Acknowledgements

The study team were very impressed by the enthusiasm, ideas and commitment towards improving healthcare in PNG that we encountered during our interaction with key informants from the health sector. Special thanks go to the NDoH and the people from the non government sector who attended the discussions and provided feedback on the recommendations. Thanks also to Dr Isaac Ake for his contribution in the latter part of this study.

Report authors

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This study has been conducted by a consulting team working for the World Health Organisation with funding assistance from the Asian Development Bank.
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All partners have unique roles; however the health system only makes progress when the partners work together.

The NDoH is part of the brain of the health system, providing policy and stewardship. Other partners, such as churches, are crucial to the brain’s function. Just as there needs to be input from each part of the head into the brain to keep it functioning usefully, so there needs to be input from all the health actors so that the health system works properly.

The eye is the church which sees and recognises the health situation of our population.

The nose represents the private sector and industry which provide services.

The mouth is the government which has the power to speak for the population’s needs.

The ear represents the NGOs who sense the need of the people and help them in both rural and urban areas.

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1 This diagrammatic representation of health partnerships was conceived by Inderlyn Oli.
Findings

This is the final report of the Papua New Guinea (PNG) Health Partnerships Study. The report presents a summary of the findings of the study and its recommendations. It also includes practical tools for strengthening health partnerships in PNG.

An in depth discussion of the issues summarised in this report is to be found in the Interim Report of the PNG Health Partnerships Study available from the WHO office in PNG.

Partnerships

Partnerships in a health system are like the glue in a chair which keeps the different parts in alignment with each other and enables the system as a whole to do things that would be impossible for any of the parts to do on their own. As health systems increase in complexity, with more and different types of health providers, funders and suppliers, the task of delivering on goals such as universal health coverage becomes increasingly challenging. Strengthening health partnerships is part of the response needed to meet this challenge.

Health partnerships come in many different shapes and sizes, with different histories and different futures. In PNG the longest running partnership is between the government and the churches. Churches are the government’s main ally in the provision of health services for the rural majority, and they offer the best opportunity to rapidly strengthen the health system to meet the Millennium Development Goals (MDGs). Other health system providers include the government and its institutions, non government organisations (NGOs), the private sector, industries involved in healthcare provision, and traditional health care providers. Partnership arrangements play a crucial role in bringing an increasing number of actors and interests together in pursuit of a common aim.

These partnerships can be of many types, ranging from relationships that are built on trust where the partners have a shared commitment to a common set of values and goals, to relationships that are more detailed and rely heavily on the legally enforceable nature of a contract. Partnerships where there is close alignment of core values and goals are more likely to be able to achieve complex outcomes, and are more likely to be sustainable in the long term. In this study we have taken a broad view across the many partnership arrangements in the PNG health system, irrespective of size. In addition we have also considered Public Private Partnerships (PPPs) which have a precise definition in PNG policy. PPPs are defined as service and infrastructure projects worth in excess of 50 million Kina (K). To avoid confusion, we use the term Health Partnerships to describe relationships between the various actors in the health system, including relationships with the private sector, and the term PPP is restricted to the meaning it has in PNG legislation. Given the narrow focus of the PPPs as defined in PNG, we have viewed it as one potential element of partnerships, but have adopted a much broader approach to the discussion.
of health partnerships consistent with the existing relationships and their potential in the PNG health sector. In other words, the “partnership” approach in this document has a dynamic of its own that is separate from the more precise focus of PNG PPP policy.

**Government and Stewardship**

The dominant provider of health services in PNG is the government, and there are compelling reasons for a strong role by government in health systems. However health is everybody’s business. Government cannot do it alone. Effective health partnerships will depend on strengthening the stewardship\(^3\) role of the National Department of Health (NDoH). This requires the NDoH to differentiate its role in service provision from its role in leading the whole sector. It will require increased recognition by the NDoH of the potential of partners in the sector, and recognition of the ability of partners to contribute to the attainment of the government’s health goals. This will need to be reflected in the way health services are financed by the central and regional level public authorities. The stewardship role of the NDoH will also have to be translated into partnerships where the NDoH (or another public authority at a different level of government to which the function is delegated) acts as a strategic purchaser that takes into account the public health goals and priorities and channels them through its decisions on what is purchased, how it is purchased and from whom it is purchased. In sum the NDoH should take into account the pluralistic nature of the health system and move away from a process-based approach to an outcome-oriented approach by actively engaging in setting the ground rules and mediating the social contract for health where it can strategically engage other health system actors.

