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| Finding the Best Value  Review of International Experiences on the Procurement of Social Services: Lessons for the Ministry of Finance, Russian Federation. |
| |  |  |  | | --- | --- | --- | | David M. Van Slyke, Ph.D. | 5/26/17 | Syracuse University, USA | |

**Introduction**[[1]](#footnote-1)

In this review of international experiences, a range of topics are presented as a baseline of evidence that can be used by the Ministry of Finance of the Russian Federation, hereafter referred to as the MOF. This document is intended to serve as a resource to inform their decisions about legal and regulatory frameworks with respect to the procurement of social services from a range of governmental, nongovernmental, and private organizations. There are a number of best practices discussed throughout this paper that include: a) Best Value Contracting; b) Performance Based and Results Focused Contracting; c) Incentive Based Contracting; d) Payment Based Contracting; e) Relational Contracting; f) Strategic Sourcing; g) Life Cycle Contracting; h) Competitive versus Sole Source; i) Commercial versus Proprietary Development; j) Risk Management; and k) Third Party Monitoring and Evaluation. In considering how results based contracting with strong accountability and compensation tied to performance outcomes varies in its effectiveness relative to the use of different payment practices depending on the complexity of the product/service being procured, analytical guidance is offered for how to think about the decisions that need to be made, what the tradeoffs are, and how to evaluate a range of options for achieving government’s multiple goals. While contracting results are often stronger for governmental units that have made strong investments in public management capacity and oversight, a number of developing and middle-income countries will use public procurement practices to produce and deliver goods and services where their own governmental capacity is undeveloped. Drawing on a range of international cases, the practices highlighted reflect the range of experiences and opportunities associated with contracting.

Governments seek to contract for products and services for a host of reasons. Chiefly among these are the expertise, innovation, resources, and capacity that service providers are viewed as bringing to a procurement arrangement with a public agency. There are other motivations that stimulate government leaders to pursue contracting opportunities. These include the contractor being viewed as more effective and efficient in the production and provision of services because they have specialized missions, personnel with types of knowledge and experiences, and especially with nonprofits that the service provider may be viewed as bringing additional resources to the provision of services through their ability to access charitable/philanthropic funding and the engagement of volunteers. These additional resources are perceived as supplementing contract funds from government, offering an additional safety net. Finally, governments may elect to use procurements and contract with service providers because they do not want the ongoing responsibility of producing and delivering services. This decision also allows political leaders to edit current regulations in order to allow for more creative and effective service delivery for contracts around a specific government bureaucracy and their permanent civil service employees. Some development banks and scholars have argued that contracting can also reduce corruption and stimulate the growth of civil society by promoting competition and limiting political interference.

A range of country experiences are considered, though a comprehensive assessment of each of these criteria relative to the respective country systems and procedures is beyond the scope of this initial memo. Rather, international experiences from developing and developed countries are used as examples for illustrative purposes. These country examples include: Afghanistan, Bangladesh, Bolivia, Cambodia, Canada, Costa Rica, Croatia, Czech Republic, El Salvador, France, Germany, Guatemala, Haiti, India, Indonesia, Kenya, Madagascar, Myanmar, New Zealand, Nicaragua, Pakistan, Philippines, Romania, Rwanda, Senegal, Slovakia, South Africa, Sweden, United Kingdom, United States (Maryland, New York City, Wyoming), and Vietnam. The information and data presented in this memo are derived from primary and secondary documentation, published academic work, and governmental and nongovernmental reports. A complete bibliography is available after the conclusion of this memo.

This memo is organized in terms of the “Make or Buy” decision, design of solicitation mechanisms and contract award processes, and implementation and execution with respect to contract management and oversight. To ensure consistency with best practices, we will draw on a range of international cases and smart practices to offer professional guidance in this executive memo.

**Make or Buy Decisions:**

The very first issue for framework consideration is the degree to which detailed guidance is provided on the types of social services to be made available using procurement and contracting services. Inherent in the decision to provide services directly through a government bureaucracy or contract them out using a public procurement competition is frequently referred to as the ‘Make or Buy’ decision. Governments often make or produce and deliver services using their own production facilities and personnel when the product or service to be provided has an inherently governmental[[2]](#footnote-2) aspect which precludes private participation. An inherently governmental service may be embedded in law, have classified elements or requires substantial expertise not widely available in the marketplace. Government officials express concerns when contractors perform inherently governmental functions that only public managers should have responsibility for such as policy development, formulation of regulations, exercise of monitoring and oversight, and the awarding of contracts. A government may also choose not to contract when it wants to retain a level of capacity to reduce the likelihood that it will become locked into a specific provider and therefore dependent on a single entity for the provision of a good or service.

Governments buy products and services frequently. The U.S. federal government buys more than $500 billion of different goods and services ranging from computers to data processing services. In OECD countries, procurement accounts for 12% of GDP and 29% of government expenditures.[[3]](#footnote-3) A ministry or unit of government may elect to buy when there is substantial competition in the marketplace thus providing options on cost, quality, and schedule, and when the product/service requirements can be easily specified in terms of quality, quantity, cost, schedule, and other characteristics that allow public officials to hold contractors accountable. Governments also buy goods and services when there is greater innovation and technological advantages from private firms relative to public provision. Ministries and public officials also elect to buy when they want to reduce the likelihood of hiring permanent civil service employees or when the need is temporary. In each of these ways, contracting offers ministries and public officials and managers greater flexibility.

To address the question of which services can be contracted out, framework guidance can be helpful in identifying whether the services themselves are easy to measure, easy to observe, and require low infrastructure, technology, and personnel cost investments. If a service meets these conditions, such as the provision of fruits, vegetables, and other nutritional elements in a health program, then the services lend themselves to being contracted out using a straight forward procurement process.

