is limited. Entering into such contracts requires skills and knowledge to specify in a contract *what* is needed, write a legally enforceable contract that captures *how* they should be provided, and to verify that these *have been* provided during implementation. Within a Ministry of Health, technical capacity may need to be supplemented by the assistance of other government departments/units, or supported by development partners.

Similarly, **financial capacity** is often scarce - especially in an emergency context. It is important that the authority (a) has a clear forecast of what the level of expenditures under the contract will be *across the full period of the contract*, and (b) makes a cautious assessment of the affordability of this level of expenditure. Failure to do so may result in unavoidable reductions in the allocation of resources to other essential health services. In addition, failures in budgetary planning may result in payment delays, which threatens the sustainability of the contract and/or the quality of outputs (e.g., if providers seek to preserve cash by 'shading' quality). Such delays also increase the likelihood of service providers seeking to levy direct payments (on a formal or informal basis) from service users, raising financial barriers to access, undermining equity of access and financial protection.

Taking these limitations of technical and financial capacity into account, it is important that the authority is able to:

- Recognise that the organisational context for the contracting process is suboptimal in key respects;
- Analyse the risks, for the authority and the objectives it has set for the contract, that are generated by current limitations in terms of technical and/or financial capacity; and
- Carefully consider how these risks will be mitigated in practice.

Table 3 outlines the main challenges decision-makers face in Step 1, the risks these give rise to and strategies for mitigating them.

TABLE 3. STEP 1: CHALLENGES, RISKS AND STRATEGIES FOR RISK MITIGATION

 CHALLENGE	 RISK	 MITIGATION
<p>The legal basis for contracting is uncertain</p> <p>In some LMICs, governments do not have the legal authority to enter into contracts for the provision of health services. In addition, private entities may not have the legal authority to deliver the specific services to be provided under a contract.</p>	<p>The private sector may be unwilling to incur the costs of setting up contracts and/or new/ expanded service delivery capacity until the legal basis for doing so is clear. This may cause a delay in response and putting lives at risk.</p>	<p>Before initiating the contracting process, the authority should evaluate the current legal basis for public/private sector engagement, identify any gaps, and formulate a plan for addressing these. In a health emergency, the authority may be able to obtain authorisation to enter into contracts with external parties for a defined period. (a good example of this is in South Africa where competition regulations were relaxed to accommodate this).</p>
<p>The best type of contract is unclear</p> <p>For many LMIC governments, an entry or service contract will often be the ‘best fit’ for their policy objectives. However, they may not have the technical or financial resources to deploy complex contracting mechanisms.</p>	<p>The authority increases the risk that the contract will be unsuccessful if it selects a mechanism that is not aligned with its technical capacity and financial resources.</p>	<p>Where the authority’s objectives require a specific type of contract (such as an entry or service contract), but it has determined that it does not have the in-house capacities and resources required to deploy this type of contract, the needed capacities and resources will need to be accessed from external sources/agencies (e.g. other government unit, development partner, or private sector intermediary where it is clear no conflict of interest exists).</p>
<p>The ‘right’ payment method needs to be determined</p> <p>Under many service contracts, the contractor is paid on a fee-for-service basis. This means that total payment is based on the volume of services provided/utilised. Alternative approaches to fee-for-service include capitation and global budgets/availability-based payments, which are not usage-based.</p>	<p>Paying on a fee-for-service basis can lead to excessive volumes of services provided/utilised, and/or make it difficult to ensure that there are sufficient funds available to pay for the outputs delivered.</p> <p>Many authorities in LMICs do not have the data available to use payment methods such as capitation. This may lead to under- or over-payment.</p>	<p>For an authority that is inexperienced with contracting, a common approach is to begin with a fee-for-service payment method – but to set a cap for the total amount of payments to be made, to provide some mitigation of budget risk.</p> <p>With time and experience (supplemented, perhaps, by the knowledge of other payers, e.g. private insurance funders, where these exist), a move to alternative payment approaches, including capitation, availability-based, DRG-based or fixed global budgets, is desirable from a fiscal and VfM perspective.</p>
<p>How much the contract will cost, and its impact on long-term budgets, are unclear</p> <p>A common challenge is to ensure that the authority has the budgetary space and systems in place to pay for services on time and in full over the contract period.</p>	<p>Failures in budgetary planning for the contract may result in disruption to other health services funded by the authority.</p> <p>Contractors that are not being paid in full – and/or on a reasonable timeframe – may resort to ‘shade quality’ and/ or impose direct payments on service users, at the expense of equity of access and financial protection.</p>	<p>If time permits, the authority can generate a ‘should cost’ model, based on an assessment of different providers’ costs to deliver the defined set of services. This model may be developed with the support of external entities, e.g. private insurance companies, private sector providers themselves, and/or consultants with detailed knowledge and experience of the sector.</p> <p>Carefully monitor payments made under the contract (especially where these are usage-based and therefore difficult to forecast) to inform any revisions that need to be made, e.g. during contract renegotiation or renewal.</p>