The government is committed to a primary health care approach, and is in the process of developing its National Health Plan (NHP). This presents an ideal opportunity to perform its stewardship role by clearly articulating the principles, values and goals of the health system, with an emphasis on universal access, equity, people-centred care, leadership and healthy public policy. Partnership development will assist in aligning the whole health sector to this strategic intent.

The current legal arrangements permit and in some aspects encourage partnership arrangements, and the recent development of Provincial Health Authorities in some provinces has created an opportunity to strengthen partnerships in provinces that have taken this option. Partnership approaches present an opportunity to strengthen linkages within government as well. Partnerships can be strengthened between parts of the government health sector that form more or less autonomous entities inside the health system (NDoH, provincial hospitals, provinces, districts) and between parts of government that impact on health (planning, treasury, education, community development).

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\(^3\) In the WHR 2000 stewardship is defined as ‘the careful and responsible management of the wellbeing of the population’. Stewardship is the responsibility of the government, usually through the Ministry of Health. Certain stewardship tasks may be delegated to actors other than the Ministry of Health. Responsibilities for different aspects of stewardship may be divided between central and sub-national health authorities, local government, other Ministries, civil service commissions, parliamentarians, professional associations. But a country’s government, through its Ministry of Health, remains the “steward of stewards” for the health system.
Improvements in intra-government relationships potentially have more impact on health outcomes than improvements within the health sector itself.

Partnerships create interrelations between the actors and they help to establish organizational and economical efficiencies in the health system. However, partnerships should not become *ad hoc* arrangements that come to life and disappear at a random frequency in time and space. In order to induce performance improvements in health systems, partnerships must be managed within a comprehensive approach that bundles them against system policies and public health priorities. This is why the stewardship role of the State is crucial since it has to be the actor that gives purpose and direction for the partnerships.

**Churches**

The churches are the most important health service provider in PNG outside of the government due to their size and service focus on the rural majority. The current relational contract arrangements could be improved by the NDoH giving increased recognition to this partnership. The increased recognition of this partnership will have to be translated into a process that will set some concrete ground rules on the ways the two actors will work together. One of the aspects that would need to be included in this partnership strengthening process is an increase in the transparency by the churches of how they use government resources and non government sources of finance for their activities; while the NDoH would need to find ways of ensuring more funding to the church sector when financing gaps exist. The relationship strengthening should also taken into account other health system building block elements such as information sharing, reporting responsibilities, use and level of patient user fees, human resource development, implementation of national standards, etc. The partnership strengthening process should be through an agreement that spells out the mutual commitments of the two parties. However, the partnership strengthening process should not focus on the contract; at centre stage should be a continuous dialogue that has a long term perspective and builds on the existing trust between the government and the church actors. The contract is only a tool that supports it.

The partnership with the churches should be built on a two-tier system:

1) At the central level the partnership between the NDoH and the Churches Medical Council (CMC) should be developed. This would first mean opening a direct dialogue through formal negotiations where the two parties should come together and produce an agreement on the way they will work together in the future. This agreement should at least include the issue of funding (defining the right level of funding, accountability); information sharing (with the objective of having one information system shared by the two parties); human resource development and training arrangements (how to fund the training activities, what category of health workers needs to be trained, how many need to be trained, who trains and where?); and other central issues related to the general way the two parties should work together in the future. From the NDoH side these negotiations will mean that there needs a to be a clear idea on how the church activities and their
public funding enter into the general planning of health service delivery in PNG; it is especially important to define the role of the churches for the implementation of the National Health Plan. From the CMC side the partnership strengthening process will need some preparatory process with the member churches so that there is a defined mandate given to the CMC to negotiate on the behalf of all the churches. And finally both parties, NDoH and CMC will need to enter the negotiations with the knowledge that compromises will need to be taken at some points.

2) At the provincial level (and to some extent at the district level) the partnership between the public authorities and the provincial level church authorities needs to be strengthened and formalized. This partnership should have an operational focus where the service delivery, supervision and other functions are planned in a coherent way by taking into account the actors’ existing activities, staff and the funding available. These partnerships at their core should have agreements on how to achieve universal coverage for particular populations based in specific geographical areas. (The current arrangements focus on facilities rather than populations.) This operational planning should lead to a situation where the church actors and the government actors find the best local setup for providing the best services possible to the population, including sharing expertise across government/church providers. A formalization of this cooperation in the form of a contract would be beneficial. In some cases there will need to be a multilateral approach where the government and church actors plan the local health activities also with NGOs, corporation-related health providers and other possible actors. In many ways the existing Rural Enclaves project will provide one of the operational models for these partnerships.