If on the other hand, the services that need to be provided are more difficult to observe and measure and require greater investments in the personnel and delivery systems to provide services, then government agencies have to carefully consider the types of organizations they should contract with and the procedures that should be in place to ensure that quality is provided, value for money and fiscal accountability achieved, and that clients receive the services needed to address their critical needs and help to put them on a path to sustainability and independence.

In some cases, legislation specifies what services can and cannot be contracted out. For example, there are a broad range of behavioral health, mental health, physical health and wellness, and social services that can be evaluated as candidates for potential contracting out using a public procurement approach. These services include: disabilities and adult/child protective services, substance abuse and addiction services, child care, poverty, housing (temporary, permanent, homelessness), job training and employment services, food assistance and nutritional supports, energy assistance, health assistance, HIV/AIDS/Disease supports, counseling services, income maintenance support (cash assistance), refugee services, services for aging populations (such as housing, transportation, elder abuse, etc.), juvenile issues (i.e., persons in need of supervision), domestic violence, LGBTQ services, and legal assistance (i.e., housing evictions, appeal a change in benefits) to identify just a few. Legislation can be used to specify that only nonprofit, nongovernmental, and community based organizations (hereafter referred to as nonprofits) are allowed by law to compete for contracts to provide mental health services if that is an organizational preference that a Ministry wishes to stipulate. Conversely, other governmental agencies, nonprofits, and private organizations are often allowed to compete for contracts to provide services that are ‘simpler’ meaning they are easier to observe, measure, and require fewer specialized investments. Under certain conditions, private firms may be more optimal partners in the provision and delivery of services, such as employment and job training services. In all these cases, legislation can be quite broad in creating opportunities for competitors to provide food assistance, housing support services, or restricting opportunities for types of service providers such as nonprofits in the provision of mental health services.

**Competition:**

The issue of competition and how many service providers should submit bids for there to be ‘adequate’ competition depends on the service or product that is being contracted for, the marketplace - urban environment, suburban, rural, the density of the population, - the relative client demand for a service, and a government’s legal and regulatory requirements. In general, the conventional rule of thumb is that there should be three independent submissions from organizations that are not currently doing business with one another to avoid potential collusion. However, for services or products that have more complex characteristics and where the government is the primary buyer on behalf of clients and beneficiary groups, there may be fewer than three bidders. The more specific the requirements, the less competition there is likely to be. The more that demand is highly dispersed and not concentrated in a geographic area, the lower the probability that more than one service provider exists.

Competition is also affected by the question of which types of firms can submit proposals. In some cases, government legislation or regulations may specify that only other units of government or nonprofits can compete. Depending on the service area being contracted for, competition may be limited because service providers are required to be pre-qualified to be eligible, or special licensing, certification, and accreditation is mandatory. In Guatemala for example, only non-governmental organizations, including private sector firms (NGOs),and community based organizations are eligible to compete for government contracts to provide health services. And, in Colombia, ‘regulated competition’ encourages private sector and community participation in healthcare delivery.[[4]](#footnote-4)

There are occasions when a government issues a sole-source contract to a single provider. In Scandinavian countries, because the government has a larger role in the production and delivery of goods and services, private providers are contracted with to provide a substantial amount of primary health care. And, in Canada, the United Kingdom, and New Zealand, the government can contract with a range of independent groups and providers. What needs to be clearly outlined in the bidding process documents are the conditions under which a sole-source contract may be used, when government may seek additional bids after a request for proposal date has closed, and the extent to which different expectations about competition are precisely defined. It is conventional understanding that when a government agency or municipality doesn’t possess public and contract management capacity, that the probability of contracting is high. This is certainly true in a country like Afghanistan where the funding for health services is received by a range of domestic and international governmental and philanthropic organizations.[[5]](#footnote-5) Where there is strong external oversight, more robust competition can be developed. On the other hand, if the region of the country for the size of the market is small, like in Bangladesh, the contract will likely be awarded without competition.[[6]](#footnote-6)

**Contract Design:**

One of the more challenging issues associated with any effort to procure goods and services outside of government is the development of a contract. There is no shortage of available secondary documentation and templates on how to create a contract, but what is missing from many of the discussions are the inherent tradeoffs in specifying some issues in very precise ways such as the qualifications, licensing, and certifications of professionals engaged in delivering services such as mental health, substance abuse, or domestic violence versus providing substantial discretion and flexibility to service providers over how best to provide services.

The State of Massachusetts (USA) is explicit in its social service contracts in specifying the exact professional qualifications required for a service provider to be eligible and successful in competing for contracts.[[7]](#footnote-7) There are risks (operational, financial, programmatic, client, reputational, etc.) and liabilities that government agencies are concerned about if service providers do not meet a minimum set of requirements. But where to set the floor in terms of minimum requirements and how to assess the cost-quality tradeoff in setting higher and more rigid requirements around personnel and specific products is a question that every public manager must confront. Another tradeoff associated with this decision is that the more specific the requirements, the greater the likelihood that fewer providers may be qualified and therefore eligible to compete for the contracts that governments seek to let in procuring goods and services from nonprofits, other government units, and private firms. In the State of Maryland (USA), for some highly-specialized types of services for which governments seek to procure services, legislation can be explicit in the acceptance of noncompetitive bids for program services such as foster care and rehabilitative and therapeutic services.[[8]](#footnote-8)

**Decision Authority:**

Over the past decade there’s been a large movement globally towards the decentralization of decision-making authority from centralized federal governments to sub-sovereign states and municipalities. However, decentralization can only be implemented when a nation has strong provincial and municipal capacity to make effective decisions. This need for strong regional governments is apparent in the health contracting experiences of Afghanistan, Colombia, and Guatemala over the past twenty years. In Afghanistan’s case, due to the weak central capacity of the state following 2003, the Ministry of Public Health created a special unit within the Ministry to manage World Bank and NGO health services contracts.[[9]](#footnote-9) Colombia’s Ministry of Health held final authority in the procurement, oversight, and regulation of health care at the national level. Like Colombia’s model, Guatemala’s Ministry of Health was also the central entity in oversight and the creation of norms for health service delivery. However, Guatemala also experimented with decentralization, developing a “social audit” entity to ensure community participation in health care services and to provide community oversight (at the local level) to the use of government funds in contracts with NGOs.[[10]](#footnote-10) Even within the centralized authorities, there is the potential for local autonomy and oversight of procurement contracts.

