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CONTRACTING AND PERFORMANCE MANAGEMENT IN THE HEALTH SECTOR

Some Pointers on How to Do It

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This 'toolkit' is a revised and updated version of the 1997 IHSD toolkit on contracting.

Examples of contracts:
The HSRC website provides free access to a number of examples of health services contracts from around the world that may be useful in adaptation in other circumstances. HSRC would be grateful to receive more such examples for review and inclusion on the site. Recognition will be given.

Target audience: This publication is aimed at senior policy makers and managers in lower and middle income country health sectors and their development agency partners. It may be of particular interest where public sector service units are being given more autonomy / independence and where new spending arrangements are being introduced in terms of purchasing organisations (tax or national health insurance funded).

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INTRODUCTION

A fundamental problem of the public sector in many countries is that it does not define the outputs expected of service delivery units (like districts, hospitals or primary care units) in return for their funding. The public sector works on the basis of cash accounting – all that matters for probity and accountability is that expenditure is properly accounted for and has not gone astray. What output is achieved for that financial input is a secondary consideration and usually is not measured at all. This means that efficiency is not measured and, therefore, that it is difficult to know if it is being improved. The same is true of equity because the traditional public sector does not measure very well who gets the outputs. Contracting aims to introduce a better method for achieving performance and accountability – one that sets service delivery targets alongside a budget. In this sense, it is little different from 'planning and budgeting' but contracting has the potential to be much more powerful in driving performance. It has been given prominence by worldwide interest in reforms separating the function of *spending or allocating public finance* from the function of *delivering or providing services*.

These reforms are creating more autonomous service delivery organisations (or units) in which government no longer employs the staff so that there is no longer a hierarchical 'chain of command' type of administration within a single organisation. In these circumstances, a form of 'contract' or 'agreement' is essential to bind the behaviour of two parties – the spending organisation and the service providing organisation. Even within the traditional public sector where there is little or no such autonomy, there is growing interest in managing performance by the use of some form of 'contract' between those responsible for allocating budgets and those responsible for providing health care services.

This toolkit aims to assist in the preparation and use of health services 'contracts'. The term 'contract' is used here to cover any form of document that provides a quantified specification of the health services outputs expected from given financial inputs within a given time period and to defined quality standards, and that is used to guide and control the behaviour of both the payer of those financial inputs and the provider of the specified service outputs. Examples include:

- A 'contract' between a public sector organisation and a privately owned hospital (or other private health services provider) to provide services for public patients. This would be a legal contract.

- A 'contract' between a social health insurance organisation and a privately owned hospital (or other private health services provider) to provide services for insured patients. This would also be a legal contract.

- A 'contract' between a public sector organisation and a statutory authority organisation providing health services. This would probably be a legal contract depending on the constitution of the statutory authority.

- A 'contract' between one layer of the public service controlling a health budget (a province say) and another layer providing services (a district, say, or a

public hospital). This is not a legal contract since the two are part of the same legal entity and a legal entity cannot contract with itself.

Unless 'contracts' are legal contracts, it may be misleading to call them contracts. Arrangements between different layers or units of the public sector may be more appropriately called 'service agreements' or 'performance management agreements'. But even 'agreement' may be misleading since, legally, there may be no difference between an agreement and a contract. Within the public sector, it may be more accurate to call such documents 'service performance specifications'.

The name does not matter greatly providing it does not cause misunderstandings or present opportunities for excuses (by a monopoly state provider for example) to block the adoption of such a useful tool. The essence of any such 'contract' is that is commits the purchaser to being clear about what it requires and the provider to providing or trying to provide a specified output in terms of health service types, quantities and qualities in return for which the provider is guaranteed a certain payment or monetary authorisation (budget).

Throughout this toolkit, 'contract' and 'agreement' are used interchangeably to cover any type of documentation that links the behaviour of two parties – one of whom provides health care services (the provider) and the other of whom (the purchaser) pays or allocates financial resources to that provider for doing so – even if no legal contract exists or can be construed.

CONTENTS

1 SOME BASIC ISSUES

1.1 WHAT IS CONTRACTING AND WHAT DOES IT DO?

Contracting is necessary where one party buys or commissions services and the other party delivers the service. This is the case when the parties are legally separate entities: when for example the purchasing body is in the public sector or is an independent social insurance organisation and the provider is an autonomous statutory authority or a private organisation (for-profit or not-for-profit). Contracts between legally separate entities are legal contracts and, in theory at least, either party can seek legal remedy for non-performance through the civil courts of the land. (In practice it is better if the contract defines an independent arbitration mechanism for the settlement of disputes so as to avoid protracted and expensive legal proceedings.) Contracts can cover services that range from comprehensive health care for a defined population down to a specific non-clinical service (hospital cleaning services, for example).

However, there is also growing interest in the use of a contracting-like process within the public sector itself where the 'purchaser' and 'service provider' are part of one legal entity i.e. the public service. Most of what follows apply to both situations although some differences are identified in Section 1.4.

The potential advantages of contracting can be summarised as:

- linking financial allocations to health services outputs, outcomes and consumption patterns and thus facilitating measurement of and improvements in efficiency and equity
- clarifying the roles and responsibilities of both parties and thus facilitating more accountability.

These potential advantages are more likely to be realised where the two parties have a high degree of independence of action and freedom to manage and deliver their side of the contract.

A contract specifies the range, quantity and quality of services the provider is to deliver during a future time period. This is in contrast to existing arrangements in many countries that allocate public finance on the basis of existing facilities and staff regardless of the quantity and quality of services that they provide. Contracts are a vehicle for linking public finance or social health insurance funds to defined results. For the purchaser, they can be a powerful mechanism to drive policy implementation whilst leaving the 'hands on' management of services to providers.

Where a (previously) public provider has been made autonomous, it has much more freedom in how its facilities, equipment, staff and other inputs are managed. It is better able to respond to the requirements of the purchaser as specified in the contract - the measure of success is in the appropriateness, quantity, quality and cost of services that result. By making performance more explicit, a contract can instil a 'performance culture' in managers and staff encouraging them to seek better ways of doing things. It is essential, of course, that the right things are measured.

Box 1: Autonomy Without Contracting

In practice, there are many examples around the world where autonomous providers have been established in efforts to promote efficiency but have not been very successful. In many cases these providers receive substantial public finance to provide services for public patients but no contractual or performance management arrangements have been put in place to define the services, cost and quality requirements and to monitor their performance. Three examples include:

Kenyatta National Hospital, Kenya
The public national hospital, KNH was set up as an autonomous organisation using existing Public Corporation Legislation. The hospital now costs more to operate and extracts more from the public purse whilst, apparently, providing no more services. The casemix has changed to maximise income and this has meant a reduction in services to the inner-city poor. Is this what was wanted by government? Since there is no specified role for the hospital in terms of a contract with government, it is hard to know.

National Heart Institute, Malaysia
The Institute was transformed into a semi-autonomous organisation (a limited company but entirely owned by government) with the objectives of introducing private sector efficiency gains, freeing up government revenue for other needs and retaining a skilled workforce who might otherwise move to the private sector. The hospital now treats more patients (58% more inpatients over the five years to 1997) but operating expenses have increased by 150%. It may be that casemix has changed to include a higher proportion of more complex procedures but the proportion of government sponsored patients (civil servants and the poor) has declined whilst that of private patients has increased yet the government financial contribution to operating costs has increased by 110%. Is this what was intended? There would appear to be a distinct loss of control over what the Institute is doing – a clear case for a stiff dose of contracting to replace retrospective case reimbursement with prospective prescription of services, quantities, quality and budget.

Mount Hope Hospital, Trinidad
A new specialist hospital was constructed with public finance and a new law established the institution as an independent statutory authority. It receives an annual subvention from government for public patients but otherwise operates as a hospital for private patients. Completed in the mid 1980s, the hospital has yet to function fully. There is insufficient population to maintain a private hospital of this scale and government has shied away from the public sector human resource implications of closing decrepit public facilities elsewhere and transferring services and budgets to Mount Hope. There is no clear government intention for the hospital and no contract has ever been prepared to define what it is supposed to provide in return for its public subvention. Recently, the hospital has been incorporated into one of the independent regional provider agencies that now provide all care in the country. But despite being funded almost entirely by the public purse, still no contracts exist between government and these providers so Mount Hope remains unaccountable.

These examples are not evidence that contracting doesn't work. They are evidence of the need for contracting – contracting based on a strategic context, targets and monitoring. Several governments have been keen to hive-off their (expensive) national hospitals to autonomous status but their motives for doing so have been concerned more with raising income from user fees than with increasing cost effectiveness or equity of access.

1.2 THE IMPORTANCE OF THE PURCHASING FUNCTION

Contracting can be a powerful tool for implementing policy and for creating incentives to improve the distribution, utilisation and cost effectiveness of health services. The role of the organisation charged with allocating or spending available finance (the purchaser) is crucial in this - the importance of purchasing is highlighted in the relative failures of many recent attempts to turn public sector hospital providers into autonomous organisations (see Box 1). By making the transfer of finance to providers conditional on specified outputs, purchasers can use contracting to seek more equity and value-for-money: the transfer of funding to under-served consumers and to more effective management and clinical practices. To do this, purchasers must have information about:

- *the health status, needs and priorities of the population concerned*
- *the efficacy of specific health care services and the cost effectiveness of different ways of delivering them*
- *consumer views and priorities.*

Health Services Needs

Purchasers should know what types of health care and how much of it their populations need and will make effective use of. This information is only partially provided by statistics of service utilisation although many countries have to plan on this basis. Effective contracting requires knowing more about local needs (including presently unmet needs) and this requires population surveys, censuses and sampling techniques. Moreover, purchasers require information on more than simply the prevalence, seriousness and distribution of ill health in the population. They require knowing how this information can be transformed into a quantified, prioritised and affordable specification of health care services so that contracting can drive the process of achieving those services. Planning techniques are available using comparative data to estimate service needs based on population parameters. These can provide a useful starting point and the contracting process can regularly refine and update this based on quarterly and annual reviews of services availability and utilisation. Purchasing may provide a useful vehicle for addressing the needs of the poor but effective targeting requires considerable thought. (see Box 2).

Box 2: Can Contracting be Used to Target the Poor?