There are also other elements that are important for the church-government partnership. The Christian Health Services of PNG Act (CHS) for example should be strengthened, and the opportunities it provides should be used to explicitly develop the central level partnership between NDoH and CMC as well as the operational partnerships between churches and the public authorities at the provincial and district level. Capacity and capability will need to be developed both within government and churches to develop this relationship further.

**Agriculture and Extractive Industries**

The extractive and agricultural industries are increasing their role in health service provision, particularly in remote areas. This development has a number of advantages for health service strengthening in areas where the government struggles to provide services, and in this way contributes (alongside other actors) to universal coverage. The Rural Enclaves project in particular is a good model of health system strengthening where industry activities are integrated with local service provision. Recent experience with the extractive industries has raised serious issues of the sustainability of these services once the extraction activities cease. Models of more sustainable financing, such as those associated with the OK Tedi mining project, offer potential solutions to this problem, and
should be explored further. Other risks that need to be managed through partnership arrangements with these industries include ensuring that health services are accessible to the local population, irrespective of whether they are directly employed by the particular industry. In addition it should be noted that, apart from more direct industry involvement in a particular area, the industries’ contribution to the national tax base is also important in supporting equity across the whole population.

The NGOs

The NGO sector is rapidly growing in PNG. There are a handful of national and international NGOs making a significant contribution to health service strengthening. Some of these activities are funded with public grants through arrangements where the public authorities delegate their responsibilities to the NGOs. Access to care, especially for the urban poor, has greatly increased through these arrangements and further partnership development of this nature will most probably be beneficial. However, the current arrangements are often built on an *ad hoc* basis and they are mainly driven by short to medium term objectives. In order to further strengthen these partnerships a similar approach is required to that discussed above for the churches. This would operate at two levels, a central level partnership arrangement between the NDoH and an umbrella body of NGOs, and more operational contracts at the provincial and district levels. The current partnership arrangements are mainly based on a very loose agreement where neither the cost of the services nor the outcomes are rigorously defined. The strengthening of these partnerships will thus also need a more rigorous approach to creating agreements in order to define the services that are paid for and the cost of these services.

Alongside the few larger NGOs, much of the NGO sector is highly donor-dependant and many organisations would not exist without external donor funding. The bulk of the NGO sector is made up of small organisations, largely focusing on HIV/AIDS awareness-raising. For this latter group, the main emphasis needs to be on capacity building, and ensuring that they are included in partnership development at the local level.

In discussing the NGO sector, attention should be drawn to the possibilities of building closer partnerships with civil society groups in general. (Civil society is composed of the totality of voluntary civic and social organizations and institutions as opposed to the structures of the government and private commercial institutions.) Some of these groupings will be formal NGOs and some will not. Recent research and commentary⁴ on local level governance in Papua New Guinea has identified the poor condition of formal local level government. However, the research has also identified the rise of informal governance-type activity at the local level. A significant finding is that large numbers of local-level groups and associations have been formed and are flourishing. They have organised in pursuit of governance, development and community-related activities and objectives. The key point here is that within each community there are civil society groups operating which will differ from community to community and which will enhance the formal health system if suitable partnerships can be formed.

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⁴ Hegarty, D., 2009. Governance at the Local Level in Melanesia - Absent the State *Commonwealth Journal of Local Governance* (3).
The Private For-profit Sector Providers

The private for-profit health service sector is small but expanding rapidly and there is value in the government entering into a partnership arrangement with it. The government already has an obligatory role to regulate and provide licences. In addition, there is a potential regulatory role for the government to ensure that public services are not undermined by any private activities of public sector employees and institutions.

However there are limits to this regulatory approach since it fails to provide effective rules and mechanisms for integrating the private sector into the health system. This means that there is a need for gaining the private for-profit providers’ commitment to follow national standards and to pursue public health priorities and objectives. This sector’s growth will impact on the overall health system development in future years and it is therefore important to start building partnerships with it straight away - once this sector has grown over a certain threshold, effective engagement will become more difficult. Poorly managed growth of the private sector will present a real threat to the government’s health goals and should be avoided. The government and the private sector working in partnership have the potential to positively shape the development of this sector so that overarching goals (such as universal access) and the resources to achieve them (such as a trained health workforce) are not compromised. The public authorities can also resort to specific partnerships, in the form of specific service agreements, with the private for-profit providers when they are in a position of offering services that either cannot be provided by the public sector or could be provided by the public sector but at a higher cost. Most probably these types of service purchasing agreements would concern highly specified health care services for which the private for-profit providers have already made the initial capital and human resource training investments.