While centralization is common in states with limited governance capacity, decentralization of social service delivery and contracting is much more common in developed countries and particularly in Western Europe, North America, Australia and New Zealand. Within the decentralized frame, both state (regional) and local (municipal) governments have experience executing social services contracts. In France, contracts for elderly and disabled care are distributed and regulated by each regional *département*, which controls the procurement budgets for public and social services.[[11]](#footnote-11) In the United States, while each federal ministry has its own procurement authority and budgets, each state government also has their own departments for procurement. In many cases, the authority for contracting is determined by what type of services are being sought: if a state wanted to contract out childcare services to a nonprofit, it would do so through the state Department of Education and often decentralize that responsibility closer to the municipal level[[12]](#footnote-12). Within each state department, there are frequently specific state employees who are the procurement officials for all contracts through their department and they provide technical assistance and oversight to their public management counterparts at the local level in executing and monitoring contracts with service providers. In the State of Massachusetts, each state department has a Strategic Sourcing Services Lead (SSSL) and Strategic Sourcing Services Team (SSST) which are responsible for the overall management of the procurement, from solicitation to evaluation and awarding of contracts.[[13]](#footnote-13) In some unique cases, like in the State of Maryland, the size (cost/value) of the contract determines which state department executes oversight. This is often driven by legal and regulatory safeguards established as minimum and maximum contract values. And at the lowest level, services are often provided by municipal and local governments; Germany, Sweden[[14]](#footnote-14), the Czech Republic, and Slovakia all deliver childcare, elderly care, and healthcare using local municipal authority, provision, and provide contract oversight on all their service providers.[[15]](#footnote-15) The general trend throughout the developed world is following the models in Germany, Sweden, France, and the United States which expands procurement options, capacity, and authority for regional and local governments to contract for service delivery.

**Award Decisions:**

In the process of awarding a contract to a for-profit or nonprofit entity, there are several considerations federal, state, and local governments should make before adjudicating the different proposals. First and foremost is the determination of what the “desired results” are for the project, mainly using performance metrics or targets. While one objective for the government agency might be to procure and deliver the good or service, there are also other social, economic, or political objectives associated with the procurement of goods and services. For example, a ministry may have certain equity objectives it wishes to achieve such as the dollar amount of contracts awarded to disenfranchised groups such as minorities, women, disabled, state residents, or veteran-owned businesses. Public officials may also want to distribute contract dollars geographically to help support employment objectives and stimulate other forms of economic development. Ultimately, the government agency needs to be intentionally explicit about these objectives and ensure that the procurement process ultimately achieves these desired objectives. For example, in the State of Wyoming (USA), state regulations require departments to award a contract to a state resident making the lowest bid if the bid is not more than 5% higher than that of the lowest responsible non-resident bidder and that the services are not of inferior quality.[[16]](#footnote-16)

Once having determined what the requirements and expectations are for the contract, governments proceed to create a set of evaluation criteria on which to adjudicate the various proposals. For the State of Massachusetts (USA) and the federal government of New Zealand, these criteria are long and exhaustive, but cover key components of the proposal including written responses, oral presentations, past performance of the bidder, references, individual satisfaction surveys, monitoring reports, quality assurance documents, accreditation, years of operation, past experience, and costs.[[17]](#footnote-17) These criteria aid governments at determining not only “best value,” but also the state’s priorities manifested in the contract.

The concept of “best value” is seen in many forms, even within the same country. While the State of Massachusetts defines a “best value” contract as one which is designed to obtain the desired results in the most efficient and effective manner, the New York City (NYC) municipal government takes a broader view of what constitutes ‘best value’ in evaluating bids for contracted service delivery. In doing so, they define “Best Value” as a bid which “optimizes quality, cost, and efficiency” and then delineates that in the criteria weights in which additional preference is given for small business, minority, women-owned businesses**.** In their 2013 revisions, NYC expands the definition of “best value” to include references, past performance/reliability, durability of the product, and the organization’s staffing, financial capacity, and compliance record.Contracts “must be procured in a manner so to assure the prudent and economical use of public funds in the interest of taxpayers in their region.” Qualifying the idea of ‘region’ is important because of variable operational costs based on geography, market, and service needs.[[18]](#footnote-18)

The United Kingdom has a different version of how particular criteria are used to evaluate competitive bids in making award decisions. Instead of primarily focusing on the specifics of service delivery, the United Kingdom is more focused on how “what is proposed to be procured might improve the economic, social, and environmental well-being of the relevant area” and “how, in conducting the process of procurement, it might act with a view to securing the improvement.” [[19]](#footnote-19) This type of language provides a broad and potentially inclusive orientation of how to evaluate bids and could lead to a more robust set of competitor submissions, but the breadth of statements can also be viewed as ambiguous in how any such weighting might influence the actual award decision. In India, a two-stage process includes a ‘best-value’ approach akin to the NYC example described above, but in the second stage those finalists are evaluated by price and price alone.