Purchasers can use contracting to drive equity and support 'pro-poor' health policies. Clearly, contracting can be a powerful tool for the redistribution of resources to those providers serving areas with greater needs – crudely, the poor can be targeted by location. More problematic is the extent to which contracting can be used to target the poor within the services of any one provider. Targeting by income level is difficult. The use of health cards or vouchers by the poor has not worked well in practice – the poor are not a static population - and all means testing is unpopular and unwieldy. There may be specific possibilities for targeting the poor by disease - this is the principle upon which the 'essential package' of services is based – but in general, this approach is ineffective. Access to the package cannot be restricted to the poor and the poor seek treatment outside the package and will not have confidence in services that do not offer it. And clinicians cannot be expected to cease treatment to a poor patient if complications arise that are not specified in a package.

Neither is differential pricing a real option (subsidising 'essential package' services) because it creates perverse incentives in providers. Providers will not want to offer free essential services when they could be providing income generating services and they will find reasons to refer patients elsewhere, to deter them or to 'creatively diagnose' to demand payment. Overall, it is not realistic to expect cross subsidisation to be practised by providers who are themselves under pressures for efficiency and balancing the books. Cross subsidisation is more effective at the point where finance is raised using progressive taxation or social insurance contributions. Where contracting can be helpful is in improving provider efficiency – getting more and better services for available resource inputs – and in defining who is eligible for services thus removing barriers to access by the poor.

A purchaser's budget should be decided on the basis of the health needs of the population it is responsible for - not on the costs of existing services (see Box 3). If a purchaser decides to cease funding a type of service, it must know that it will still have the equivalent budget to spend on other things for its population.

Box 3: A Population-Based Formula for Resource Allocation

Public finance for health services should be allocated to purchasing agencies on a basis of a weighted population formula based on a combination of factors including:

- population size, age and sex
- mortality/morbidity rates or other health indicators
- measures of relative social deprivation
- relative costs of providing services.

This offers a way in which to distribute public finance for health services that is potentially more equitable than funding based on historic expenditures - with funds flowing to meet population needs rather than to maintain existing services. Putting public funds in purchasing organisations' hands in this way leaves them more able to make the decisions about how best to purchase services for their populations.

Efficacy and Cost Effectiveness of Services

Many health services are providing treatments that are not very effective but have been provided traditionally - or may be more for the financial benefit of the provider than the health of the consumer. Some treatments are being provided at a cost greater than another equally effective treatment or may have been superseded by new interventions. Other treatments may have no known benefit whatsoever. The purchaser will want to know why this is happening - from the purchaser's perspective; these treatments are a waste of money and should be curtailed.

Unfortunately, there is limited knowledge about the effectiveness of many health care interventions currently practised. Neither do many countries know much about the real costs of interventions - effective or otherwise. Whilst the movement for 'evidence-based' practice is accelerating and sources of information are growing, much of this information is of more use to industrialised countries and less is focused on the health problems of lower income countries. Nevertheless, some of this work is relevant and it is available for countries to

review and use as appropriate. Two major sources of such information are shown in Boxes 4 and 5.

Box 4: The Cochrane Collaboration

The Cochrane Collaboration is an international non-profit organisation that aims to help people make well-informed decisions about healthcare by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions. About fifty Collaborative Review Groups preparing and maintaining Reviews do the main work of the Collaboration. The main output is the Cochrane Library, which includes a number of different databases.

For information contact:
The Cochrane Library at: http://www.cochrane.co.uk
or the Collaboration's web site at: http://www.cochrane.org

Consumer Views and Priorities

Whether they are technically right or wrong (in terms of the efficacy or cost effectiveness of services), the values and views of consumers ultimately constitute the moral and legal basis upon which the financing of public sector health care rests and they should be taken into account in purchasing decisions. Traditionally, decisions on the rationing of care have been seen as the prerogative of medical professionals although in fact rationing is the result of a combination of political, managerial, and historical as well as clinical factors. Increasingly, as technology has expanded what is possible and as costs have risen, doctors are reluctant to be held accountable exclusively for rationing decisions and have demanded more explicit approaches to rationing. It is to be expected that, more and more, purchasers must seek the tacit or explicit approval of the consumer both in terms of national 'big issues' and local situations. Purchasers should and will increasingly demand that providers seek systematic ways of obtaining patients' views.

Box 5: The UK NHS Centre for Reviews and Dissemination

Established at the end of 1993 in the University of York, the Centre has two roles within the NHS, the first relating to reviews and the second to dissemination. The Centre "proactively commissions or itself carries out reviews on behalf of the NHS, principally in areas of effectiveness and cost effectiveness of health care interventions, management and organisation of health services." It also disseminates the results of its research to the NHS in order to aid effective decision making. This is done in part by means of databases of published reviews and studies reporting economic evaluation of health care and an enquiry service for handling appropriately filtered requests for information on the availability of reviews.

For information contact: http://www.york.ac.uk/inst/crd

1.3 CONTRACTING AS A PROCESS

If contracting is to be used to drive national policy for efficiency and equity (as opposed to getting a competitive price for the hospital laundry services), it must occur within a strategic context aiming to make the best use of available resources. The context must be set by the purchaser and, whilst it may be

tempting to think that policy goals can be achieved by a ruthless, market approach to awarding contracts to conforming providers whilst withholding them from others, only rarely will this be the case in practice because, often, genuine competition is not possible (see *Lack of Provider Competition* in Section 2). More commonly, there needs to be a high degree of collaboration between a purchaser and its providers and this requires:

- mutual understanding, ownership of and participation in the contracting process
- an appreciation that both parties need to manage and share financial risk
- new skills (to provide the necessary confidence as well as abilities)
- systems (to support the management of the process)
- a contract framework, which doesn't inhibit innovation through over specification but instead, introduces sufficient flexibility to encourage innovation in delivery.

Where a purchaser is a public sector organisation, contracting has to be an integral part of the planning cycle so that providers' budgets can be rationally allocated and brought together to constitute a national health budget. Elements of this cycle are the production of specific plans, budgets and contracts.

Strategic purchasing plans

If providers are to respond to the requirements of purchasers, they need adequate advance warning of a purchaser's intentions. Purchasers should produce 'strategic purchasing plans' that cover a period of three to five years and set out the vision and broad strategy for achieving it. They might cover:

- assessment of the health care needs and priorities of the population concerned (and incorporating any national health targets and objectives)

- the purchaser's strategy for meeting those needs including any broads shifts of emphasis in the types of services required and how they are procured and delivered

- identification of all significant changes in budgetary allocations aimed at achieving that strategy – allocations that will be phased out and others that will be increased

- guidance on quality standards and on quality assurance procedures (even if these are still to be developed in detail)

- guidance to providers on information requirements and formats that the purchaser will expect to see implemented

- details on the services the purchaser wishes to contract for in the following year and on budgets and budgetary constraints including inflation allowances.

All actual and potential provider organisations should have access to this document and the purchaser should solicit their views on its content. Provider organisations may also see advantages in producing their own longer term strategic planning documents to guide their own development, to inform all staff and to demonstrate intentions to purchasers. Indeed, providers may be required by purchasers to be transparent about their plans.

Annual business plans

Both purchaser and provider organisations should produce annual business plans that contain details on specific targets for the next year and on how these will be met. The provider will produce this plan within the context of the purchaser's strategic purchasing plan. It might cover:

- details of the specific services the organisation will offer
- identification of specific improvements the provider will implement in the following year
- a brief strategy section for the next three to five years
- proposals for capital investment for the next three years
- details on what all this will cost in terms of recurrent expenditure for next year
- projections of quantities and sources of income to meet those costs.

The nature and level of detail will depend on whether the provider organisation is also in the public sector or is a private organisation. A private provider will not be willing to disclose everything about its cost structure but, nevertheless, a purchaser could well require sight of a coherent and convincing business plan to satisfy itself that the provider could really perform on what it is offering and will not go out of business during the contract period. A purchaser's annual business plan will show the totality of its purchasing activities within its anticipated budget and the details of how this budget will be spent.

Linking plans in the planning and budgeting cycle

Where a government public expenditure budget is fixed in, say, November of each year, a Ministry of Finance will require line ministries to submit applications for allocations in the previous July. The planning cycle might be as shown below assuming, for illustrative purposes, that the purchasing role is undertaken by Provincial Health Departments (PHD) and that the role of the Ministry of Health (MoH) is that of policy and priority setting including overseeing the allocation of the national health budget to PHDs on the basis of a weighted population formula. The months indicate the completion dates for activities that may have started earlier, MoH policy guidance to PHDs is ongoing and all documents will be prepared with stakeholder participation.

Year/month	Activity	Actor
Year 1:		
February	PHDs issue strategic purchasing plans highlighting specific purchasing intentions for Year 2	PHDs
March	Providers prepare 1st draft annual business plans for Year 2 and submit to PHDs	Providers
	PHDs prepare basic 1st draft contract documents for Year 2 and submit to providers	PHDs
April/May	PHDs and providers discuss draft annual business plans and contracts and prepare 2nd drafts	PHDs/providers
June	PHDs prepare their own business plans and submit to MoH	PHDs
	MoH works on budget submission to MoF	MoH
July	MoH submits budget to MoF and informs PHDs of actual budget requests	MoH
	PHDs inform providers of budget requests and implications	PHDs
September	PHDs and providers discuss implications for draft contracts	PHDs/providers
October	Agreement in principle of contracts by PHDs and providers	PHDs/providers
November	MoF allocates health sector budget and informs MoH	MoF
	MoH informs PHDs of their amended budgets	MoH
	PHDs inform providers of amended budgets and implications	PHDs
December	PHDs and providers finalise and agree contracts for Year 2 and prepare revised business plans	PHDs/providers
Year 2:		
January	Contract period begins	PHDs/providers
	Annual performance reviews for Year 1	PHDs/providers

Performance evaluation

The objective of separating the spending function from the provision of services function is to produce a better result for the money spent, not to bankrupt the provider. It is in the interests of both parties to achieve that result and a degree of co-operation is helpful in doing so. An annual performance evaluation (supported by regular in-year reviews) undertaken jointly by the purchaser and the provider can be as important as the contract itself. The contract constitutes the basis for the evaluation of performance allowing actual performance to be compared with the targets negotiated at the outset of the contract. Differences can be discussed and analysed to determine why these occurred and what can be done to improve things in the future. In this way, systematic progress can be made against longer term goals. Given the investment in developing a common purpose between the two parties (and the corresponding development of capacity and systems to achieve that purpose), a purchaser may find it more productive to develop a long term partnership with its suppliers and assist in their development rather than constantly to switch from one to another. This requires very regular contact between the parties (in addition to formal evaluations and reviews) to

identify and assess problems and agree solutions preferably recorded 'at the table' in the form of signed notes appended to the contract document. It may also require contractual arrangements for periods longer than that of an annual planning cycle.

