Contracting NGOs for Health

MMI advocates contracting as an efficient method for the integration of NGO health services into the District Health system.

Better Health Care by Contracting Not-for-Profit, Public Serving, Non- Governmental Health Care Institutions as an Integral Part of the Health Districts

A Statement Made by Medicus Mundi International (MMI)

MMI is in Official Relationship with the World Health Organisation since 1974

Abstract
Medicus Mundi International (MMI) recommends that governments adopt a contracting approach with those non-governmental (NGO) Health Care institutions, which assume a public purpose. This will be an efficient means of integrating existing health care facilities into the district health systems.
In order to achieve a good co-operation between Governmental and Non-Governmental organisations within an integrated health system, MMI recommends:

- To classify the Health Care Institutions according to their technical capability, performance and catchment area, and not only according to their ownership or institutional identity.

- To base the operational definition of "public purpose" on the access for all people in need within a defined area to the level of care offered, without discrimination with regards to race, sex, religion nor social status, and on the contribution to the implementation of the national health policy, including the co-ordination with other institutions of the health system and the exchange of relevant information.

- To define the terms of collaboration between national or local authorities of the health system and a public purpose-based NGO, by means of a contract, based on sharing trust, responsibility and transparency.

- To establish within that contract an agreement between the collaborating partners, on the criteria for regular evaluation of the relevancy, quality and efficiency of the care provided, and, accordingly, on how to gradually adjust the offered services.

- To open the district management team or other relevant platforms to the NGO health services, which play a significant role in the health district, in order to formulate local priorities in a joint effort.

- That the national or local authorities, support the work performed by NGOs in their public services functions, giving them logistical and methodological support, as well as covering the costs entailed by operating in an integrated system.

Underlying considerations

i. In 1978, a world-wide accessibility and quality analysis of health care in different economic, political, social and cultural settings led to the declaration of Primary Health Care (PHC). This analysis has shown that the organisation of « health care as an integral part of overall development » requires balancing between the operating of **rationally organised health services** and the **participation of the served population** (WHO, 1978).

ii. Moreover, successful implementation of PHC is only possible if hospitals at the **first referral level** are fully involved and are complementary to the **first line health services** (H.Mahler, Aga Khan Foundation, 1981).

iii. Many developing countries currently face **serious difficulties in sustaining their national health systems**. The culprits identified by the World Bank are misallocation of resources, inequity, inefficiency and exploding costs (WDR, 1993). New health system reforms are being propagated everywhere, in order to make better use of resources and improve efficiency, especially with regard to the management of drug programmes, manpower and infrastructure of services. Pursuing avoidance of **unnecessary duplication** through co-operation among the public and the non-governmental health services is one way to improve efficiency and make national health services **affordable** (WHO, 1987).

iv. The health care providers of the« private sector » are organised in very **heterogeneous** institutions. Many of them respond to the need of the local population. There is a distinct category of **non-governmental health care providers with a public purpose** and a clearly defined ethical attitude of not-for-profit. Part of them are rooted in the former "**charity**" health facilities, which have played an important role in so many developing countries by serving the underprivileged. Besides that, there are categories with different degrees of financial profit making and proportionally less responsibilities of public interest.

Traditionally, government-owned health institutions in many countries have offered their services free of charge. Now that resources for these institutions have become insufficient, health-sector reforms authorise the health care providers, both non-governmental and governmental, to complement their income through the introduction of various cost-recovery systems. Therefore, **there is no more clear distinction between the public and the non-governmental sector**, apart from the ownership of the health care institutions. Indeed, some governmental health institutions have covertly or overtly followed the commercial trend, while many of the NGO-owned health facilities, used to charge a reasonable fee, maintain a « public purpose ».

v. The NGO health institutions present a **large potential** for improving health care and health care delivery in developing countries. Though varying in different countries, their proportion is substantial. In sub-Saharan Africa for example, NGO-hospitals provide 43% of medical work in Tanzania, 40% in Malawi, 34% in Ghana, and 9% in Congo (DR). The figures for Asia are 26% for Taiwan, 15% for India (with over 200 NGO-hospitals), 13% for Bangladesh, and 12% for Indonesia (Contact, Geneva, 1995).
As a consequence of the global trend towards privatisation and liberalisation this proportion is rather increasing.

vi. NGOs, especially the not-for-profit ones, often **operate successfully and at low cost**, offering a "service perceived to be of higher quality " (WDR, 1993) and achieving **acceptable levels of adequate health and medical care**. Examples include Designated District Hospitals or state supported First Line Health Care Services, working in conjunction with state owned providers, such as seen in Tanzania, Uganda, Congo, Ghana, and other countries. They often operate under rather difficult conditions in remote and insecure areas, where state-owned institutions are so to speak non-existent (Van Lerberghe et al, 1990 and 1992). These NGOs respond to an obvious and pressing need of the civil society. They adjust their services according to the spontaneous initiatives taken by the local population, as advised by governments and authorities.