STEP 2. PLAN THE PROCUREMENT PROCESS

Step 2 focuses on planning the procurement process – i.e. the sequence of actions required to select the contractor and establish the contract.

The focus of the procurement planning process is on two key issues:

- What is the capacity of ‘the market’ to provide the service(s) at the required level of quality and in the required timeframe; and
- The structure of ‘the market’ and whether this, and the timeframe available for procurement, allows for a *competitive bidding process* - and, if not, what measures will be put in place to safeguard value for money for the authority and service users.

→ **Market capacity**

The authority may not have complete data on the capacity of the domestic private health sector in a given service area (see Table 2) (the initial focus, at least, should be on the domestic market, as these are the providers most familiar with local conditions). However, the crisis situation may preclude the collection of new data – and it is therefore important to source what data exists on the following aspects:

- The scale and composition of the private sector in the relevant service area(s) (e.g. numbers of facilities, equipment, beds, registered doctors, and other health cadres);
- Geographical coverage and the urban/ rural split;
- Current approaches to revenue collection, and prices charged; and
- The user groups for which they perform the relevant services.

A range of data sources can be consulted to address these questions. For example, administrative records for facility licensing and registration, alongside health facility surveys, provide data on the ‘supply-side’ of the market - private sector capacity and geographical coverage. National Health Accounts, household expenditure surveys, the WHO Global Health Expenditure Database and Private Sector Assessments (PSAs)¹ provide data on the ‘demand side’ - payment methods, prices paid, and user groups.

Analysis should focus on the opportunity for leveraging existing provision for the COVID-19 response, reshaping provision, or expanding provision - so that it is available to a larger proportion of the population, including the poor. Note that the capacity to provide specific services (such as testing, treatment, support services, and vaccination) may be *created through the contract, even if it does not exist now*, i.e., at the time of analysis. For example, in the case of testing, a given laboratory chain’s capacity to perform e.g., gene testing, molecular biology testing, antigen testing, and serology, may imply that it has systems in place to carry out COVID-19 testing services – *if it is encouraged and/or financed to do so under a contract*.

→ **Assessing eligibility**

In some contexts, existing regulatory processes, such as empanelment or accreditation (which, in effect, set quality standards that service providers must meet to ‘pre-qualify’ for contracts, and/or reimbursement under a social/ national health insurance or other financing scheme). In such cases, and for **entry contracts**, a new, *contract-specific* procurement process may be unnecessary. Instead, the authority’s requirements can be met by simply expanding the package to include health services from eligible providers. In the case of service contracts and concessions, these processes can also be leveraged to assess the eligibility of specific providers for contracts.

¹The PSA approach was developed with support from USAID and the World Bank and has been running for several years. As a result, PSAs are available for a large number of LMICs and/or specific jurisdictions.



the Philippines

In the Philippines, PhilHealth used its existing accreditation process to approve private provision of COVID-19 services. Once the Department of Health approved COVID-19 guidelines, then PhilHealth-contracted private providers certified as 'COVID-ready'. Certification entailed the private facility be in current good standing (e.g. licensed by Department of Health, accredited by PhilHealth) and inspected to ensure COVID-19 compliance. Approval was also dependent on facility level with all public and private facility levels 1, 2, and 3 having undergone accreditation. Level 1 facilities were accredited to manage milder cases of COVID-19 while level 2 and 3 hospitals were approved for treatment of complicated COVID-19 cases.