Contracts should require the provider to generate prescribed data on services activities and quality and in prescribed formats so that performance can be measured against targets as specified in the contract and so that contracts can be compared. This is another important potential benefit of contracting. The annual performance evaluations provide an 'audit trail' - a story of what happened year after year, what activity levels were achieved, what expenditure was incurred, what productivity gains were made and what improvements were possible.

1.4 WHERE THE PARTIES ARE DIFFERENT PARTS OF THE SAME LEGAL ENTITY

In this case, any agreement between two parts of the same legal entity does not constitute a legal contract. Nevertheless, it may be possible to go through a similar process and to gain some of the advantages of contracting. In several countries, this is now being referred to as the introduction of a 'performance management' process.

Performance management is possible at various levels in the public sector. A province or region could 'contract' with districts to try to ensure that its budget is directed at meeting needs (and correcting inequities) across the province. It would set explicit district targets for health services provision and link these to budgets. In smaller countries, the ministry might contract directly with the districts to achieve the same aims. In larger countries, districts could be purchasers and hold services agreements with individual service provider units: the public hospitals and primary care providers. They might also choose to make up the package of services they require for their populations by buying some services from the private or NGO sector.

Contracting works best when each party has a high degree of control over its resources and operations. The district purchaser, for example, must have control over the spending of the district budget so that it can make resource allocation decisions to achieve a cost effective balance between primary, community and secondary care to meet its targets. This might include ceasing to fund redundant facilities and transferring the relevant budget to where it is more needed and to where it can be more cost effective. The provider must have control over how to use its finances and how to manage its resources to provide the required services.

Where such services 'contracts' are not legally enforceable, there can be no recourse to law for failure to meet the targets concerned – although arbitration arrangements can be built into the contract and there are, of course, laws to deal with fraud or theft or the misuse of public funds! So how can contracting arrangements work within the public sector? What are the incentives for providers to strive to meet the contract targets? They include:

i *the prospect that performance evaluation will reveal that money is being wasted in certain areas and the accompanying threat that it will be deducted from any subsequent contract or that the purchaser will spend its money elsewhere in future*

ii *the prospect that the careers of the staff responsible will be effected by promotion, demotion and reputation - performance evaluation identifies good and bad managers.*

This highlights that there must be someone responsible and who can be held accountable for the performance of the service agreement – a chief executive accountable to the organisation's board for example. Boards will have an interest in removing a manager who persistently performs badly and in giving more freedom of decision making to one who performs well. The individual should sign a contract with ultimate responsibility for ensuring that targets and terms are met i.e. the chief executive or equivalent. The increased clarity about who is responsible rapidly highlights the need for those individuals to have authority over the deployment of their resources including staff. Moreover, for this to work in practice, the corporate contract needs to be translated into personal objectives for all staff through the introduction of individual performance management and appraisal systems. These should define roles and responsibilities so that all individuals within the organisation have annual targets to meet and are clear about what is expected from them.

Contracting should be 'owned' throughout the organisation and this requires consideration of issues of fear and motivation. The introduction of a more transparent relationship between resources and outputs often results in people feeling threatened by the process. Traditional measures of importance (like the number of beds in the hospital concerned) will lose their status in the drive to improve efficiency. It is important to involve people throughout the process to ensure that they understand and own it. This includes clinical staff who must also be involved in and own the process if performance management is to be realistic. Although there may be a reluctance to use the valuable time of clinical staff in contracting, not to involve them may be a false economy if agreements turn out to be undeliverable. Ultimately, the decisions of clinicians are the main determinants of the provider organisation's level of expenditure. Clinicians must become effective managers of the resources they have at their disposal if provider organisations are to achieve their outputs efficiently.

For the contracting process to be fair, there is a need for a conciliation and arbitration function between the purchaser and provider where agreement cannot be reached or one party claims a breach of the agreement which cannot be reconciled without recourse to a third party. Whoever carries out this function must be seen to be independent and it should only be used as a last resort.

Efforts at decentralising management within the public sector offer opportunities for contracting. New district management units, for example, could be involved in a contracting process with the Ministry of Health. It is true that without more structural reforms involving more autonomy for these district units their control over the use of resources remains limited (particularly over human resources if

these remain controlled by a central public service agency). Nevertheless, the use of contract type documents specifying target outputs in relation to budgets will produce incentives for more management freedoms on the part of those charged with meeting those targets.

A well known example of contracting within the public sector is that of Britain. There providers – hospitals initially – were allowed to become 'trusts' run by boards and with more freedom to manage the services they provided. See Box 6.

Box 6: The Introduction of Contracting in the UK National Health Service

Radical changes were made to the UK National Health Service (NHS) following government proposals in 1989. The essence of these was the creation of an 'internal market' - introducing competition for public finance by separating purchasing from providing functions. Contracts were introduced to link payments to providers with defined workloads. These had no legal status because both purchasers and providers remained in the public sector. There was little central guidance on implementation and during the period of preparation for contracts, there was much bottom-up innovation, with managers devising systems on the ground and sharing them with others through centrally funded initiatives. Also, at that time, financial and activity data were basic. During 1991/2 - the first year of implementation - contracts between purchasers (Health Authorities) and providers (NHS Trusts) did little more than map existing volumes of activities and costs and major changes were forbidden. Purchasers were largely concerned with learning about how to design and use contracts and in setting priorities for making changes in the following years. Many quickly encountered problems as, early in the year, Trusts claimed that they had fulfilled or exceeded the volume of activities required in their contracts and now needed more money to continue providing a service. There were two main reasons why this happened. Firstly, many clinicians believed that if they fulfilled their activity commitments early, more money would be found to allow them to keep on operating. In fact, only a very small injection of new money was made available and a few providers were forced to limit their activity to emergency cases only. The second reason was that contracting had created new incentives to count patient activity and this quickly remedied earlier genuine under-recording. But it was also tempting for Trusts to inflate activity where they could - for example, by counting outpatient minor procedures as day surgery cases.

As purchasers refined their contracting mechanisms however, providers became better able to respond. By the second year of implementation, providers were beginning to organise themselves into operational sub units (clinical directorates) to create clearer responsibilities for cost control and management. By 1993, some purchasers had decided to move contracts from one Trust to another where they were offered a better service. Sometimes this was a hospital-to-community move rather than hospital-to-hospital. By 1996, both Health Authority purchasers and Trust providers had gathered experience in the technicalities of the contracting process. Although no national standard contract exists, most purchasers were operating similar processes breaking down contracts into general terms and conditions together with a number of schedules covering different aspects for service delivery. The majority of contracts were on a block basis, guaranteeing access by the purchaser's population to all services offered by a provider, with levels of expected activity within each specialty made explicit at the outset and with specific arrangements for events outside the contract.

Recent Developments

After some eight years of implementation, contracting within the NHS is still very much developing (see the example in Section 7). The documents are still very 'rough and ready', not very thorough or well presented and sometimes contradictory in places. This has not resulted in serious problems because the 'contracts' operate within a public sector and the UK NHS remains very much a managed system - and managed very centrally in terms of policy, procedures, standards and data requirements etc. Such loose documentation would be more risky if private sector providers were involved – although even there a high degree of collaboration and tolerance could be expected when a provider hopes to win contract renewal i.e. when both parties need each other.

In addition, contracting is going through another transition phase currently resulting from new policies introduced by a change of government bringing a change of emphasis from 'internal market speak' with its emphasis on competition (as introduced by the previous government) to 'collaboration and shared ownership speak' (more comfortable for the current government): 'contract' has become 'service agreement'; 'purchasing' has become 'commissioning'. Current contracts also display a good deal of confusion about the implications of the new Primary Care Groups (PCGs) and who will be responsible for commissioning.

This all serves to highlight that, within the UK public sector, it has been the *process* of contracting that has been important rather than the strength of documentation alone. By separating functions, defining roles and expectations and agreeing to try to implement the intentions as expressed in the contract documents, a lot of clarity has been achieved and endeavours have been focused on implementing policy and improving cost efficiency. It highlights also, that providers are far from autonomous and that the 'reforms' are still very much in transition.

2 POTENTIAL PROBLEMS WITH CONTRACTING

Insufficient Provider Autonomy

In practice, it is no use contracting public sector providers to provide services if they have no real ability to perform. A provider cannot manage its business effectively if 75% of its budget is tied up in the fixed costs of its staff employed by a central public service agency on rigid and protected terms and paid directly by government transfers. Realising the potential advantages of contracting requires providers to have sufficient autonomy to control their resources including the virement (transfer) of finance between budget heads. Nevertheless, the introduction of performance management in the public sector can be a powerful force from within for more autonomy for provider units.

Lack of Provider Competition

In practice, it is frequently not feasible for a purchaser to move a contract to another provider because of the negative impact on patient travel times, particularly for acute and emergency care. In this case, genuine commercial competition is only possible for elective care – but it may make little sense not to buy this from the hospital already providing acute care. If there is little real competition between providers, purchasers have little choice and the managers of providers have little incentive to perform. In the public sector, withdrawing funding from unwanted or badly performing providers remains a difficult option where significant redundancy costs would be incurred.

But creative contracting may still help to drive performance by:

- clarifying the relationship between strategic management and operational delivery, allowing priorities to be identified and targeted and offering greater accountability to government and public
- focusing attention on outputs, outcomes and service quality
- establishing realism between resources available, resource requirements and health services outputs
- establishing a systematic approach to measuring progress and monitoring risk (performance management) thus facilitating systematic improvement in efficiency, effectiveness and equity
- encouraging responsible staff initiative and motivation through clarifying roles and responsibilities.

Moreover, the quality and price of a provider's services can be compared with those of other (non-competitor) providers elsewhere and used to identify weaknesses and argue for better performance. Sub-dividing public or soon-to-become-autonomous providers into smaller but viable units may reduce monopoly situations. Grouping purchasers to cover larger populations may open up more provider competition. Many markets are contestable – new bidders can enter them - and will become more so as governments remove themselves as monopolies and as purchasers become more articulate about what it is they want to buy.