NGOs have a good track record in medical care and in supporting community-based health care activities. They have important qualities including reliability and low staff turnover, freedom from rigid bureaucracy, experience in (partly) cost-recovery systems, proximity and adaptation to the needs of the target population, preference to support and serve the under-served, and high staff motivation (Contact, Geneva, 1995). NGOs with such qualities are capable of developing and testing new solutions such as in the fields of building (M. King), financing (e.g. Moens 1990, Criel 1997), appropriate technology and community involvement (see various Contact issues, CMC, Geneva).

vii. The **first referral hospitals** often have an inequitable geographical distribution, are often inefficient and suffer from highly centralised decision-making, wide fluctuations in budgetary allocations and poor motivation both of facility managers and health care workers (WDR 1993). Central authorities often favour tertiary high technology hospitals, depriving first-referral hospitals. Most NGO hospitals operate adequately at first referral level. However they suffer from the lack of good co-ordination with the government district health services. Whether governmental or non-governmental, first referral hospitals have to co-operate and work to an acceptable level and at an affordable cost. More generally co-ordination and tuning-in of the services at different levels are the best tools for the implementation of the health district

approach, aiming at a reliable functioning, a high quality of care and a confidence-based relation with the community. (Van Lerberghe et al, 1997).

viii. WHO advises the governments to foster close co-operation between governmental and non-governmental hospitals and the establishment of an integrated district health system (WHO, 1987). Moreover, the World Bank propagates « the effective use of non-governmental resources » as one of its four policy reforms. The **government's role of regulating**, in accordance to their national health care policy, the conduct of all health care providers, including governmental, non-governmental non-for-profit and even private for-profit ones, is put on top of the priority list.

ix. **Mutual prejudice and problematic practices must be overcome**, in order to facilitate on-going dialogue and co-operation between state authorities and NGOs. How can this be achieved? Joint efforts can be made at both governmental and non-governmental sides, at central, district and regional level. NGOs need more consultations with the health authorities at early stages of planning and programming. More consistent commitments are needed without imposing rigid instructions and bureaucratic controls over the NGOs. On the NGO side there need to be less preoccupation with institutional protection and independence and more concern for the overall objective of improving health care of a given district or locality.
NGOs have to be realistic about their commitments and should enhance the climate of good co-operation by disclosing relevant information in a transparent way.
At the district level, good communication enables the non-governmental health institutions to put forward their great potential of improving health in the community served. Deployment of officials to run health districts needs to reflect expertise and competence. Well-planned integration of NGO-facilities in the health district favours the development of a sustainable concerted action by both the state and the NGO-facilities. Making good use of the existing capacities leads to better efficiency, at lower costs than by creating new capacities, parallel to the existing ones.

Suggestions for ways ahead

1) Given the heterogeneity of the NGO sector and the blurring definition of "public", non governmental" and "private", it is strongly **recommended** to develop a classification of health care institutions in order to determine their public purpose. This classification should be based on their **technical capability, performance and output**, rather than on ownership and institutional identity. In this way, a government will be more accurate in targeting its support towards both government and NGO health care institutions which serve a public purpose (Giusti a.o., 1997).

2) It is **recommended** (Giusti a.o., 1997) to base an operational definition of "public purpose" on the following:

- The concern for the enhancement of the people's **well-being** and self-determination,
- The responsibility for and the accountability to a well **defined population**,
- The concern to contribute to the development and implementation of the national health policy and of the master plan of health services,
  The concern for the delivery of "rational" care and for limiting "irrational" care, even if it is demanded and even if it generates lucrative financial returns,
- A technical perspective related to the pursuance of universal access to care of good quality, the willingness to specify the tasks to be performed and procedures to be followed, the co-ordination of the activities with other institutions, and the exchange of relevant information in order to optimise the functioning of the health system based on the district.

3) Where, as a result of open and frank discussions, the authorities and the NGOs agree to collaborate, to co-ordinate their activities integrating for instance the NGO into the district health system, it is necessary to **draw up a contract** which clearly states the purpose of the co-operation, the **responsibility and obligations** agreed upon by both partners, and the arrangements made.

4) It is **recommended** to establish **agreements** that can safeguard the NGO's **flexibility**, their **motivation** and their **identity**, since the areas of comparative advantage of the NGOs serving a public purpose have to be protected. Only essential administrative procedures should be shared. Thus, the contracting partners will avoid unnecessary bureaucratic constraints that interfere with the smooth running of the institution. Co-operation will be based on **trust, responsibility, transparency** and **exchange of information**.

5) Both contracting partners, the governmental and the non-governmental, need to work out **agreements** on the criteria for regular evaluation of the **relevance, quality** and **efficiency** of care provided. Gradually, some

necessarily corrective mechanisms, budget revisions or new guidelines need to be introduced, in order to allow for institutional adjustments and to prevent jeopardising continuity and quality of care in general.

6) It is recommended that districts without adequate state district hospitals **integrate available first referral level NGO-hospitals** into the district health system, whenever the NGOs concerned have a public purpose.

7) NGO-hospitals, which play a significant role in the health district, should by contract be made **co-responsible** for the implementation of the official health policy and should join the **district health management team** or any other relevant platform, where they can contribute to the planning and formulation of local priorities. Within that same contract NGO-held health care institutions might be given support by the government, for public services rendered. This system might include the logistical and methodological support and the financial support necessary to cover the cost entailed by operating in an integrated system (e.g. the costs of rationally referred patients).

Conclusion

In every country of the world there are various types of health care institutions, which present the backbone of and an important resource for health care and health care delivery. However, if they want to function well, and if they want to realise a common goal, serving the society, the health institutions need to be organised rationally, in a sustainable way, by means of an appropriate co-ordination. This is difficult to achieve, because health institutions are often a mix of public, governmental and non-governmental facilities, the latter ones operating either on a not-for-profit or a partly for-profit basis.

Nevertheless, many not-for-profit, public serving non-governmental health care institutions have a « public purpose ». When given the mandate to contribute more fully to health and health care development, they need to be well integrated into the national health system.

The integration can be implemented at the central, district, regional, and the local level, within the national context. This paper recommends the contracting of such institutions as an integral part of the health system, especially at district level.