However, where such processes are absent or inadequate, a new process for establishing eligibility may need to be introduced. Where a licensing process exists, this can provide a useful starting point for determining who has the 'right' to bid. A given business and/or facility should be licensed (by all relevant national/ regional authorities) if it is to perform the services under contract. However, the authority may wish to ask a series of additional questions to ascertain capacity to meet the contract's objectives, including:

- Do all staff have current licenses with relevant professional bodies, and the capacity (now or after appropriate training) to perform the service?

- Does the business and/or facility have the capacity to achieve and sustain compliance with all quality/ clinical/ reporting standards relevant to the service?

→ **Competition in procurement**

A key decision to make in Step 2 is whether a competitive selection process is feasible and desirable, given the capacity of the market and the urgency of the identified objectives.

Key advantages to a competitive process include:

- Greater transparency, and therefore public trust in the process; and
- Greater pressure on service providers to ensure that their pricing is aligned to the actual costs of delivery (thereby reducing the scale of excess profits); and to optimise the number of outputs and/or maximise the level of service quality.

A lack of such competitive pressure is likely to reduce value for money for the authority and service users. However, in many countries, the supply-side of the relevant market (e.g., diagnostics, primary care, hospital services, IT-enabled services, etc) may be concentrated and / or not yet fully developed. In such contexts, only a small number of providers may have the capacities to fulfil the eligibility criteria set by the authority. In addition, during the crisis situation, the need for capacity to be deployed on an *urgent timeframe* may outweigh transparency and value for money considerations that are paramount in more 'normal' times. However, this creates risks for the authority, which will require careful mitigation to protect the authority's interests and safeguard the objectives of the contract.



South Africa

In South Africa, contracts were entered into with large private hospital companies, on a non-competitive basis, for Covid-19-related critical health care services. There were no contract-specific procurement processes, but, instead, agreements were made with a specific group of companies (the private hospitals market in South Africa is heavily concentrated – i.e. there are a small number of private hospital businesses that dominate market share) at the provincial level, with prices set for each specific service according to fixed tariff structures set at the national level. The prices were based on what public authorities understood the average historical costs of each specific service to be. This was complicated by the fact that individual clinicians (in clinical care, laboratory, radiology and physiotherapy) operate as independent contractors to the private hospital companies. Prices were therefore fixed according to a five-part tariff for three levels of care: 'critical', 'ward', and 'palliative'. There is also a clause to deal with 'carve-outs' for specific services, such as dialysis, and the complex management of co-morbidities.

→ Mitigating risks during Step 2

The first actions in Step 2 focus on (i) assessing the capacity of the private sector to address gaps in the availability of services critical to the COVID-19 response, and (ii) establishing eligibility criteria for pre-selection of businesses/facilities. In many contexts, the data to support decision-making against these considerations is incomplete, or unreliable. In such cases, there are clear risks to the authority and users that contractors will be unable to deliver the specified range of outputs at the required level of quality and at a reasonable cost. Against this, however, there are also risks to inaction and delay – if these imply that the availability of services is inadequate.

Before awarding contracts, authorities should conduct due diligence checks on suppliers and associated

parties to ensure they have the equipment, staffing and quality systems in place to deliver the services. In addition, where possible, and consistent with the objectives of the COVID-19 response, it may be useful to consider a **phased approach**, in which *initial contracts* focus on relatively simple service areas while later contracts include more complex outputs *if and only if* observed pricing and quality outcomes support the value for money case for an extension.





Ethiopia

In Ethiopia, the Federal Ministry of Health (FMoH) contracted with a small number of licensed private laboratories to deliver COVID-19 testing services. The agreements initially focused on screening (i.e. asking a series of questions to determine a person's risk for COVID-19) and referral of patients assessed to be at high risk of having the disease to public sector laboratories. Once the FMoH determined that contractors' performance was satisfactory, they expanded the scope of contracts to include collection of COVID-19 samples, analysis and, eventually, reporting. The FMoH monitored but did not regulate the fees charged to users by the contracted laboratories.