Weak Purchaser Organisations

Where decentralised providers have been created and given considerable autonomy, it is often the case that all the reform effort has been directed at the development of these new organisations and insufficient attention has been directed at restructuring and developing the new purchaser role. See Box 1 in Section 1. Where ministries of health have assumed the role of purchaser (commissioner) of services from newly autonomous providers, there have been failures. The public service culture of staff has prevented them taking on the new purchasing role and made it difficult for them to stop trying to micro-manage the provider's business.

Purchasers will not get the services they want if they are not proactive. There must be advance warning to providers about a purchaser's policies. This requires general intentions and strategic direction to be clear, with opportunities outside formal contract negotiations for full discussion and provider contribution. Specific changes in policy and priorities should be signalled in good time for providers to respond (see section 1.3, Linking plans in the planning and budgeting cycle). This can be done in the form of an annual purchasing statement or plan (see Box 7).

Box 7: Ministry Guidance to Provinces as Purchasers

Making Purchasing Intentions Known in the Context of Annual Service Agreements and Performance Management (extract from Ministry Circular)

In the context of very considerable autonomy being given to Health Districts as the new provider organisations, the Provincial Health Departments (PHDs) will no longer be in a position to issue detailed instructions to districts. However, a PHD will need to hold districts to account for the delivery of health services in such a way as to take forward its policies and strategic planning priorities. Unless a strong purchasing function is developed by the PHDs and effective mechanisms for this are in place, there are dangers that:

- the present "provider" led domination of the system (which the reform programme is attempting to break) will be perpetuated
- provider business plans will be developed in a policy vacuum, making value judgements of them difficult and storing up potential for conflict
- it will not be possible for effective accountability to be maintained - a strong district would be able to play off one part of the PHD against another; whilst a weaker district would be overwhelmed by the potentially conflicting demands being placed upon it.

To reduce these risks, prior to the negotiation of annual service agreements, the PHD should provide an annual statement of its overall priorities, planning intentions and performance expectations. This needs to be:

- early enough in the planning cycle to inform providers' business planning activities
- a participatory process, involving district managers in comments on drafts

and to contain:

- a statement of values and longer term (3-5 year) policy objectives expressed in terms of broad service changes required etc.
- a statement of what the purchaser reasonably expects each district to achieve in the following year focused on a small number (maximum 8 - 10) of key, preferably measurable, objectives
- advance warning of any changes in budget.

The PHDs will need to develop an internal capacity to coordinate this function and to service the regular review of district performance.

Purchasing organisations need the capacity to undertake needs assessment work for the populations for which they have responsibility but the skills needed to collect and interpret this data may be in short supply. Available literature and guidelines should be shared between purchasers and, if tasks can be pooled in consortia of purchasers, duplication of effort can be avoided. Similarly, purchasers need the capacity to manage and monitor contracts. Both parties interests are best served where contracts are kept simple with agreed trigger points for changes in activity and expenditure and a manageable number of critical quality issues.

Transaction Costs

It is easy to see transaction costs escalate particularly where contracts become overly complex and/or large numbers of small purchasers and providers are engaged in contract negotiation. Pitfalls include too many cost-per-case contracts (see Section 3, Schedule 1), bureaucratic procedures for handling cases which fall outside of contracts and excluding large numbers of procedures from contracts. Having longer running contracts, keeping contracts simple, sharing standard forms of documentation and focusing monitoring on what is important are all ways of keeping transaction costs down.

Perverse Incentives

Badly thought out purchasing can create perverse incentives for providers to maximise their income or to minimise their workload by, for example, encouraging longer or inappropriate inpatient stays, discouraging transfer to a (more appropriate) 'competitor' or encouraging transfer to an inappropriate provider - depending on how the provider is being paid. At the very least, badly formulated and run contracting can risk purchasers and providers blaming each other rather than taking joint responsibility for sorting out problems.

3 WHAT CONTRACTS SHOULD CONTAIN

The Basic Content

A contract or services performance specification should cover the following:

Preamble
A statement about the purpose of the contract, what it aims to do and who the parties to it are.

It is important at the outset to stress the behaviour expected of the two parties including recognising that there is to be a risk sharing approach, that innovation will not be deterred and that potential problems will be raised in time for them to be managed. The contract should be identified as part of a process of creating an effective, positive, problem solving culture. If a contract is perceived as a one sided (threatening) document and not part of a whole system of managing the overall service, it can create behaviour that seeks to hide potential problems rather than manage them.

Authorised persons and signatures
Identification of the individual from both the purchaser and the provider who signs the contract and who is responsible for ensuring the terms of the contract are fulfilled.

Contract period
The time period covered by the contract (and, possibly, the assumed arrangements for its renewal subject to satisfactory performance).

Summary content
A summary of any key points that the contract incorporates (e.g. any significant changes required in services) and that attention should be drawn to. This may also usefully identify the key undertakings and commitments of both parties.

Levels of services and access
A summary of the health services that will be delivered (details should be given in a separate attached schedule) and a clear statement on who is to have access to the service.

Quality standards
A summary of the standards required for services (details should be given in a separate attached schedule).

Finance
A summary of the level of financing to be available to the provider (details and other financial considerations should be contained in a separate attached schedule).

Terms of the agreement:

a) Monitoring and Reviews – the principles of joint monitoring and review, when progress reports shall be exchanged and when formal reviews of the contract shall take place.

b) Variations to the agreement - the procedure for making variations, normally in writing and mutually agreed.

c) Best endeavours - both parties to have a duty to resolve matters without arbitration if possible.

d) Arbitration - what happens in the event that a dispute cannot be resolved by the two parties and an arbitrator is required; who this will be and how they will be appointed.

e) Statutory regulations – noting that both parties must be acquainted with and act in accordance with all relevant legislation and national policy (they must anyway but this can be a useful reminder of any particularly relevant legislation or national guidelines).

f) Confidentiality - patient confidentiality is to be assured.

g) Payments - what is to be paid by the purchaser to the provider and when (e.g. one twelfth of the annual contract price could be paid on a set working each month).

Attached schedules - while there is no limit on the number of schedules to be attached to a contract, there are advantages in simplicity and the minimum should include:

- Schedule 1 Services to be Provided and Contract Pricing
- Schedule 2 Quality Standards to be Achieved
- Schedule 3 Finance to be Allocated

Information requirements and reporting formats can be defined within the schedules or as a separate schedule if useful. Other possibilities include: procedures for audit, monitoring and evaluation, and provisions for academic activities (if the provider is involved in education). Contracting within the public sector may also wish to include schedules on: capital investment programmes and procedures; human resource plans including development and training; organisational development procedures and targets. However, purchasers should resist the temptation to use contracting to try to operationally manage providers. Basically, a contract must set out only what has to be done. How it is done should rapidly become the responsibility of the provider.

Key Technical Schedules

Schedule 1: Services to be Provided and Contract Pricing

The nature and quantity of services to be provided in a contract can be specified in varying degrees of detail as can the way in which services are linked to financial compensation. Each of these may have important repercussions for the incentives of providers to provide too little or too much care and for equity in the sense of who gets too little or too much. Examples of this in practice include capitation as opposed to fee-per-item-of-service in primary care and what are commonly called block contracts, cost-and-volume contracts and cost-per-case contracts in hospital care.

Initially, services specifications can be fairly crude using existing utilisation data and based on correcting known inequities and inefficiencies in the current delivery system and getting change moving in the right direction. But as soon as possible, a quantified health services plan should be developed for the population concerned so that the purchasing agency can decide how to allocate its financing between providers over the longer term. The plan should show the incremental stages (annual changes say) of moving from what currently exists towards what is really required and what this will cost at each stage.

Technical modelling is available that uses comparative population data to generate required service levels by types of service - corrected for age and sex structure and for factors for basic epidemiological differences in birth rates, communicable disease rates etc. (An HSRC Toolkit on 'how to purchase/commission health care services' is in preparation and provides information on services planning for contracting. Information will be available on the HSRC web site: www.ihsd.org). Whilst these models do not provide the 'right' answer, they can provide a quantified 'best estimate' target for contracting from which changes can be introduced as experience unfolds. As contracting is introduced, the services specified can start from the existing levels and distribution of services and move incrementally towards the target levels and configuration. Preferably, this modelling should use comparative data from health systems that do not have built in incentives to over consume (i.e. where there is little or no supply driven consumption) provided the system concerned is known to demonstrate acceptable performance and value for money – and that adequate data is available.

Primary Care Services

How services are defined in contracts and how payments for them are to be made will vary greatly depending on the situation concerned. In most countries primary care services have never been defined except in the broadest terms – nor is it necessary to try to do so in order to introduce more of a contractual relationship between provider and payer. Indeed, there may be disadvantages in over-specification in that providers may claim that because a service function has not been specified, they do not have to provide it. It may be better to base contracting on:

- a crude outline of what constitutes primary care (e.g. "those personal health care services appropriately provided by a general practitioner" or "from a health centre" or "non-specialist ambulatory medical care for children and adults of all ages, first aid for minor accidents and emergencies, preventive services including patient education and immunisation, pre and post natal care, management of certain chronic conditions"), plus

- a list of additional functions that may include other specific preventive and public health services, referral procedures to specialist care, prescribing procedures, quality standards, record keeping or data collection, plus

- exclusions (e.g. not including dental care if this is provided for elsewhere), plus

- regular review and evaluation of what is actually being provided and what needs emphasising or pinning down in subsequent contractual arrangements.

There are three broad ways in which providers of primary care can be remunerated by contracted payers: a fixed payment per specified service (fee-for-service); a fixed payment for each patient entitled to use the service concerned (capitation); or a salary. Each of these – and their variations and combinations – will result in different incentives for providers to provide services and have different implications for equity, efficiency and cost containment. The perverse incentives of fee-for-service have led many countries to seek alternatives.

Hospital Care Services

Payment methods for hospital services should seek alternatives to retrospective reimbursement based on fee-for-service with its incentives to over provide. Alternatives include the following:

Block contracts:
These involve purchasers paying providers an agreed sum of money over a defined period to deliver a range of services - sometimes including indicative targets for activity or workload level. At its most basic, a block contract can simply commit a purchaser to pay a fixed amount for unlimited access to services provided by a facility (a local general hospital for example) with payment normally in 12 monthly instalments. With minimum administrative cost, this guarantees the provider an income and the purchaser access to the basic block of services likely to be required.