Public Private Partnerships for Infrastructure Development

PPPs may be of benefit to the PNG health sector, particularly if the infrastructure concerned supports the government’s intention to deliver services to the rural majority. However, the PPPs in health are a high-cost option, and their long term impact on resources available to deliver health services relevant to the needs of the population has to be carefully considered. The current intention is to consider PPPs for urban hospital infrastructure.

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5 The costs and benefits of PPPs in Health Systems are strongly debated. Some groups (such as The Global Health Group in Public-Private Investment Partnerships, 2009 and Delloite’s Closing the Infrastructure Gap, 2006) are very supportive of PPPs, whereas other researchers such as Hellowell and Pollock take a more negative view (Hellowell M. & Pollock A., 2007, Private finance, public deficits: A report on the cost of PFI and its impact on health services in England). See also commentary by McKee (McKee N et al 2006 Public-Private Partnerships for Hospitals). Given the challenges PNG currently has with straightforward purchasing modalities, the study team is of the view that concluding a favourable price from a health sector PPP which is much more complex will be extremely challenging. Furthermore, the opportunity costs of the very limited number of key staff in the NDOH with broad health sector knowledge that would need to commit time to make a success of a PPP negotiation also needs to be considered, given the need for their expertise to be focused on other aspects of health system strengthening. The Asian development Bank (ADB) is currently assisting PNG with strengthening the policy, legislative and support systems for PPPs. This study looks specifically at PPPs as they may impact on the health sector and not their more general application.

6 See National Public Private Partnership Policy, pages 2-3
development and this raises resource allocation and equity issues. Any infrastructure development project should be carefully linked to a general prioritization exercise. It must be understood that infrastructure projects, especially for specialized hospitals, will have high recurrent and capital costs; in the PNG context this cost will inevitably be a big share of the total health spending. This in turn will mean that if there is no prospect of substantially increasing the total health expenditure, the large infrastructure projects will inevitably lead to a decrease in the resources available for other areas – especially for rural health.

The risk of large infrastructure projects is that they will “invert” the planning process; in other words, the infrastructure will determine the shape and outcomes of the health system. If the projects are not carefully planned inside the health planning process, the cost of these projects can impose constraints on spending that will make it impossible to achieve the National Health Plan. This may indeed lead to a worsening of health outcomes through the spending of an increasingly disproportionate amount of the health budget on a small section of the population, resulting in a worsening of the services and health outcomes for the majority. The NDoH must avoid creating a situation where there is a government subsidy to the more prosperous and already better-served urban populations at the expense of rural services.

In conclusion, PPPs have the potential to overcome bottlenecks in management and financing that are currently facing the PNG health system. However, this comes at a high cost in the medium to long term, and may distort more comprehensive sector planning processes and reduce flexibility to meet changing needs. Our advice is that because of these difficulties, PPPs should have a limited role in the PNG Health system. A full discussion of these issues is to be found in the Interim Report.

**Wider Health System Barriers to Partnerships**

The advice in this report is built on the assumption that improving the partnership relationships between the various parts of the health system will positively impact on the health system’s effectiveness and efficiency. However, improved partnerships are only one element of the necessary requirements of a robust health system, and will be of little use without concomitant development of all the other elements such as adequate funding, widespread acceptance amongst health providers and the workforce of the government’s vision for health, workforce development, improved monitoring, and improved governance and regulatory arrangements. Developments outside of the health sector are also crucial, such as transport infrastructure, law and order issues, and communication technologies.

Fundamental to effective partnerships are their funding arrangements. There is widespread acknowledgement that a fundamental driver of PNG’s poor health sector performance in recent times is related to the overall lack of funding. PNG spends significantly less per capita on health services than nearby island states (such as Solomon Islands and Vanuatu) and, unlike these two countries, real per capita health spending has until very
recently been on a declining trend.\(^7\) As an example of underfunding, the operational money going to government health services has been demonstrated by the National Economic and Fiscal Commission (NEFC)\(^8\) to represent only 31% of the funding required to deliver the estimated cost of a core level of services. The NEFC is taking steps to fill the gap between what is currently provided and what is needed to enable the delivery of services. The lack of overall funding is compounded by inefficiency, waste and limited absorptive capacity in the sector.