During Step 2, authorities must also determine the process of selection (in particular, whether this will take place through a competitive process - or not). The absence of competition does *not* mean that contracting is inappropriate, but it does create risks to transparency and value for money and may be corrosive of the public trust on which an effective response to the pandemic depends. Therefore, the authority needs to take steps to ensure that prices, volumes and quality expectations are clearly set out, and can be benchmarked as the procurement process proceeds (see Table 4).

TABLE 4. STEP 2: CHALLENGES, RISKS AND STRATEGIES FOR RISK MITIGATION

 CHALLENGE	 RISK	 MITIGATION
<p>The market's capacity to provide service(s) at the required level of quality may be uncertain</p> <p>In some countries, only a small number of service providers may have achieved certification from a third party, such as accreditation or an ISO, confirming the quality of services offered, and enabling eligibility.</p>	<p>There is a risk to the authority and service users if agreements are entered into with contractors that are unable to achieve or sustain the level of service quality required. But there are also risks to inaction – if this means the availability of services is reduced.</p>	<p>The authority may wish to conduct visits to facilities before entering into contracts, to establish the presence of critical equipment, capacities and competencies (perhaps in lieu of longer-term qualification processes).</p>
<p>The structure of the market and the urgent timeframe may preclude competitive bidding</p> <p>In many LMICs, the supply-side of the relevant market (e.g. diagnostics, primary care, hospital services, IT-enabled services, isolation capacity, support services and vaccination) may be highly concentrated, at an immature stage of development, or non-existent such that only a small number of providers can feasibly bid for the contract.</p> <p>In addition, the time pressures related to the emergency may preclude competitive bidding.</p>	<p>Where competition for contracts is absent or inadequate, there will be insufficient pressure on the service providers to:</p> <ol style="list-style-type: none"> 1. Ensure that the prices offered are aligned to the actual costs of (technically efficient) delivery; and 2. Maximize the number of outputs at the required level of technical quality. <p>This lack of competitive or market pressure may diminish value for money for the authority and service users.</p>	<p>The authority needs to generate pricing and quality benchmarks against which those offered by service providers can be assessed.</p> <p>For pricing, the 'should cost' model (as previously described in Table 3) can be useful. For quality, existing certification, quality assurance, empanelment or accreditation processes can help to establish key benchmarks. In addition, when procuring directly from one or a small number of service providers, authorities should provide clear documentation on how they considered and managed conflicts of interest or bias in the procurement process.</p> <p>Before awarding contracts, authorities should conduct due diligence checks on suppliers and associated parties. In addition, it may be useful to consider a phased approach, in which initial contracts focus on simple service areas (e.g. screening and referral) with latter contracts including more complex outputs (e.g. testing and reporting) if the observed pricing and quality outcomes support the value for money case for this.</p> <p>After awarding contracts, it is important to keep a publicly accessible database of contracts for the public to view and address concerns around selection bias. Also, it is valuable to give the public the opportunity to rate the services provided by contractors as a means of collecting quality data that can be used by the authority both during and after the emergency.</p>

STEP 3. EXECUTE THE PROCUREMENT

By Step 3, the authority has identified a single contractor (in a *sole source procurement*) or, preferably, a range of contractors (in a *competitive procurement*), that have met the eligibility criteria and are thereby assessed as having the capacity to deliver required outputs. In Step 3, the authority needs to:

- Ensure that its plans are ‘sense-checked’ by the market and are informed by likely market responses;
- Adopt an approach to bid evaluation and contractor selection that safeguards value for money – especially in contexts in which competition is absent or inadequate; and
- Ensure transparency while mitigating risks to value for money and service quality.