Block contracts can also include indicative targets for activity or workload - including minimum and maximum estimates and with a description of the casemix required. They can be based on the previous year's pattern of work modified if necessary by changes of circumstances or needs projected for the following year. These contracts will not usually allow for variation in the payment specified if the workload turns out to be different from that contracted for. Its purpose is rather to allow both purchasers and providers to feel their way into contracting and to ensure the generation of data for performance review, negotiation and more

focused contracting in subsequent years. Quality measures and markers and outcome indicators can still be added into these contracts.

Most start-up contracting arrangements are likely to be a form of block contracting. For one thing, there is rarely the data to do much else. And nor is this necessarily a bad thing in that it is likely to ensure continuity of services when much else may be in a state of change and reform. Simple block contracts provide a high degree of certainty for both parties. However, they provide few incentives for efficiency improvements.

Cost-and-volume contracts:
These contract a purchaser to pay an agreed price in return for a provider delivering a specified volume of work. Volume can be broadly specified (e.g. 5,000 outpatient attendances) and/or defined by clinical specialty (e.g. 2,000 gynaecology inpatient cases) or even by number of specific clinical conditions. These workload measures may be specified in terms of minimums and maximums. If there is a variation in the actual volume of work undertaken, the contract will allow for additional payments or deductions. There are obviously inherent risks in cost-and-volume contracting and a high degree of monitoring is required to ensure it is fair to both parties. The provider has the incentive to undertake more activity than specified if this means more money will be paid - and this is neither in the interests of purchasers nor necessarily in the interests of consumers. By increasing throughput rates, providers can free workload capacity for other contracts (and income) but this efficiency gain should not be achieved at the expense of quality. It then becomes useful for purchasers to have access to comparative data with which to assess the services of their providers. Annual performance reviews also become important to understand what is really happening under a contract - and possibly to agree sensible compromises between purchaser and provider. Obviously transaction costs are higher than with block contracting but, within reason, this is no bad thing if it results in generating decent cost and activity data with which to measure efficiency gains.

Cost-per-case contracts:
In this type of contract, the purchaser agrees the price to be paid for the treatment of specific care episodes provided within specific quality standards. Volumes are not specified and the purchaser is effectively billed after the event for each care episode actually provided. Variations are possible and common including for example a block (or cost-and-volume) contract to apply up to a certain maximum number of episodes with cost-per-case billing to apply thereafter and subject to prior notification. Cost-per-case contracting inevitably generates high transaction costs not just in raising individual invoices but in the whole system of extracting accurate costs/prices. They can be useful, however, for small volume services where block (or cost-and-volume) contracting is being used for the bulk of services required by a purchaser. In the UK they have been used, for example, by fund-holding general practitioners to buy treatment for individual cases not covered in other forms of contract.

In practice, established contracting systems may employ a combination of all three of the broad methods outlined above.

Schedule 2: Quality Standards to be Achieved

Contracting should attempt to specify the quality standards expected for each of the services covered and, again, this can be done at various levels of detail. In practice, it is more useful to keep quality standards simple with an emphasis on key priorities. For example, general standards can require the provider to:

- have in place an explicit quality improvement programme including clear statements of purpose, targets and responsibilities in its annual business plan
- heed national legislation and guidance on services and priorities
- demonstrate that an ongoing staff training and development programme is being put in place
- demonstrate that it is involving the consumer in improving quality
- undertake multi disciplinary clinical audit on a regular basis and develop explicit standards (for nursing for example)
- maintain records of problem incidents, major complaints, periods of drug shortages or unavailability, average and maximum patient waiting times etc
- ensure that health promotion activities are integrated in the delivery of services and that healthy workplace targets are set and observed (no smoking for example).

Standards can also be set for specific patient services in terms of, for example:

- inpatient admission procedures and waiting times
- outpatient appointment systems and waiting times
- casualty services procedures and waiting time targets
- minimum level of staff available at all times and for specific services
- procedures for patient discharge and follow-up.

Schedule 3: Finance to be Allocated

Much of what is required here may already be contained or implicit in Schedule 1 – depending on how providers are to be paid under the contracting arrangements. Whether or not this is the case, one of the key objectives of contracting is to exert downward financial pressures on expenditure whilst achieving better value for money and Schedule 3 should provide a summary of expected annual recurrent expenditure by the purchaser (income to the provider) by key service area - so there is no doubt about this. In addition, contracting (performance specifications) within a public sector will need to specify something on capital spending during the contract period if that finance is to come from public finance.

Degree of Specification

How specific should contracts be? Should they specify services and volume in as much detail as possible or should they focus more on significant and priority changes? The detailed approach runs the risk of over-specification - if something is not specifically written into the contract the provider will claim that it need not be provided. It also detracts from the advantages of more management

autonomy for providers if purchasers feel that they must monitor the contract on a highly detailed basis. Conversely, a less detailed contract may mean that if things do go wrong, a purchaser may be open to criticism for not having specified things sufficiently. A good first step is the setting of a realistic baseline of activity and money which is recognised by both parties as representative of what is already happening or of what is desired and achievable. From year to year new developments or service changes can be judged as falling within or outside the baseline, which will be updated each time the contract is negotiated and will provide the starting point for the next year's discussions. It is vital, therefore, that development of good information systems is part of the contract management process.

Who Should Be Involved?

Involvement in developing a contract

In the purchaser organisation, the following should be involved:

- head of the organisation
- heads of the planning, public health, finance, human resources and information departments or their equivalents.

In the provider organisation, the following should be involved:

- the chief executive or equivalent
- heads of service departments (including clinicians)
- key individuals from the planning, finance, human resources and information departments.

Identification of key individuals

Preparing the contract and doing the early negotiating will be a full time job and at least one individual in each of the purchaser and provider organisations should be identified and given responsibility for this. In the purchaser, this individual should be at a senior/director level and would probably be based in the planning department (or whatever this department has become during adoption of the contracting process). He/she will be responsible for liaison with all those involved and with their counterpart in the provider unit(s) and with drafting the contract. He/she will also be responsible for organising the quarterly performance monitoring meetings and ensuring the necessary information is available.

The ‘authorised persons’ named in the contract should be the chief executives or equivalent in both purchaser and provider organisations to emphasise the commitment and responsibility involved.

Orientation of key people

At the outset, it is important to ensure that the key people who will be involved in the development and fulfilment of a contract (or services performance

specification) are fully briefed as to what contracts are, what they involve and what they aim to achieve. This publication might provide a useful starting point.

4 A MODEL CONTRACT (PUBLIC SECTOR)

The Basic Agreement

The following is a draft Performance Management Agreement between a Provincial Health Department (as payer) and a hospital services provider.

Performance Management Agreement for Year 1999 - 2000

Between

. . . . . Provincial Health Department

and

. . . . . Hospital

Date: . . . . . .

Contents

Adapted from model contract prepared by the Institute for Health Sector Development, London

NB. This draft Performance Management Agreement can be downloaded from the HSRC web site < www.ihsd.org > and edited for use in specific situations. The site also provides examples of other contracts from around the world. Acknowledgement would be appreciated.

1.0 Preamble

Whereas the . . . . . Provincial Health Department, (hereinafter referred to as 'the Department'), represented by

. . . . . (name)

. . . . . (title)

the Authorised Representative for the purposes of this Agreement

and the . . . . . Hospital (hereinafter referred to as 'the Hospital') and represented by

. . . . . (name)

. . . . . (title)

the Authorised Representative for the purposes of this Agreement

wish to enter into an agreement (hereinafter referred to as 'the Agreement') to provide health services in terms of Section . . . of the . . . . . (relevant legislation) and since both parties wish to define and formalise their respective roles and responsibilities in the provision of such services, it is hereby agreed as follows:

- That the Hospital will provide services as set out in Schedule 1.
- That the Hospital will meet the quality standards as set out in Schedule 2.
- That resources will be made available to the Hospital as set out in Schedule 3.

This agreement shall come into force on the . . . day of . . . 1999 and shall cease on the . . . day of . . . 2000.

2.0 Summary of Key Points

To contain a summary list of the important points – especially any key changes from what happens now – regarding service types or volume, finance, quality, patient base and accessibility, reporting etc.

3.0 Terms of the Agreement

Reviews

2.1 The Authorised Representatives of this agreement (see Section 1) shall exchange progress reports on a quarterly basis to a format to be prepared by the Department. Quarterly Reports submitted by the Hospital shall provide such information as may be required by the Department to meet its duties to monitor the activities of the Hospital. Notwithstanding these Quarterly Reports, the

Hospital is bound to provide the Department with all legitimate information required for the Department to perform its duties.

The Department and the Hospital shall jointly review progress on the implementation of this PMA in July 1999, and quarterly thereafter, the two Authorised Representatives named on this agreement to be present.

Variations to this agreement

2.2 Variations to this PMA may only be made by agreement between the Authorised Persons (see Section 1) in writing and in numbered sequence. Post agreement variations to revenues due under the agreement must be reflected in the expected caseload figures and/or other activity levels. All variations to the financial allocation above must also be in numbered sequence over the signature of the Authorised Representatives.

Best Endeavours

2.4 In the event of disagreement, both parties have a duty of care to resolve matters without resorting to arbitration arrangements. In particular, the Authorised Representatives must meet to try to resolve the issue(s) and there must be a written record of this meeting, which must be jointly agreed.

Arbitration

2.5 In the event of an un-resolvable dispute relating to any matter in this PMA, the Department shall appoint an Arbitrator (from a list agreed by both parties). Both Authorised Representatives will submit a joint statement of the matter in dispute to the Arbitrator. The Arbitrator's decision shall be binding and is specifically not open to legal challenge.

Statutory Regulations

2.6 Both parties shall be deemed to be acquainted with all relevant legislation and with national policy and guidelines of the Ministry of health and will act in accordance.

Confidentiality

2.7 Neither party may disclose to any third party information acquired during the period of this PMA which concerns the identity, personal details, or the details of any treatment administered (unless the individual gives written consent).

Payments

2.8 The Department will pay the total budget sum due under this Agreement in 12 instalments by the first working day of each month. These instalments will reflect the needs for cash flow in the Hospital for the month as estimated in advance by the Hospital in its Business Plan and agreed with the Department.

3.0 Signatures of Authorised Representatives

Signed

. . . . . Date . . . . . .
(for the Department)

Witness . . . . . .

. . . . . Date . . . . . .
(for the Hospital)

Witness . . . . . .

Schedule 1: Service Provision

This should set out the health services that will be delivered by the provider unit over the period of the agreement. It should state what clinical services will be provided including where possible the estimated volume or level of activities.