This limited absorptive capacity when funding is available has recently been documented. Both in 2006 and 2007, 41% of the budgeted central government and donor partner resources for health were unused at the end of the year.\(^9\) The PNG health system funding mechanisms are extremely complicated, are under the control of multiple decision makers, and are in a state of flux. Disbursing and allocating resources in the PNG health system is thus not easy and several bottlenecks exist. This would suggest that simply throwing money at the problem will not solve it. There is also a need to find new solutions for channelling resources for health at the macro and micro levels.

The fragmentation and uncoordinated health funding activity is particularly apparent in infrastructure spending through Tax Credit Schemes (TCS) and District Improvement Plans. Significant amounts of health resource allocation currently occur through these modalities; however there is little or no alignment with health system prioritization or planning activities. Provincial health authorities should work with NDoH, the Department of National Planning and Monitoring (DNPM) and industries to align the Tax Credit Scheme with government health priorities and to advocate and facilitate health infrastructure delivery through the TCS modality.

**Wider Health System Activity That Will Strengthen Partnerships**

The NDoH has a number of very significant projects currently under way that are relevant to the further strengthening of health systems in general and partnerships in particular. The first of these is the development of the National Health Plan for the next ten years with its strong emphasis on the principles of primary health care, universality and equity. This has the potential to be the guiding document for the PNG health sector, and should form the basis of the government’s perspective in any partnership agreements.

In addition, provincial health authorities are being established and regulations are being drafted to implement the *Provincial Health Authorities Act*. This is a major sector change, with the potential to streamline the provincial and national governments’ activities in health. The regulations associated with this legislation present an opportunity to ensure that

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\(^8\) National Health Conference, Goroka PNG 2009, *Contributing to better service delivery in PNG*, presentation by Dr Badu, National Economic and Fiscal Commission

partnerships are given adequate recognition and structure as these new organisations are formed. The Christian Health Services of PNG Act is being examined for legal soundness and options are being considered to address any shortcomings. Once again this presents an opportunity to more effectively articulate the framework for continuing partnerships between the churches and the government.

Projects that are currently underway in the drug supply and decentralised financing to overcome the bottlenecks in these systems will also be very important in improving the government’s credibility in entering into health partnerships.

**Conclusion**

The PNG health system is complex and dynamic, and faces enormous challenges. The report has identified the potential that improved partnerships in health can offer, as well as the limitations of partnerships if the other key drivers of health system strengthening are not addressed at the same time. It describes the overall approach to partnerships, and emphasizes the need to proceed with both a general framework, and the capacity to use health service agreements to address the specifics that are unique to every relationship. All partnerships have an obligation to fit into the context of the overall strategic and planning processes at national, provincial and lower levels. The partnerships should contribute to national and lower level goals for the sector particularly in regards to universal coverage leading to improved, sustainable, and equitable health outcomes.
Two-step Approach to Partnerships

At the national level

At the national level the NDoH and the non-state actors come together and agree on the basic principles for the way they should work together and how they are going to implement the National Health Plan, in particular universal health coverage, and other national strategies. This central level partnership should address all the different health system building blocks and it should therefore result in an agreement on aspects such as financing (accountability, disbursement methods, etc.), information sharing, and human resource development.
At the provincial level

This is built on the scenario of full roll-out of the Provincial Health Authorities but is also applicable to provincial administration.

Firstly, an explicit agreement is developed between the NDoH and each PHA on the objectives, priorities and resources for each province. Secondly, operational-level partnership agreements are drawn up between the major stakeholders at the provincial level. These partnerships should have, at their core, agreements on how to achieve universal coverage for particular populations based in specific geographical areas (the current arrangements focus on facilities rather than populations). This type of partnership should lead, for example, to a joint planning effort where all the stakeholders are aware of each others’ funding and where the service provision can be optimized. Also, questions such as referrals, supervision and mentoring should be included in the partnership approach at this level.
Recommendations

The Churches Partnership

1. Strengthen the CHS ACT by creating the Churches Medical Council (CMC) as an entity under the law, by giving the CMC a clear role in relation to the National Health Plan. Link this with the Provincial Health Authorities Act and provincial and district planning.