In the case of a competitive procurement, the authority should consult all potential bidders/contractors before issuing the Request for Proposals (RFP) as discussed in the box to the right. Consultations should be through open engagements and include as many potential bidders as possible. For example in South Africa, an RFP was advertised in all relevant media (newspapers, magazines, websites, etc) with a date set to explain the Terms of Reference in a Tender Briefing Session where all potential bidders were expected to attend in order to understand what the service delivery expectations were. The written Terms of Reference documents were sent out to potential bidders upon request - and only those that attend the Briefing session were eligible to submit a bid.

→ **Public private dialogue**

Consultation is best achieved through an institutionalised process of public private dialogue (PPD)(5). This process needs to be transparent, and open to all actual or potential bidders, to mitigate the possibility of (or appearance of) selection bias - through, for example, individual preferences, personal connections or bribery/ corruption. The authority can use the PPD process to ensure that the draft RFP is



What is the purpose and content of the RFP?

The RFP is a document developed by the authority which provides details of the forthcoming contract. In general, the RFP should include clear information on:

- a) The objectives for the contract in terms of the COVID-19 response;
- b) The scope, scale and location of services to be included;
- c) Who the services are to be made available to (i.e., service users);
- d) How contractors will be paid, on what basis and schedule, and by whom;
- e) Specific issues that contractors should include or address in the proposal; and
- f) Proposed evaluation criteria, output specification, key performance indicators, definition of terms and required bid structure.

‘sense-checked’ by the full range of potential bidders (noting, again, the importance of ensuring the range of bidders is as inclusive as possible, to avoid bias in the procurement process) before it is advertised.

Key questions to address within this initial phase of the PPD process are:

- Are the authority’s objectives for the contract clear?
- Is delivery of the output specification achievable?
- Is the proposed payment mechanism acceptable to contractors - what level of risk is implied by this, and what are the implications for bid prices?
- Are there ways of reducing risks, and thus prices, through adjustment to the mechanism while maintaining value for money?

→ Bid evaluation and contractor selection

Proposals should be evaluated by a committee that has no conflict of interest (CoI) with the contractor(s). A detailed CoI process is required. This should be documented, signed by all committee members, and archived for future reference to ensure that future questions on selection bias can be addressed. Where a potential conflict is declared, there should be a documented process for adjudicating this.

Typically, in the case of a competitive procurement, a shortlist will be drawn up, and the bid that offers the best combination of low prices, high quality and security of supply – i.e. the ability to respond quickly and reliably² – is selected. Negotiations at this (non-competitive) stage of the process should be limited. While some ‘fine-tuning’ of contractual terms is permissible, negotiations should not lead to changes in the ‘substance’ of the contract (e.g., in output, quality standards, payment mechanisms or pricing structures).

Before contracts are signed, the authority should have resolved a number of key questions concerning the implementation of the contract, including:

- How will performance be defined and monitored?
- Who will monitor performance? What access rights are needed to do this?



India

In India, a national price list (package rates) was developed from the federal level under the national health insurance scheme (PMJAY or Ayushman Bharat). States could use this, but many adjusted the price list. The price setting process was informal and not based on costing models, “many states are calling around and finding out at what prices private hospitals are willing to provide services.”



The Philippines

In the Philippines, the government passed the “We Heal as One Act” which created the legal and regulatory framework for PhilHealth to cover COVID-19 and obligated PhilHealth to develop benefits for COVID-19 services. Reimbursement levels were based on treatment of diseases with symptoms similar to those of COVID-19, for example, complicated pneumonia for COVID-19 ICU treatment. PhilHealth then conducted cost studies to verify the provisional rates and standardized these for public or private providers.

- What will monitoring cost and how will the budget for this be secured?
- What will be the payment mechanism?
- How and by whom will disputes be mediated, arbitrated or settled?

→ Mitigating risks during Step 3

If competition during the procurement process is absent or limited, there is no guarantee that prices will be reasonable and/ or that the level of quality/ scope of service volume committed to by bidders will be optimal. The authority will need to leverage its negotiating skills to maintain pressure on the bidder(s) to:

- Ensure that **bid prices** approximate those outlined in the ‘should cost’ model (as described in Table 4); and/ or can be adjudicated to be ‘reasonable’ based on prices being charged by private providers for similar services in the market; and
- Ensure that the **volume and quality of services** bidders commit to can be adjudicated to be ‘reasonable’ given the standards set down by the eligibility criteria and current practice in the health system.