It must be realistic and not merely reflect last years activities if the budget is being substantially reduced. It is important to realise that, in most health services, demand increases year on year and this must be taken into account in reconciling finance and activity levels. Trends can be monitored by examining patient activity data retrospectively for three to five years against the final financial out turn for these years.

When reducing projected activity levels it must be recognised that it will not be possible to turn emergency patients away and therefore reductions in services to meet reduced budgets (other than by increased efficiency) will have to come from either providing them from fewer facilities or by doing less elective work.

This schedule in particular is one where the information may be very simple in year one and can mature year by year. It should however set out the following:

Level of facilities
Number of beds by specialty
Number of peripheral units and services – if any
Any outreach or mobile services – if any.

Number of inpatients to be treated by specialty
Where possible this should be broken down into emergency and elective. In the more expensive specialties, it may be possible to set out the number of individual procedures.

Number of outpatients by specialty
New and return.

Number of Accident & Emergency (Casualty) attendees
New and return.

Schedule 2: Quality Standards

Objectives

Through this PMA, the Department seeks to commission services from the Hospital that meet the needs of the population served by the Hospital in a cost effective manner, that takes account of national health priorities and that conform with good practice and the findings of evidence-based clinical research.

Organisational Development for Quality

The Hospital will develop a practical programme for creating quality awareness and commitment in staff at all levels and a culture of continuous improvement. The Hospital will make this programme known to all staff and will demonstrate implementation of the first steps of this programme during the period of this PMA. In particular, by 30 September 1999 the Department will wish to see a clearly stated plan for quality development covering objectives, responsibilities, training and incentives and created with wide participation of Hospital staff and including:

- quality improvement targets for major care activities, specialties and departments including standards for outpatient and inpatient waiting times for appointments and admissions
- the introduction of quality development measures in job descriptions
- management structures for quality improvement including specific responsibilities, reporting and monitoring arrangements
- plans for the development of multi disciplinary clinical audit including arrangements for implementation, monitoring and acting upon the outcome of audit activity
- plans for ascertaining changes in consumer satisfaction, for seeking the views of consumers, for providing consumers with information and for dealing with consumer complaints and appreciation's
- arrangements for the reporting and audit of untoward incidents and accidents.

Good Practice

The Hospital will ensure that its services are based on good practice taking account of international standards and protocols, the recommendations of professional advisory bodies and guidance that may be issued by the Department from time to time.

Service Quality Targets

The Hospital will aim to ensure that the following targets are incorporated into quality planning and are being met by the end of the period of this PMA.

Accident & Emergency Services

1. at least 90% of patients are to be clinically assessed within 10 minutes of arrival time and no patient is to wait more than 3 hours.

2. After initial assessment, treatment is to commence within 30 minutes (for urgent cases) and within 120 minutes (for others).

3. at least 50% of staff working in A&E Departments will have received training in A&E clinical care by year end.

Outpatient Appointments

1. Appointment systems will be planned and put into operation during the period of this PMA.

2. Patients are to be offered appointments within a maximum time period from first referral. This time period will be agreed between the Department and the Hospital after a trial period and recording current time periods by department.

3. Cancellations of appointments will be recorded by consultant and specialty, explanation will be given to the patient and a new appointment offered at the same time.

Outpatient Clinic Waiting Times

1. at least 90% of attending patients are to be seen within 30 minutes of their appointment time; patients are to be provided with an explanation if their wait exceeds 30 minutes; and no patient is to wait for more than 60 minutes.

Pharmacy Waiting Times

1. Patient waiting times are to be reduced; targets will be set for 1999 following the collection of baseline data during 1998 by the Hospital and joint analysis with the Department of causes contributing to delays.

Elective Inpatient Admissions

1. Patients are to be offered admission dates within a maximum time period from first outpatient consultation. This time period will be agreed between the Hospital and the Department after a trial period and recording current time periods by department. An improvement of 20% over baseline waiting times will be sought by year end with priorities set following needs analysis by major specialty.

2. Where admissions are cancelled, patients are to be offered alternative dates within 7 days of cancellation for admission within 30 days.

3. Neither children nor adults are to be admitted where home, day or social care is more appropriate.

Consumer Relations

1. 20% of staff are to have participated in basic training/sensitisation by year end.

2. Total quality management (TQM) and consumer satisfaction components are to be included in all training programmes delivered or purchased by or for the Hospital during the year.

Information Generation

1. The Hospital will develop information systems adequate to provide data for monitoring all quality targets and will provide the Department with this information as part of the quarterly reports (end March, June, September, December) required.

Schedule 3: Finance

Financial Framework and Responsibilities

The financial year will be from April 1st to March 31 of the following year.

The Hospital will submit annually, before the end of September of each year, a proposed budget for approval by the Department.

The budget will be reviewed by the Department taking into account Schedule 1 this Agreement.

Both parties must agree to the budget and to Schedule 1 for the particular financial year.

The Hospital must thereafter provide the Department with quarterly financial statements – and more frequent statements as required by the Department if particular problems arise.

Annual financial statements must be submitted by the Hospital to the Department within 45 days after the end of the financial year.

The budget submitted by the Hospital must include a three-year financial forecast.

More than one budget may be submitted in respect of one financial year.

Once both parties have signed the Agreement, both the budget and Schedule 1 become binding on both parties unless variations are agreed as per Section 2.2 of the main body of this Agreement.

The Department will pay the total budget sum due under this Agreement in 12 instalments by the first working day of each month. These instalments will reflect the needs for cash flow in the Hospital for the month as estimated in advance by the Hospital in its Business Plan and agreed with the Department.

The Hospital may undertake capital projects subject to the written approval of the Department.

Financial Allocation

This must clearly state the level of resources to be made available to the provider. These will include the broad total budget but will also detail those sums that are tied to resource inputs of the provider (e.g. public sector staff salaries) as well as those sums which come as cash to be spent by the provider. This schedule will have to evolve as financial powers are decentralised and initially it may comprise line budgets against which the providers expenditure is drawn by the Department. However as decentralisation takes place this should be replaced by broad totals such as the following:

Personal emoluments for Public Service Staff . . . . . .
Other personal emoluments . . . . . .
Non staff costs delegated to Hospital . . . . . .
Drugs and supplies in kind . . . . . .
Non staff costs retained by Department . . . . . .
Special grants recurrent . . . . . .
Special grants non recurrent . . . . . .
Capital investment funds . . . . . .

5 AGREEMENTS IN THE UK NATIONAL HEALTH SERVICE, 1999/2000

Where has contracting reached in the public sector in the UK after eight years? A recent example of a service agreement between a health authority and a large hospital is summarised below.

Contents

Introduction

States: the new context for this year's Services Agreement introduced by government legislation and guidance on the way services are to be delivered – specifically the introduction of Primary Care Groups (PCGs), formal groups of General Practitioners, with whom the Health Authority must collaborate in planning service agreements with hospitals.

States: the general principles underlying the preparation of this Services Agreement and its implementation including equity, a collaborative/partnership approach to achieving objectives and resolving issues, responding to national guidance on priorities, etc.

General Commissioning Principles

States: the objective of reducing bureaucracy and of simplifying Service agreements.

States: the Service Agreement is to be within a fixed cash envelope (no variable elements, no contract exclusions, no additional payments for over-performance) but must still meet service and quality targets (national and regional targets on patient flows, waiting lists for elective procedures).

States: implications of changes in Government policy and guidelines on such things as transfers of deficits, the funding of clinical negligence and personal injury claims; various principles and targets specific to the location of the provider including procedures for tertiary referrals, cross boundary patient flows and out-of-area treatments.

States: lots of good intentions of collaboration, need for new PCGs to work closely with the HA and the need for clarification and to work out how the new arrangements will function.

States: the need to work towards longer term service agreements (following national policy directives) in the interests of predictability of funding and allowing sustained focus on health objectives in specific disease priorities, services quality and efficiency.

The Agreement

States: the provider (Hospital trust) will be responsible for providing the agreed level of services within the cash envelope as specified in Schedule A and to the standards set out in Schedule B (Schedule A shows the services the Health Authority is commissioning from all of its major providers; Schedule B applies also to all the commissioners providers save those for which another commissioning body is the major purchaser of services in which case the HA accepts the quality standards agreed between those two parties).

The Agreement Period

States: the agreement will start on 1st April 1999 for one year and may be rolled forward for the following year subject to satisfactory provider performance; service specifications and funding shall be reviewed annually.

Monitoring Information

States: the provider will ensure the accurate maintenance and availability of information, records and documentation for effective monitoring of the agreement (see Summary of Monitoring Information Requirements below); and notes the need for the commissioner to develop with the Hospital Trusts the disaggregation of information for the new PCG arrangements.

Reviews

States: the commissioner and the Trust will jointly review the performance of this Agreement as follows – services activity bi-annually, funding annually (except for variations), and quality every three months and with *ad hoc* reviews; plus open access by the commissioner with reasonable notice.

Payment Mechanism

States: one twelfth of the annual value of the Agreement will be paid on the 15th of each month or on the nearest working day; specific arrangements for the payment of 'extra contractual referrals' resulting from the past year and for those likely to result from the current year.

Collaboration and Financial Risk

States: that financial risks will be borne by the party best able to forecast, manage, plan and control those risks; that because the financial envelope is fixed, any ' tolerances' will be taken up in activity levels and that where this is the case, this will act as a trigger for discussions between the parties; that nevertheless, the agreement recognises that there may be financial risks for the commissioner and the Trust resulting from circumstances beyond their control and that in such event both parties must discuss implications and agree joint action.

States: that either party may request a variation in the manner in which services are provided or charged for and that all such changes must be agreed prior to implementation and recorded in a 'variation order' (raised by the commissioners nominated officer) and signed by the nominated officers of both parties.

Demand Management

States: that this will be important for the emergent PCGs to consider in partnership with the Health authority and the local Trusts and that pilot schemes are planned to assist understanding of how to do this.

Benchmarking Prices

States: providers are required to produce costings of their services (in conformity with national guidelines on this) to be used for national benchmarking and value-for-money reviews (to be used to target efficiency savings).

Non-Elective Services

States: the procedures for emergency admissions including directives for referrals where the trust is unable to admit a patient (first to another appropriate hospital within the commissioners local area) and for reporting to the commissioner on such events; that in times of high demand, the provider may be required to restrict planned elective admissions.

Prescribing Principles (Drugs and Supplies)

States: that providers should recognise an ethical and professional responsibility to prescribe rationally and notes the relevant national and local guidance on this; that the provider should have its own Formulary or approved list and that additions to this should be on the basis of published evidence and consideration of (named) national guidance.