There are of course criticisms about the way some contractors compete for contracts by indicating that highly qualified professionals are part of their contract proposal team. Upon being awarded the contract, these same contractors may substitute their ‘proposal team’ with other personnel. In industry parlance, this is often referred to as bidding with your “A” team (your best people) - but that upon award of the contract, using your “B” team (individuals with less experience and fewer qualifications) for implementation. One specific example is a service provider stating that their substance abuse counselors will have a Master’s Degree in Social Work with additional certifications in alcohol treatment or opioid interdiction but then having personnel who are only licensed social workers providing the treatment without possessing advanced graduate training and specialized certifications. Ministries have great flexibility to state explicitly in the contract what the personnel requirements and qualifications are to be for all bidders. A contractor can replace personnel with individuals who possess the same certifications and degrees stated in the contract or with more senior staff. However, the importance of stating these requirements in the contract is to reduce the likelihood that less senior or qualified staff are used in the actual development and delivery of procured goods and services after a contract is awarded. This is a place where contract management and oversight are important to ensure quality, value for money, and accountability.

The final steps in the awarding process are the negotiation and awarding of the contract. Governments will often use rankings of bidders to determine the “best value” and optimal contract proposal. These rankings are typically based on evaluation criteria, reference checks, oral presentations, and negotiations. In many international cases (New Zealand, United Kingdom, United States), the prices are determined by adequate price competition, established catalogs/market prices of commercial items, or legislation and regulation[[20]](#footnote-20). After awarding, states can often opt to enter a multi-year contract for social services to ensure the continuity of service and care delivery.

**Performance Metrics and Evaluation:**

Performance evaluation using metrics and data is central to the success of any contract in any sector. It’s imperative that not only is the contract executed properly, but that it brings the “best value” to the community. This evaluation can take three different approaches to measuring success: a) focusing on inputs, b) focusing on process and activity, and c) focusing on outputs, or performance. In thinking through tradeoffs, government officials, in their own quest to demonstrate value for money, may often establish too many measures and then invest few of their own resources in the data collection, analysis, and feedback. Too many measures not only impose a public management cost on the governmental agency, but it can increase the operating costs for a service provider given the capacity investments that will need to be made to comply with expected performance reporting. Accountability is important, but how that will be measured should be defined so that there is mutual understanding between the government agency and contractors. This helps to manage expectations and ensure goal alignment. The New Zealand Ministry of Social Development’s definition of performance, for example, is “focused at service delivery and client outcome levels.”[[21]](#footnote-21) Specifying with more granularity how these measures are to be operationalized and the frequency with which they are to be measured and reported are the types of decisions that need to be addressed.

Within performance measurement, there are three key types of metrics used worldwide for health and social services: access, quality, and efficiency. These metrics need to have a limited number of indicators, be independently measurable, entail clearly defined targets/thresholds and time periods, and establish a clear link between service provision, measures, evaluation, and performance review. In many countries, performance review is the ability to measure and evaluate outcomes. The central component here is that the service provider’s performance can be measured using data.

To evaluate access to their nutritional service contracts for example, the governments of Madagascar and Senegal measure the percentage of women attending weekly health and nutrition educational services through the contract. The Croatian government assesses access to its primary health care contracts through the scheduling of visits by telephone[[22]](#footnote-22). Quality is assessed by a range of metrics, from unidimensional structural and process indicators to multidimensional indicators and health outcomes. While Cambodia measured the quality of one of its contracts for primary health services through perceived quality of care, Haiti’s maternal, child, and family planning services contract is assessed through the percentage of clinics with at least four modern methods of family planning[[23]](#footnote-23). Finally, efficiency is commonly assessed through cost (Bangladesh, Costa Rica, and Guatemala), service usage by a particular demographic (Cambodia with poor individuals), or with input shares and unit costs (South Africa).[[24]](#footnote-24)

In many of these developing countries, contractors are often more effective than governments at providing and delivering services to citizens, especially since contractors can expand and reduce access and coverage to rural areas based on demand with greater flexibility than government. This is the case with Haiti for maternal and family planning services. However, the efficacy of these programs is often difficult to measure in these countries because central governments often lack the capacity to gather data from their service populations, either in usage, health, or socioeconomic status. This is one of the key problems facing developing nations in the procurement and provision of services through contracting[[25]](#footnote-25). However, governments can contract out for monitoring and evaluation (M&E) services with an objective, qualified third party that is not involved in the delivery of services or organizational relationship with the contractor providing the service. There are numerous organizations that are contracted to provide M&E services ranging from think tanks, professional program evaluation firms, universities and research centers, and international groups such as the World Health Organization and the United Nations Children’s Fund (UNICEF).

**Contract Management:**

Contract management remains a very important issue, but one that most governments fall short of investing in and creating substantive capacity. Conventional approaches to government contracting reveal that many public agencies allocate personnel, time, and resources to developing the contract, soliciting bids, and evaluating and awarding the contract. However, one of the more challenging issues associated with government’s use of private and nonprofit service providers is in managing the contract relationship.

Developing contract management protocols varies by many criteria ranging from the length and value of the contract, the simplicity or complexity of the product or service being procured, the degree of competition in the respective marketplace and availability of alternative service providers, and the reputation of the contractor and government’s experience in working with the organization. For example, some scholars assert that if a government agency is procuring a simple good or service – one that is easy to observe and measure and which doesn’t require high value specific investments – and there are alternative service providers in the marketplace, then government should use a more transactional approach to managing the relationship, especially if the contract is for a short period such as one to two years and if the value of the contract is low.