²If security of supply is not guaranteed upfront, this may lead to a more expensive procurement process with government having to buy out of the agreed tender from suppliers who may have originally lost out on the bid based on price and quality criteria.

In addition, authorities should provide clear documentation on how they considered and managed conflicts of interest or bias in the procurement process. These risks and mitigation strategies are summarised in Table 5.

TABLE 5. STEP 3: CHALLENGES, RISKS AND STRATEGIES FOR RISK MITIGATION

 CHALLENGE	 RISK	 MITIGATION
<p>Potential contractors need to be consulted to ‘sense-check’ the authorities contracting plan</p> <p>In many LMICs, existing relationships between public authorities and private sector actors are under-developed. Often there is no institutionalised PPD process, in which consultation/engagement can occur.</p>	<p>Without consultation, the authority is:</p> <ol style="list-style-type: none"> 1. Unable to assess whether its planned contract terms and prices/ payment methods are acceptable to providers. 2. Uninformed about how the market will evaluate levels of risk (mostly a result of payment methods), and the probable impact of this on bid prices. <p>The authority may miss out on opportunities to reduce risk, and thus prices, without compromising on service volumes or quality.</p>	<p>The authority can establish <i>ad hoc</i> but effective PPD processes to discuss individual contracts. The OECD has produced detailed guidance on establishing effective PPD structures(6).</p> <p>In addition, a range of donors, including the World Bank, IFC, USAID, and the Global Financing Facility can provide technical assistance on PPD approaches.</p> <p>In all cases, open and well-advertised <i>Tender Briefing Sessions</i> are an important step in sense checking the ToR.</p>
<p>Ensure that contracts are comprehensive in specifying the authority’s main requirements</p> <p>In addition to the financial implications of service contracts, these are inherently complex agreements to define and implement, requiring, at a minimum, the range and quantities of services to be defined in detail.</p>	<p>Many contracts leave out important requirements or are ambiguous as to how these should be achieved in practice.</p>	<p>Use a check list before a contract is signed to ensure that the authority’s main requirements will be fulfilled at the required level of quality.</p>
<p>Ensure contract prices are ‘reasonable’</p> <p>In LMICs, authorities may not know the ‘true’ cost of delivering the targeted services. As a result, they may be unable to set or negotiate ‘reasonable’ contract prices (i.e. the payments to be made to the contractor) for a set of services.</p>	<p>Without well-informed cost estimates, authorities run the risk of:</p> <ul style="list-style-type: none"> • Setting prices <i>too low</i>, making it impossible for the contractor to sustainably offer the service; or • Setting prices <i>too high</i>, leading to over-payment, and reducing value for money for the authority and users. 	<p>At an early stage of the process, estimate the cost of providing the defined services. Costs can be estimated with reference to the ‘should cost’ model previously described, and by examining:</p> <ul style="list-style-type: none"> • Prices <i>currently</i> charged by private sector providers in ‘the market’; and • Prices charged to the government for similar services (today, or in the past). <p>Note that government can use the advantage of its market power to negotiate even lower than market prices - though volumes and payments above marginal costs have to be guaranteed in order for providers to remain viable</p>

STEP 4. MONITOR PERFORMANCE

During Step 3, the authority should have invested in the capacities needed to monitor the performance of the contractor(s) under the contract. By Step 4, the contract has been signed, but the authority's responsibilities to monitor performance are only just beginning. Monitoring is the authority's *main tool* for motivating good performance. Therefore, the costs of monitoring – both in terms of budget, and the re-direction of senior staff to lead the process – should be seen as a valuable investment and allocated accordingly.

→ **Contract monitoring**

Most health services (diagnostics, primary care, hospital services, even most support services and vaccination programmes) are extremely complex. Therefore, writing a *comprehensive contract* – one that covers how services should be delivered, and at what price, and in all circumstances, is not possible – even for authorities with a lot of experience in contracting. In contexts where authorities have limited experience, the extent of contractual incompleteness is likely to be greater.