Continuing Care Policy

States: the provider will supply the commissioner with regular information for monitoring continuing care policy implementation (including hospital discharge data).

Summary of Monitoring Information Requirements

States: the details of the information required by the commissioner and the format, coding, data quality targets and methods and frequency of submission (maximum days after month or quarter end) most of these in conformity with detailed national guidelines and systems for such data and covering numerous measures of activity and waiting lists for elective procedures (with some priority services like breast cancer disaggregated)

Signatures of Nominated Officers

For Commissioner and Trust.

Schedule A: Summary of Services Required and Payments

This contains a one-page summary of the cash envelope for the year covering estimated levels of activity plus inflation allowances plus any special non-recurring payments resulting from national policy and funding such as HIV/AIDS, new drugs allowances, special programmes etc. This is followed by details of the activity workload, unit prices for procedures and total funding based on simple broad categories of activity (see format in table below).

Schedule A: Summary of Services Required and

	Activit					Prices					Finance					
Surgery	Non-Elective	Elective FCEs	Day Case FCEs	OP Referrals	Other	Non-Elective	Elective FCEs	Day Case FCEs	OP Referrals	Other	Non-Elective	Elective FCEs	Day Case FCEs	OP Referrals	Other	Total Finance
General	1,332	832	1,341	3,227	-	1,532	1,532	522	144	-	2,040,624	1,274,624	700,002	464,688	-	4,479,938
Urology	312	335	773	1,175	-	2,261	2,261	543	247	-	705,432	757,435	419,739	290,225	-	2,172,831
T&O Surgery	845	263	338	4,100	-	2,929	2,929	843	129	-	2,475,005	770,327	284,934	528,900	-	4,059,166
Ophthalmolog	7	100	801	2,848	-	847	847	633	158	-	5,929	84,700	507,033	449,984	-	1,047,646
Total Surgery	*2,496*	*1,530*	*3,253*	*11,350*	*-*	-	-	-	-	-	*5,226,990*	*2,887,086*	*1,911,708*	*1,733,797*	*-*	*11,759,581*
Medicine																
General	3,600	241	1,240	4,129	-	1,210	1,210	238	226	-	4,356,000	291,610	295,120	933,154	-	5,875,884
Clinical	522	33	638	572	-	2,050	2,050	330	803	-	1,070,100	67,650	210,540	459,316	-	1,807,606
Cardiolog	324	33	383	1,174	-	3,334	3,334	1,027	257	-	1,080,216	110,022	393,341	301,718	-	1,885,297
Dermatolog	10	2	113	1,723	-	1,634	1,634	215	129	-	16,340	3,268	24,295	222,267	-	266,170
Oncolog	450	524	2,101	212	-	2,691	2,691	524	2,771	-	1,210,950	1,410,084	1,100,924	587,452	-	4,309,410
Rheumatolog	21	10	140	1,332	-	2,661	2,661	295	410		55,881	26,610	41,300	546,120	-	669,911
Radiotherapy Follow	-	-	-	-	8,199	-	-	-	-	52	-	-	-	-	426,348	426,348
Total Medicine	*4,927*	*843*	*4,615*	*9,142*	*8,199*	-	-	-	-	-	*7,789,487*	*1,909,244*	*2,065,520*	*3,050,027*	*426,348*	*15,240,626*
Childrens																
Paediatric	1,763	19	567	1,654	-	677	677	407	211	-	1,193,551	12,863	230,769	348,994	-	1,786,177
NIC - Special care	247	-	-	-	-	5,329	-	-	-	-	1,316,263	-	-	-	-	1,316,263
NIC - Maximal Intensive	-	-	-	-	599	-	-	-	-	975	-	-	-	-	584,025	584,025
PDAU	-	-	-	-	1,953	-	-	-	-	50	-	-	-	-	97,650	97,650
Paediatric Ambulatory	-	-	-	-	376	-	-	-	-	60	-	-	-	-	22,560	22,560
Total Childrens	*2,010*	*19*	*567*	*1,654*	*2,928*	-	-	-	-	-	*2,509,814*	*12,863*	*230,769*	*348,994*	*704,235*	*3,806,675*
Womens																
Community	-	-	-	-	113	-	-	-	-	1,655	-	-	-	-	187,015	187,015
Post Natal Care	-	-	-	-	971	-	-	-	-	253	-	-	-	-	245,663	245,663
Obstetrics	-	-	-	-	2,358	-	-	-	-	1,646	-	-	-	-	3,881,268	3,881,268
EPAU	-	-	-	-	996	-	-	-	-	77	-	-	-	-	76,692	76,692
Gynaecolog	882	158	557	2,312	-	1,315	1,315	590	117	-	1,159,830	207,770	328,630	270,504	-	1,966,734
Gynaecology	-	-	881	332	-	-	-	273	58	-	-	-	240,513	19,256	-	259,769
Total Womens	*882*	*158*	*1,438*	*2,644*	*4,438*	-	-	-	-	-	*1,159,830*	*207,770*	*569,143*	*289,760*	*4,390,638*	*6,617,141*
Direct Access																
Imaging A	-	-	-	-	12,521	-	-	-	-	15	-	-	-	-	187,815	187,815
Imaging B	-	-	-	-	7,227	-	-	-	-	37	-	-	-	-	267,399	267,399
Imaging C	-	-	-	-	666	-	-	-	-	88	-	-	-	-	58,608	58,608
Imaging D	-	-	-	-	8	-	-	-	-	176	-	-	-	-	1,408	1,408
Cytolog	-	-	-	-	9,752	-	-	-	-	5	-	-	-	-	48,760	48,760
Chemical	-	-	-	-	251,805	-	-	-	-	2	-	-	-	-	503,610	503,610
Haematology	-	-	-	-	49,583	-	-	-	-	5	-	-	-	-	247,915	247,915
Histolog	-	-	-	-	290	-	-	-	-	23	-	-	-	-	6,670	6,670
Microbiolog	-	-	-	-	22,786	-	-	-	-	5	-	-	-	-	113,930	113,930
Physiotherapy	-	-	-	-	2,665	-	-	-	-	94	-	-	-	-	250,510	250,510
Total Direct Access					*357,303*	-	-	-	-	-	-	-	-	-	*1,686,625*	*1,686,625*
Other																
Accident &	377	-	-	-	78,420	294	-	-	-	51	110,838	-	-	-	3,999,420	4,110,258
ITU - Intensive	-	-	-	-	1,440	-	-	-	-	1,227	-	-	-	-	1,766,880	1,766,880
Pain Relief	2	7	150	1,584	-	1,256	1,256	807	75	-	2,512	8,792	121,050	118,800	-	251,154
Breast Screening	-	-	-	-	10,619	-	-	-	-	40	-	-	-	-	424,760	424,760
Total Other	*379*	*7*	*150*	*1,584*	*90,479*	-	-	-	-	-	*113,350*	*8,792*	*121,050*	*118,800*	*6,191,060*	*6,553,052*
Totals	10,694	2,557	10,023	26,374	463,347	-	-	-	-	-	16,799,471	5,025,755	4,898,190	5,541,378	13,398,906	45,663,700

Footnote: FCEs are finished consultant episodes.

Schedule B: Quality Standards

This is a detailed schedule structured as follows.

Introduction

This refers to relevant national guidance and responsibilities for ensuring monitoring and follow-up actions through, for example, the formation of a clinical governance committee and the development of written local standards and disease specific user guidelines.

The national context is noted and includes: statutory duties on clinical governance, reference to the National Institute of Clinical Excellence, a national performance framework (focus on health improvement, fair access, health outcomes etc), survey of users and carers, clinical indicators etc.

The local context is noted and includes principles in developing leadership for ensuring quality, up-to-date procedures on best practice, performance review etc. Dates for specified local consultation are fixed and responsible individuals are named.

Patient's Charter Monitoring Requirements

This sets a number of targets for access and waiting times including, for example, absolute maximum waiting times for general elective inpatient admissions, for specialist outpatient referrals (with specific details for suspected breast cancer), waiting times at outpatient clinics and in Accident & Emergency etc.

Monitoring Requirements

This provides details of required monitoring and reporting in terms of timing and formats and emphasises specific requirements resulting from recent national initiatives (e.g. in mental health).

Prescribing Principles

Requires the provider to have active membership of the Joint Prescribing Committee, to ensure coordination with a patient's General Practitioner and sets out standards for supplies for discharged patients etc.

Complaints

Requires the provider to maintain complaints procedures in line with national guidelines and to report quarterly information to the commissioner to a given format including details of actions taken.

Footnote on Section 5

See comments under Recent Developments in Box 6 'The Introduction of Contracting in the UK National Health Service' in Section 1.4. UK contracts are currently becoming less coherent in planning and management terms as they strive to demonstrate an adequate response to different policy directives. It is simply not clear what some of the points mean; why they are there is what they will achieve in practice. It highlights that the UK system is still very much a centrally managed one and very much politically driven – for better or worse.

6 CONTRACTING SERVICES FROM THE PRIVATE SECTOR

In many countries where private providers are predominant (in the USA for example), some of the contracting and payment methods employed may be very inappropriate for lower and middle income countries. Payment methods that rely on retrospective reimbursement per item of service and/or that require detailed and complex definitions (Diagnosis Related Groups for example) are bound to introduce high administrative and transaction costs into the system. Countries embarking upon using contracting should try to avoid these costs by exploring the potential of simpler block contracting methods as outlined in Section 4 and illustrated in the contract examples above.

Nevertheless, a private provider may be unwilling to enter into such simple contracting arrangements and it may be necessary for a purchaser organisation to accept the financial uncertainty associated with a form of itemised payment. This currently occurs for many smaller nations that must purchase a lot of specialist care from private providers overseas (this is the case for many Caribbean countries, for example, that must purchase such services from southern states of the USA). Some of this uncertainty can be reduced (as can administrative costs) if such contracts are based on a simple and pre-agreed cost-per-case for broadly defined, commonly required procedures. Purchasers should try to negotiate all-in rates for such procedures including:

- all professional, technical, skilled and semi-skilled care and any other care and tests that the patient shall normally require to be satisfactorily treated for the condition giving rise to the procedure
- all hospitalisation, including recovery and rehabilitation, drugs, special diets and any other products or services that would normally be provided for the procedure concerned
- all transportation and administrative costs
- no extra per diem charges for a patient whose length of stay exceeds the Standard Length of Stay for the specific procedure concerned (except there will need to be a cut off point and arrangements for catastrophic situations)
- a percentage reduction based on the volume of services purchased.