However, if the product or service to be procured under contract is more complex and therefore difficult to measure and observe and requires significant investments to produce and deliver, and there are few alternative service providers and product substitutes, then the government should strongly consider a more relational approach to managing the contract arrangement. In such cases, the contracts may be for longer periods of time, be of higher value, and require more active engagement, coordination, and information exchange between the government buyer and service provider. Through more active interactions, both partners can help define the rules of exchange, use a range of mechanisms to govern the relationship, reduce risks and uncertainty, and work toward a level of mutual understanding that can promote goal alignment and value for money.

Developing this type of active contract management relationship requires time, resources, and leadership commitment. Like any relationship, the partners must mutually invest in one another so that the outcomes are consistent with the goals being pursued. Leadership commitment begins at the top of an organization, but should be decentralized and institutionalized in the culture of the respective public agency and service provider. This leadership, either at the top of the department or through a contract manager, is critical to the successful implementation of the contract. The State of Massachusetts (USA) notes the importance of open communication for both the department and the contractor to developing a successful contractual relationship.[[26]](#footnote-26) Again, scholars assert that it does not make sense to invest time, resources, and personnel capacity into a relationship with a service provider for a simple good or service that has a short period and low cost.

In Haiti where performance based contracting has become more standardized in health services, there’s a balance between transactional and relational approaches to contract management.[[27]](#footnote-27) In other Latin American contexts, scholars found that successful health procurement allowed greater autonomy for contractors by focusing on outputs and results rather than processes and methods.[[28]](#footnote-28)

Finally, it’s important both in the design of the contract and management of the relationship that procedures are put in place to resolve disputes and conflicts. Potential conflicts can arise because of proprietary information, a client complaint, an unintended cost/expense because of a quality standard, or a contract omission which needs to be renegotiated. Preference is typically for mediation intervention by an agreed upon third party that can engage the respective contract parties, hear both sides, seek to arbitrate the respective differences, and make a binding decision that the parties agree to abide by. This type of process can take less time, cost less, and avoid the punitive decisions made in a court of law. Taking steps to preserve and even strengthen a relationship between a government agency and a service provider can result in services being provided on schedule and budget with mutually agreed upon quality standards.

**Monitoring and Oversight:**

Much of the discussion on monitoring and oversight in the literature surrounds the use of metrics and performance evaluation to manage social service contracts at the federal, state, and local level. However, monitoring can also take many different forms from formal site visits (announced and unannounced) and inspections by a government overseer or by a contracted third party. Performance reports, financial audits, required meetings, and other mandated expectations around coordination and information exchange are a few of the ways in which government implements oversight. These requirements and their frequency may occur monthly, quarterly, or annually. Accreditation agencies also play a formal role in evaluating organizations. Government agencies might require that service providers in certain program areas have formal accreditation as in the case of child care. In such cases, governments may rely on these third-party evaluators as proxies for performance review. The contract ideally specifies what types of monitoring will take place, how often, and what the rewards and penalties are in accordance with stated performance expectations. In the event a performance review leads to a recommendation for termination of the contract, there should be specificity on how termination is to proceed.

In many of the international cases analyzed, local governments who contract out social services are most often the entities responsible for oversight. For example, local municipalities in the Czech Republic are responsible for the monitoring and maintenance of the network of healthcare providers.[[29]](#footnote-29) The oversight can also come from entities within local government. For example, the French federal government created *centres communaux d’action sociale* (CCAS) in 1986, which are public law corporations which provide oversight for nurseries and childcare within the municipality.[[30]](#footnote-30) On the other hand, developing nations are more likely to execute and monitor contracts from a federal level. For example, the Colombian Ministry of Health is responsible for managing all health contracts for the nation.[[31]](#footnote-31) As was discussed earlier, this centralized approach is often more effective for developing nations because of the lack of data collection at the local level, which creates challenges for measuring the efficacy and efficiency of service delivery.

In addition to the “who” aspect of monitoring, the New Zealand Treasury notes that other components of monitoring include the type/form of monitoring, the frequency and timetable, the way information is gathered, the documentation on which the evaluation is based, and the types of follow-up which complement the evaluation.[[32]](#footnote-32) In many of the international cases studied, each social service contract had its own timetable in terms of evaluation. For example, Guatemala’s contracts for primary health care included bi-monthly monitoring updates and an annual holistic contract evaluation.[[33]](#footnote-33) These timetables in developing countries were usually based on annual or bi-annual data collection efforts gathered by both public entities and NGOs[[34]](#footnote-34). As noted above, metrics and contract performance were the two main sources of evaluation criteria, with data coming from government and NGOs. Sweden uses metric-based evaluation for social services, particularly elderly care, through *Management by Objectives (MBO) and Management by Results (MBR)*. Nearly all municipalities in Sweden use a combination of these two plus purchaser-provider models to evaluate the performance of the contract and to exercise political control over the provision and management of a contract.[[35]](#footnote-35)

**Payments and Compensation:**

Compensation and the application of rewards and bonus payments or sanctions and the withholding of funds is shaped by several issues including the simplicity or complexity of the product/service, the scale of the product that is being procured, the availability of substitute products and alternative service providers, and the proprietary nature of what is being contracted for. There are different compensation systems based on which party bears the risk and how much risk is shared. Risks can range from production to operational to financial. The most common unit-based compensation structure is a time and material contract. In this case, a government agency pays a service provider for the time it takes the contractor to produce each unit of some service. South Africa used a “fee for service” in its primary health care contracts, in which compensation was based on paying the contractor a fee for each service provided plus a flat fee for each prescription[[36]](#footnote-36). The advantage of time and material contracts is that there are standard expectations of cost and completion time for routine activities. However, in social services, a potential risk of using time and material contracts is that a service provider might use their information advantages to charge a government purchaser a higher cost by claiming that a client service takes longer and costs more because there are fewer standards and evaluation benchmarks against which the government can verify this claim.