Therefore, the monitoring arrangements to be put into effect in **Step 4** need to be strong enough to (a) capture the effects of any contractual ambiguities on performance, and (b) enable 'course correction', and the need for re-negotiation, to ensure that the contractor's operations are fully aligned with the contract's original objectives (see examples in Table 6).

→ **Dispute resolution**

Underpinning most successful contracts are mechanisms to resolve disputes and ensure that the parties deliver on what they agreed without recourse to arbitration or – *in extremis* – court action, which can be both extremely costly and disruptive. To avoid disputes in the first place, it is important to maintain open channels for communication to help clarify issues that could, if left unchecked, lead to a dispute. For example, some authorities schedule regular meetings with contractors to discuss how the contract is being implemented and agree on any needed changes.



India

In India, contractual negotiations between the public and private sectors on contract terms has not always resulted in common interpretations on what the contract requires. For example, private providers have interpreted the contract, and the related government reimbursements, to cover the patient's occupation of a hospital bed and access to clinical care – but not the provision of consumables (which are therefore being charged for). In contrast, the government considered the contract was inclusive of all inputs. Such misunderstandings are likely in the context of rapid contracting processes conducted in a health system context in which experience with contracting is limited.



Ethiopia

In Ethiopia, given the 'light' touch for a select number of private facilities to provide quality COVID-19 testing services, the Federal Ministry of Health aggressively monitored these facilities using a wide range of approaches including multiple inspections, random verification of lab analysis by the National Health Laboratory, and mystery clients to observe if the private provider complied with quality standards and price caps.

→ **Paying the contractor(s) in full and on time**

As noted earlier in this section, failures in budget planning may result in delays in payment, leading to reductions in the quantity or quality of services delivered. In addition, another reason for payment delays is the process of administering invoices.

This can be due to challenges of processing the claims, including the difficulty of ensuring that claims are not a result of over servicing, or fraud. These risks and mitigation strategies are summarised in Table 6.

TABLE 6. STEP 4: CHALLENGES, RISKS AND STRATEGIES FOR RISK MITIGATION

 CHALLENGE	 RISK	 MITIGATION
<p>Contract terms are difficult to operationalise</p> <p>Most health services are relatively complex. Therefore, writing a <i>comprehensive contract</i> – one that covers how services should be delivered, and at what price, and in all circumstances, is not possible – even for authorities with a lot of experience in contracting</p>	<p>In the absence of a comprehensive contract, the service provider may not have a strong incentive to deliver each of the required services at the expected level of quality/cost.</p> <p>There is also the potential for financial liability to the government if it commits large payments to a private provider that does not deliver services appropriately.</p>	<p>The authority can invest in a robust inspection regime during the contract's implementation phase, including evaluation of outputs/outcomes (through techniques such as visits by 'mystery clients' or independent validation of test results). This can enable contracts to be entered into without the need for long-running and resource-intensive certification/qualification processes, especially in countries where clinical quality accreditation systems are not widely followed.</p>
<p>Capacity to monitor and evaluate is limited</p> <p>Authorities may have limited capacity to monitor performance, verify outputs against critical contract goals/indicators and enforce necessary revisions to contract terms, prices and conditions. Authorities may be reluctant to invest in new or enhanced capacities – or defer such investments until too late in the contractual lifecycle.</p>	<p>Without strong monitoring capacity, the authority lacks the means to motivate performance under the contract (even if the contract is well-defined).</p> <p>A lack of conciliation, mediation and arbitration procedures may lead to a breakdown in the relationship, undermining performance.</p>	<p>The contracting authority can bring in outside entities – specialist government units, consultants, multilateral agencies, or donors – to provide expertise on contract monitoring and evaluation approaches.</p> <p>These same experts can assist in dispute resolution (conciliation, mediation and arbitration).</p>
<p>Trust is hard to achieve and sustain</p> <p>In the emergency context, authorities need to balance the need to procure large volumes of services quickly, with the risks associated with non-competitive procurement. It will often be the case that the need to act quickly will lead to rapid procurement decisions that bypass normal rules and procedures.</p>	<p>Where a procurement process is non-competitive, this means that an important mechanism for ensuring that processes are fair, service providers are treated equally, and there is transparency in contract award decisions, is absent. This may lead to an erosion of public trust in the system.</p>	<p>Without competition in the procurement process, it is important that authorities document their procurement decisions and actions fully, publish contract awards in a timely manner, manage conflicts of interest assiduously, and provide transparency about project outputs and outcomes, where possible.</p>