An extract from the Schedule of Prices of a current contract along these lines is shown below. Such a schedule cannot form a comprehensive list of all services that may be required and there will have to be arrangements for pricing others (e.g. 65% of the provider's standard charge for a procedure).

Contract for the Provision of Hospital Services

Inpatient Procedures

Item No.	Procedure	ICD-9 Code	Standard LOS in Days	Rate US$
2.01	Lithotripsy	51.41 or 51.49 or 7.0 or 51.88 or 51.04 or 56.00	O/P	3,098
2.02	Mastectomy	85.41 to 85.48	2	7,770
2.03	Arthrodesis - Major Joint	81.11 to 81.29	2	10,710
2.04	Scoliosis Surgery			65% of Charge
2.05	Ligament Repair of Knee	81.42 or 81.43 or 81.45 or 81.46	4	12,390
2.06	Total Knee Arthroplasty	81.54	5	16,590
2.07	Operative Arthroscopy - Knee	80.26	2	7,140
2.08	Diagnostic Arthroscopy - Shoulder	80.21	O/P	4,830

etc

7 GLOSSARY OF COMMON TERMS

The following are some terms sometimes encountered in health services contracting.

Accrual Accounting
Sometimes called 'commercial accounting', this is the method of accounting used in industry and commerce. It attempts to measure the true costs of resources consumed in producing the output of an organisation over a year or other time period. This is in contrast to 'cash accounting' (used in most public services) which simply measures the receipt and use of cash, regardless of the level of workload.

Activity Based Costing
This identifies the activities of a cost centre, costs those activities by looking at the resources deployed and links the activities to services by using cost drivers (that is the volume measure of service activity that requires the work in the first place like number of tests, number of ENT admissions etc).

Adverse events
Untoward events involving patient treatments (and that may be used as part of quality measures in contracting). They may be unanticipated poor patient outcomes, such as death or readmission to the hospital or events involving poor administration (of drugs for example).

Asset accounting
Assets are things that have value. 'Current assets' such as drugs and supplies get consumed rapidly and are usually included in an organisation's cash accounts and expenditure accounts. 'Fixed assets' are long-life resources which do not get 'consumed' at one point in time but wear out and reduce in value more gradually like buildings and equipment. Typically in the public service, fixed assets are financed out of 'capital' funding allocations and, unlike in the private sector, the costs of their gradual consumption do not have to be met from operating budgets funded from 'revenue' allocations (or earnings). Unless a form of capital charging is introduced and incorporated in their contracts, health service providers within the public sector do not have to pay for the depreciation of their fixed assets.

Autonomous provider
A provider organisation having a high degree of autonomy or independence in the running of its business including the application of its income (budget) and the hiring and firing of staff.

Block contract
A block contract, in its simplest form, is one where the purchaser pays a fixed amount for unlimited access to a provider facility, payment occurring in twelve monthly instalments. An indicative block contract has indicative targets for activity or workload. Such indications may include a minimum and/or maximum expected number of treatments and may specify the case mix expected. A multi-specialty block contract is a single contract covering several specialties.

Budgets/Budgeting
Budgets are plans formulated as monetary authorisations of cost or expenditure. These plans should also include agreed targets of workload, or output. Budgeting is the process of preparing budgets in which, hopefully involving key participants, target workloads are related to the costs of inputs.

Business Plan
A document setting out the purpose or values of an organisation together with the short and long-term strategic direction in relation to its customers and competitors in the market place, its operating costs and its projected income and sources of income. It is an important internal document as a measure of progress towards targets.

Capacity Planning
See *Service Capacity*

Capital Cost
The cost of investment in an item (greater than a specified sum and that would be included in recurrent cost) that will be deployed over a number of years such as buildings and equipment.

Care Profile or Protocol or Pathway
The treatment that is expected (agreed in a contract for example) for a specific diagnosis or casemix type - the number and type of radiological or pathology tests, the nursing skills and time requirements, length of stay, drugs prescribed etc. The actual care provided to an individual patient can be compared with the contracted profile or protocol audit and performance review purposes.

Casemix
A measure of the mix of cases handled by a health care provider that reflects the patients' different needs for resources. It is usually established from recent data on the numbers of different types of patients (in the year prior to the current contract for example) and may be measured in terms of simple diagnostic group, severity of cases, services utilised etc.

Cash Accounting
To maintain government financial control over public funds, health services have invariably been subject to 'cash funding' - both revenue (and current) and capital. The health service is allocated a specified amount of cash to spend in the financial year. To monitor compliance, each health services unit is given a 'cash budget' and a 'cash accounting' system is used to record cash expenditure against cash income. This is in contrast to accruals accounting (see above) or commercial accounting used in the private sector and that should be adopted by newly autonomous organisations.

Cash Limit
A limit set on the amount of cash which the health service or a public body may spend in the financial year. Separate cash limits are set for revenue and capital.

Clinical Directorates
A management in which staff (nurses, doctors, professions allied to medicine) working within a particular specialty or specialties or service area (e.g. pathology) are responsible to a Clinical Director.

Commercial Accounting
See *Accrual Accounting*.

Contingency Funds
A contingency fund represents a proportion of a purchaser's budget that is not allocated through the contracts established at the beginning of the year. These funds are retained to deal with any unexpected demands for additional expenditure.

Contract Minimum Data Set (CMDS)
A set of data which supports contracting and has a consistent definition throughout the health service of a country.

Cost-and-Volume Contracts
Contracts where the purchaser and provider agree that funds are to be provided for the delivery of a specified volume of service.

Cost Driver
The measure of the volume of services provided, gives rise to costs incurred. For example, the number of clerks in pathology reception (and their costs) is related to the number of pathology tests. It is used in the estimation of overheads and the apportionment of overhead costs.

Cost Improvement Programmes
These are efficiency savings that may be targeted by government as a whole or by purchaser organisations such that a provider(s) should consciously budget each year for cost savings (of, say ½% to 1% of revenue). The sources of intended savings have to be agreed and specified in advance and the achievement of savings has to be monitored and may be subject to performance review. The savings are intended to be spent on approved new developments and priority areas and should be made through increased efficiency without cuts in volume or essential standards of care.

Cost-per-Case Contract
A contract in which generally the purchaser expects to be invoiced after a patient has actually received treatment. Exceptions will occur in high cost treatments (ITU for example) and long stay care (mental illness for example) where invoicing on a per day basis may be used. Contract prices are agreed before the contracting period commences.

Cost
The actual expenses incurred in providing a service including direct and indirect costs. Costs may not be the same as charges or prices where providers are allowed to cross subsidise one service by another and where they are allowed to maintain an operating margin.

Diagnoses-related groups (DRGs)
Groupings of diagnostic categories used for costing and charging care. Classifications may include factors such as patient age, requirement for a surgical procedure, the presence of complications, etc. DRGs could be used as the basis of contracting but the requirement for detailed cost data is immense and likely to be beyond most countries for many years.

Direct Cost
Direct expenditure that can be directly attributed to a particular activity or cost centre of a provider organisation. For example, supplies consumed directly by a specific hospital ward will be a direct cost of the ward.

Fee-for-service
A provider payment mechanism where the provider charges separately for each patient seen and service provided - in contract, for example to salary, block contract or capitation-based payment systems.

Fixed Costs
Costs that do not vary with the level of activities undertaken - for example building rent.

Health Investment Plans (HIPs)
Statements that describe a purchaser's intentions in terms of the level of investment in healthcare and the specific services to be purchased over a number of years. Also known as Purchasing Intentions Documents.

Hospital Information Support System (HISS)
This is an information system covering all operational and information needs for an acute general hospital.

Indirect Cost
Expenditure that cannot be directly attributed to a particular cost centre - because for example it is shared over a number of cost centres in ways that are not easily recorded. For costing purposes, practical ways need to be found to estimate the apportionment of indirect costs to the departments/cost centres concerned. For example, linen costs could be allocated to a ward on the basis of the number of occupied bed-days provided by that ward as a proportion of the total provided by the institution.

Medical Audit
The systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient.

Mission Statement
A broad statement of intent concerning the main purpose or objectives of an organisation.

Overhead costs
Costs of services that contribute to the general running of an organisation but cannot be directly related to the volume or quantity of activity or service provided in individual departments or wards - the costs of management for example.

Programme Budgeting
Analysing expenditure by reference to targets (for example, increased level of day care)

Priority Setting
Usually used in the context of purchasing - determination, in order of priority, the areas for service developments or resource allocation. Prioritisation might be based on improving choice, equity or health gain for example.

Purchasing Intentions
Purchasing Intentions documents set out a purchaser's service requirements in advance - particularly in areas where change is required or desirable - to allow providers to begin to organise to provide those services.

Semi-variable Costs
Costs that are fixed for a given range of activity but may increase or fall as activity rises to, or drops below, specific levels of activity, i.e. they are partly affected by changes in activity. Also known as 'semi-fixed costs' or 'step costs'.

Service Capacity
The throughput that can be achieved by a provider over a given period of time.

Service Level Agreement
An internal agreement used within a provider organisation to define the level and

standard of service that is to be provided by a department for another department/service area, or by a department for the provider as a whole.

Service Specifications
A definition of the service to be provided under a services contract and that can be used to monitor performance.

Total Absorption Costing
A costing process that takes the total costs of running an organisation and absorbing the entire cost into the individual cost units (treatments) so that every cost is ultimately attributed to one or a number of these cost units.

Top-Slice
A financial term used to describe the practice where an allocating authority keeps back money normally given to sub-authorities in sub-allocations. Top-slicing is used to provide finance for schemes where the allocating authority considers that it is the appropriate managing authority.

Trigger-Point
An indicator within a contract (number of specific operations performed for example) that once reached may instigate a set of pre-defined actions. These actions need to be clearly defined and are usually contained within the variation clauses of the contract. The usual start point is the opening of discussions with the other party's key manager.

Utilisation review
Evaluation of the need for, appropriateness and efficiency of the use of services delivered by a provider including possibly admissions, specific diagnostic and treatment provided and length of stay.

Variable Costs
Costs that vary with the level of activity undertaken.

Virement
This is a transfer of resources from one budget heading to another. It is a means of using a planned and agreed saving in one area to finance expenditure in another area.