If governments elect to use fixed-price compensation systems, the contractor bears risk if they state a fixed-price but then are unable to provide the service at the quality and performance level expected. The fixed price element means that the contractor will not be paid additional funds. Governments may use a fixed-price payment mechanism such as in the delivery of substance abuse services because there are standard treatment protocols. In a fixed price contract arrangement, it is the service provider that bears the risk of the client’s performance improving, but it’s incumbent on the government to measure and track client performance. However, delayed effects such as successfully completing a 30-day drug treatment program but becoming addicted again to drugs 120-days after treatment has concluded can be a challenging issue for government to control for. In this case, public managers would have to look at client recidivism rates as an indicator of effective treatment intervention. This example provides a point of contention because a service provider can claim programmatic effectiveness but a set of confounding factors for a client can undermine service effectiveness. Reviewing client results in the aggregate can help public managers to disentangle effective programming from client conditions and subsequent compensation systems that should be used in certain service areas.

If a fixed price contract is used and the government is unable to assess the ‘true’ cost of service provision at a quality and performance level, then the government could end up overpaying. Fixed cost is a recommended best practice for simple services or where the government already has oversight expertise. It is not a recommended approach if the service being contracted for is more complex or where it lacks public management capacity for oversight. In this case, the government agency bears more of the risk associated with this type of compensation. In using a fixed-price payment structure (per unit) in its nutritional intervention contracts in 2002, the Bangladeshi government assumed a great deal of risk for the contract because it lacked public management capacity.[[37]](#footnote-37)

Contracts might also specify compensating a service provider on activity or service delivered. For example, Romania’s fee for service also included capitation mechanisms, where the payment was determined by the number of patients a doctor/contract saw. In this case, compensation is not linked directly to the client’s improvement because the nature and quality of the intervention is not necessarily causally related to the client’s set of broader psycho-social health issues.[[38]](#footnote-38) As might be expected, this type of performance-payment system is ripe with perverse incentives and thus an area for potential abuse[[39]](#footnote-39).

In other situations, government offers lump-sum payments based on particular budgeting methodologies and offers a service provider an overall amount to provide or deliver as much to a specific population of a community as possible. This is typically the case with social services that provide direct material assistance as in food or clothing. This approach relies on governmental oversight to ensure that the provider is delivering the quality and quantity of services claimed.

In each case, there are a set of tradeoff decisions to be considered with respect to contract design. Implementing the performance monitoring systems upon which these payment systems are dependent is the responsibility of public managers. A secondary consideration is the degree to which incentive or bonus payments should be used to motivate faster performance or providing services to a larger population based on, for example, if an epidemic were to break out, then a government would likely suspend competition considerations and think about payment linking a service provider’s ability to see as many individuals as possible for treatment intervention. Finally, time period for payment and connection to performance results must be explicitly specified in a contract document when entering an arrangement with a service provider.

In both developed and developing countries, variations on project or performance-based compensation are the most common forms of payment structures for contracting social services. While some contracts may receive payment for the achievement of general outcomes (i.e. Bolivia and primary health care), many use specific metrics and indicators to determine both achievement and compensation. Haiti used a “Performance for Pay” structure in its health services contracting after destructive earthquake in 2010 to provide incentives to strengthen NGO capacity to deliver health services using a monthly sum payment based on performance.[[40]](#footnote-40) In addition, Bangladesh, Madagascar, and Senegal used project-based compensation structures for the payment of their primary and maternal health care contracts. Bonuses were also used to incentivize exceptional performance; for example, both the governments of Afghanistan and Haiti provided bonuses to NGOs and contracted organizations based on their performance above agreed-upon targets. In the Afghani case, this bonus system was highly structured: NGOs received a bonus of 1% of contract price for good performance, which was defined as achievement of 10% or more above the baseline forecast.[[41]](#footnote-41) Finally, in these systems of payment, penalties were often assessed for non-achievement of agreed-upon targets. From education in the United Kingdom to health service delivery in Cambodia and Costa Rica, this is a common method to incentivize efficacy and goal alignment behavior with contractors. Best practices and the use of randomized control groups and other experimental and behavioral science approaches can be used as part of the program evaluation process with contractor compensation tied explicitly to results. The World Bank has provided intellectual leadership in this area.[[42]](#footnote-42) [[43]](#footnote-43)

**Conclusion:**

A government’s decision to contract for social services and other types of social protection activities with private and nonprofit organizations is a governance movement that more countries are electing to develop, implement, and institutionalize. This is often motivated by a government’s desire to decentralize fiscal and service delivery responsibilities. Such efforts can lead to more effective matching of localized needs and creating more accountability. However, many governments struggle with the range of issues that are highlighted in this memo from planning the contracting effort to the development of market competitors, soliciting bids, making award decisions, and negotiating contract terms. The responsibilities then transition to managing the contract relationship, monitoring contractor performance, evaluating client success post-intervention, and then considering next steps ranging from extending the existing contract relationship, rebidding the contract, or terminating the programmatic intervention efforts.

The decision to transition from government service provision to contracting out for service delivery with other government units, private firms, and nonprofit organizations is a significant step for a ministry. In addition to enabling legislation, regulations, and the development of procurement policies and guidelines, robust investments in governmental contract management capacity will be needed. This requires the hiring and training of personnel, creating management systems and processes for effective contract design, implementation, and evaluation. For many government ministries this will be new, require leadership to champion contracting, motivating staff, and holding managers accountable for results. This requires an incremental strategy because the transition to contracting is a change management and culture transformation. Existing staff will need to be retrained, reassigned, or terminated and substantive and integrated structural, systems, policy, procedure, and personnel change will be needed. One method for experimenting with a shift to contracting is to develop a pilot project to test what works, modify systems where results are less than desired, and work back and forth to design, implement, and evaluate a system that leads to the intended outcomes. When best practices are incorporated and organizational learning takes place, then a ministry or governmental unit can begin to move to scale up its contracting activities. This takes time, resources, leadership commitment, broader stakeholder engagement internal to an agency and in localized markets, and patience.