BUILDING BACK BETTER

Health emergencies represent a threat to long-term health policy objectives, such as universal health coverage. However, they also present *opportunities for learning* that may ultimately help policy makers to reconfigure governance arrangements for health systems, and accelerate the rate of progress towards their long-term objectives. One important lesson from the COVID-19 pandemic is this: countries with effective governance arrangements for contracting have been able to rapidly scale up their response efforts, by leveraging the (often substantial) resources of the private health sector. In contrast, countries with nascent, or emerging, governance arrangements for contracting, have not been able to achieve scale-up on a necessarily urgent timescale. In most countries, the process is underway, but it has taken more time, and the capacity that exists in the private sector has been left unutilised for long periods.

Overall, this experience suggests that, in their future planning and strategies, **governments should consider their ability to effectively contract with the private health sector as a component of their strategies to strengthen core health systems functions – which are, as “common goods for health”** - fundamental to protecting and promoting health and well-being(7).

For countries that are still developing the process for contracting with the private health sector, WHO and the World Bank would emphasise the following key messages:

- Contracting is a tool that governments can use to strengthen their responses to COVID-19 by utilising and co-ordinating the resources of *whole health systems, public and private*;
- It is challenging, but worthwhile, to leverage resources and align activities and behaviours with emergency response goals, in order to optimise the response;

- It is important to define as clearly as possible – and place on record – the details of the contract’s focus and content and (e.g., scope, eligibility, service volumes, minimum quality standards; and monitoring arrangements);
- Be pragmatic - start by contracting private providers with known (or easily verifiable) quality standards in place, e.g., those with current licensure and/or accreditation, before - if capacity needs require this - moving to engage others in the market;
- Focus on improving data analytics for the planning of service needs, and to gain better insight about the private health sector and mechanisms for routine engagement of it, utilize public-private dialogue structures; and
- Where it is necessary to temporarily relax procurement regulations and/or any other aspects of normal governance procedure, make sure to establish even stronger/ stricter monitoring mechanisms to ensure that quality and reporting standards are upheld.

Successful implementation of these principles depends on the will of policy makers to build a set of **core contracting capacities** – those needed to *define, plan and execute* an effective procurement process, to write a comprehensive contract, and to monitor the performance of contractors. For countries with limited contracting experience, new, and perhaps unfamiliar activities will be needed - *new data to be generated or collected, new structures for public-private dialogue to be established*. Often, these activities will need to be achieved on an *urgent timescale*. This urgency may require established procedures to be relaxed, generating new risks - for the authority, the private sector and service users. These risks require diligent management – but the experience of several countries, including LMICs, shows that this is achievable.

In addition, through this process, authorities can develop – and should seek to *institutionalise* – new capacities, activities, and ways of working that will strengthen current response efforts and enhance their ability to tackle future emergencies. As we have demonstrated in the country examples outlined above, many governments had developed the core capacities for successful contracting before the pandemic struck. They were, as a result, well-placed to take a resource-based approach that included both public and private complements, by rapidly putting in place new contracts to strengthen access to, and utilisation of, relevant testing and treatment services.

For others, for whom such capacities are now being strengthened, the pandemic creates an important opportunity to *build back better*, so that when the next COVID-19 wave, or indeed the next epidemic or pandemic hits, the range of services that can be contracted from the private health sector is known, the individuals and agencies with the contracting experience required are in place, and the dialogue structures – which are so critical to the process of mobilisation the private health sector for the response – are established and ready to be engaged.

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