International experiences are provided throughout as illustrations, but should not be treated as comprehensive. Inherent in government’s efforts is the need to develop appropriate legal, regulatory, and institutional frameworks that guide governmental decision makers and contractors in understanding the processes by which procurement opportunities, decisions, and management and oversight will take place. The references provided here are representative and incorporate academic, think tank, and government documents. The limitation of this memo is the breadth of issues represented and the tradeoff is that each issue can be elaborated in its own memo. The MOF may find that several new strategies and approaches for decentralizing social services delivery are moving forward in terms of institutional frameworks.

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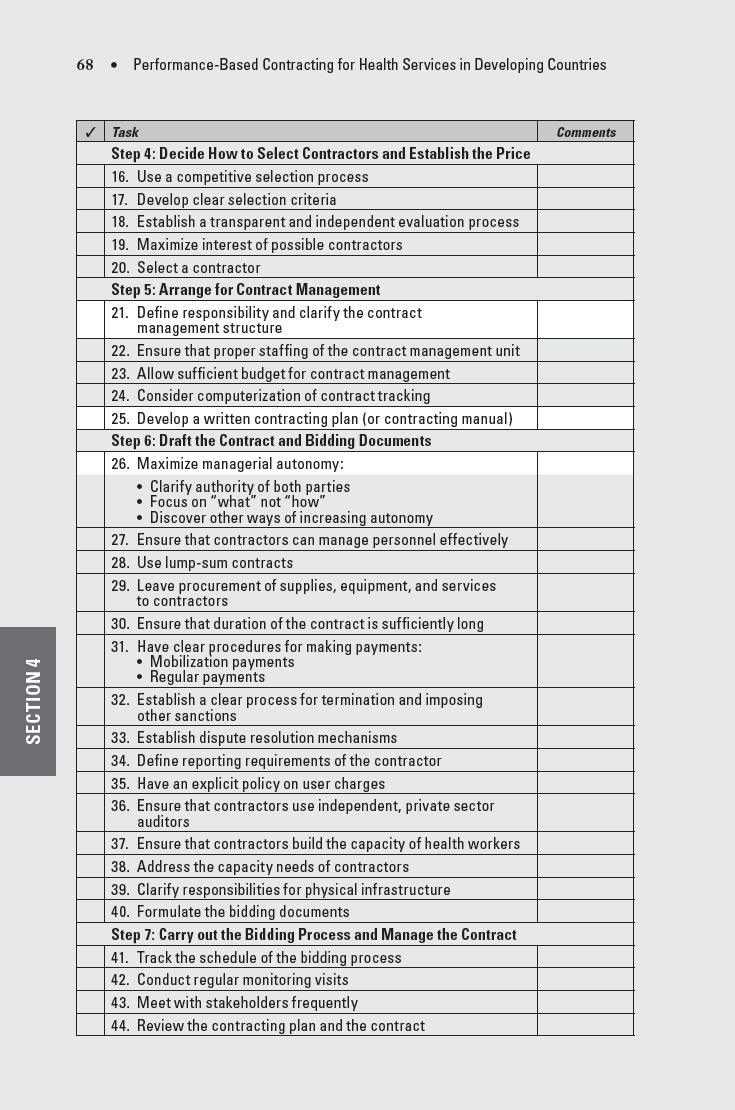
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**Appendix**

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1. I am grateful for the generous research assistance provided by Ryan D. Van Slyke. [↑](#footnote-ref-1)
2. A good resource for what is considered inherently governmental in U.S. federal procurement can be found at <https://fas.org/sgp/crs/misc/R42325.pdf>. Additional resources include: <http://www.gao.gov/products/GGD-92-11>; <http://www.gao.gov/products/GAO-11-192>; Examples of inherently governmental functions may include: Examples of inherently governmental activities include “awarding and administering contracts, determining budget priorities, and hiring or firing federal employees” (See: <http://www.govexec.com/oversight/2011/01/gao-army-contractors-performing-inherently-governmental-functions/33120/>.) [↑](#footnote-ref-2)
3. See OECD, 2017 at <http://www.oecd.org/gov/ethics/public-procurement.htm>. [↑](#footnote-ref-3)
4. OECD, 2011. [↑](#footnote-ref-4)
5. Palmer et al, 2006; Sabri et al, 2007. See also the World Bank’s RHESSA Project in El Salvador and the NGO Mobile Teams: <http://siteresources.worldbank.org/INTLAC/Resources/En_Breve_Salvador_149.pdf>. [↑](#footnote-ref-5)
6. Liu, Hotchkiss, and Bose, 2008. See also World Bank OED 2015 report, <http://documents.worldbank.org/curated/en/683211468006046063/pdf/344620PAPER0BD1tum0to0201501PUBLIC1.pdf>; WHO report on the Bangladesh Integrated Nutrition Programme (BINP), <https://extranet.who.int/nutrition/gina/en/node/23333>. [↑](#footnote-ref-6)
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13. Massachusetts Operational Services Division, 2016. [↑](#footnote-ref-13)
14. For further information about Sweden’s elderly care system, see OECD/European Commission. (2013). Country Note: Sweden. In *A Good Life in Old Age? Monitoring and Improving Quality in Long-Term Care*. Paris, France: OECD Publishing. Retrieved from <https://www.oecd.org/els/health-systems/Sweden-OECD-EC-Good-Time-in-Old-Age.pdf>. [↑](#footnote-ref-14)
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16. Wyoming Department of Administration and Information, 2016. [↑](#footnote-ref-16)
17. Massachusetts Operational Services Division, 2016; New Zealand Treasury, 2009. [↑](#footnote-ref-17)
18. Cushman and Friedman, 2013. [↑](#footnote-ref-18)
19. Government of the United Kingdom, 2012. [↑](#footnote-ref-19)
20. For further reference, see the Government of New Zealand’s Principles of Government Procurement, specifically Section 4: Awarding the Contract, at <http://www.procurement.govt.nz/procurement/for-agencies/key-guidance-for-agencies/the-new-government-rules-of-sourcing/principles-of-government-procurement>. [↑](#footnote-ref-20)
21. New Zealand Ministry of Social Development, 2016. [↑](#footnote-ref-21)
22. While Croatia decentralized much of healthcare provision in the 1990s, county governments were not well equipped with either the expertise or capacity for effective healthcare service delivery. However, the Croatian Government has taken steps since 2002 to improve the ability of counties to build capacity and increase county control of healthcare financing. For further reference, see the European Observatory on Health Systems and Policies at <http://www.hspm.org/countries/croatia30062014/livinghit.aspx?Section=2.3%20Organization&Type=Section>. There are also still inconsistencies with measurement and evaluation of healthcare privatization; see the Government of Croatia’s National Health Strategy 2012-2022 at <https://zdravlje.gov.hr/UserDocsImages/dokumenti/Programi,%20projekti%20i%20strategije/National%20Health%20Care%20Strategy%202012-2020.pdf>. [↑](#footnote-ref-22)
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24. Liu, Hotchkiss, and Bose, 2008. [↑](#footnote-ref-24)
25. Governments can also contract out the measurement and evaluation of contracts (i.e. data collection) to capable organizations such as the World Health Organization (WHO) or the United Nations Children’s Fund (UNICEF). For further reference to contracting out measurement, see the Guatemala and Liberia case studies in OECD. (2009). Contracting Out Government Functions and Services: Emerging Lessons from Post-Conflict and Fragile Situations. In *Partnership for Democratic Governance.* Paris, France: OECD Publishing. Retrieved from <http://www.oecdbookshop.org/get-it.php?REF=5KSF09SV5WBX&TYPE=browse>. [↑](#footnote-ref-25)
26. Massachusetts Operational Service Division, 2016. [↑](#footnote-ref-26)
27. Loevinsohn and Harding, 2005. [↑](#footnote-ref-27)
28. Loevinshon and Harding, 2005. [↑](#footnote-ref-28)
29. Nemec and Soukopova, 2016. [↑](#footnote-ref-29)
30. Marcou, 2016b. The French Ministry of Social Affairs and Health published a study on the use of local government oversight on the affairs of the elderly which fits this discussion on the role of CCASs. This study can be found at <http://drees.social-sante.gouv.fr/IMG/pdf/dss71.pdf>. [↑](#footnote-ref-30)
31. OECD, 2011. [↑](#footnote-ref-31)
32. New Zealand Treasury, 2009. [↑](#footnote-ref-32)
33. OECD, 2011. [↑](#footnote-ref-33)
34. NGOs and nonprofits are used interchangeably throughout. [↑](#footnote-ref-34)
35. Montin, 2016. [↑](#footnote-ref-35)
36. Fee-for-service compensation for health services is the most commonly used system within OECD countries. Reimbursement schedules are used in order to determine the price of a specific service. For an international comparison on the use of fee-for-service compensation, see Kumar, A., de Lagasnerie, G., Maiorano, F., and Forti, A. (2014, May). Pricing and Competition in Specialist Medical Services: An Overview for South Africa. *In OECD Health Working Papers No. 70*. Paris, France: OECD Publishing. Retrieved at <https://www.oecd.org/els/health-systems/Pricing-and-Competition-in-Specialist-Medical-Services_South-Africa.pdf>. [↑](#footnote-ref-36)
37. Liu, Hotchkiss, and Bose, 2008. [↑](#footnote-ref-37)
38. Liu, Hotchkiss, and Bose, 2008. [↑](#footnote-ref-38)
39. The Romanian National Health Insurance House faced a great deal of controversy within the country for the renegotiation of contracts with doctors due to this issue of patient thresholds. In the new contracts, family doctors were only allowed a maximum limit of 20 consultations per day, with NHIH officials saying that this limit will improve quality of care. However, it was met with criticism from doctors, who rely on patient consultations for compensation. For more on this, see Grosu, L. (2012, September 10). New Contract Erodes Family Health Care in Romania. *Global Press Journal*. Retrieved from <https://globalpressjournal.com/eastern_europe/romania/new-contract-erodes-family-health-care-in-romania/>. [↑](#footnote-ref-39)
40. Loevinsohn and Harding, 2005. [↑](#footnote-ref-40)
41. Palmer et al, 2006. [↑](#footnote-ref-41)
42. See: <https://siteresources.worldbank.org/EXTHDOFFICE/Resources/5485726-1295455628620/Impact_Evaluation_in_Practice.pdf>; <http://documents.worldbank.org/curated/en/166601468139781960/pdf/WPS6587.pdf>; [↑](#footnote-ref-42)
43. Alternatively, newer approaches such as the use of social impact bonds is another mechanism for tying contractor compensation to programmatic results. This topic is beyond the scope of this paper, but there are a range of materials that can be accessed. However, this approach depends heavily on a mature public procurement system. See the following as an example: <http://www.urban.org/sites/default/files/publication/85601/results-based-financing-approaches_1.pdf> [↑](#footnote-ref-43)