2. Encourage donor partners to strengthen the capacity of church health service providers to meet higher expectations regarding information sharing (monitoring and evaluation), accountability and transparency.

Partnerships in general

3. Revise the existing Partnerships Policy to acknowledge all health partners and to ensure that:
   - universal health coverage is given priority in the activity of all health partners
   - agreements explicitly address the building blocks required for service delivery (supplies, finances, Human Resources (HR) effects, infrastructure, technology and communications, and governance including community engagement)
   - all health partners supply information regarding their health activities to government and the government in turn provides timely information and feedback.
   - a schedule to the policy is created which is a timetable for implementation of the recommendations in this report which are accepted by the NDoH.

4. Give partnership relationship management a greater focus at all levels of the health system, led by NDoH giving the responsibility to one deputy secretary and ensuring that there is adequate support to the partnership task force.

5. Health partnership activity to be reported in the annual report to the National Health Board and Parliament, detailing the financing, outputs and activity to improve universal coverage.

6. Enter into strategic partnerships with the umbrella bodies of provider groupings (churches, NGOs, the agriculture and extractive industries and the private providers) to increase their engagement in the planning process for the National Health Plan and to delegate responsibility to them for the implementation of the Plan.

7. Encourage health partners to take a wider mentoring role of government services in rural areas where they have senior health expertise available or are better situated to provide mentoring because of their location.

8. Criteria should be included as a regulation under the Provincial Health Authorities Act for considering new entrants into the health service delivery field (who might partner or contract with provincial health authorities).

9. Health partner activity should operate inside the national, provincial and district health plans, policies and standards.
10. Ensure partnership arrangements at the district level engage with community learning centres.

**Public Private Partnerships**

11. Public Private Partnerships for infrastructure development should be used in a restricted way due to their high cost to the health sector in the future.

12. Consider PPP as an option to overcome management bottlenecks in infrastructure development, provided the PPP strengthens the capacity of PNG to manage infrastructure development in future, closely aligns with national priorities such as universal coverage, and justifies the high level of engagement that will be required from senior NDoH officials in the negotiation process.

**Agricultural and Extractive Industries**

13. Agricultural and extractive industries with an interest in health service provision should work cooperatively with each other by forming a board to assist and dialogue with the government in providing direction and coordination of industry health service activities.

14. The extractive industries should further explore the suitability of mechanisms, such as trust funds, to be used more widely to sustain health systems in remote areas once the industries leave.

15. The NDoH should engage directly with the PNG LNG (Liquefied Natural Gas) project, to ensure health activities and resources related to the project are consistent with and are also supportive of the National Health Plan so they do not increase inequity between provinces.

**NGO and other Civil Society Groups**

16. Ensure partnership arrangements include the NGOs and other civil society groups active in communities, and supports capacity building for these groups to engage with the formal health sector.

**The Private Health Sector**

17. The private sector should form a strategic partnership with the NDoH to address areas of common interest (including regulation and accreditation of providers and institutions) especially in relation to access to health activity information.

18. Ensure that consideration is given to a formal arrangement for the purchase of specific hospital services from the private for-profit sector providers.
## Recommendations in detail

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Organisation to carry it out</th>
<th>Timeframe</th>
<th>Assumptions</th>
</tr>
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<tbody>
<tr>
<td>1. Strengthen the CHS ACT by creating the Churches Medical Council (CMC) as an entity under the law, by giving the CMC a clear role in relation to the National Health Plan. Link this with the Provincial Health Authorities Act and provincial and district planning.</td>
<td>NDoH and CMC</td>
<td></td>
<td>There is currently confusion about the operation of this Act. It is important that priority is given to the review and amendment of this Act or it will continue to be an impediment to the improvement of partnership relations between churches and the NDoH.</td>
</tr>
<tr>
<td>2. Encourage donor partners to strengthen the capacity of church health service providers to meet higher expectations regarding information sharing (monitoring and evaluation), accountability and transparency.</td>
<td>Donor partners</td>
<td>Now</td>
<td>Increased support by donor partners to churches will assist them in entering into partnerships with the NDoH and provincial governments.</td>
</tr>
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10 The timeframe column will be completed as once these recommendations are incorporated into the responsible organization’s plans.
<table>
<thead>
<tr>
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</table>
| 3. Revise the existing Partnerships Policy to give special acknowledgement of the CMC and church health services, and to ensure that:  
• universal health coverage is given priority in the activity of all health partners  
• agreements explicitly address the building blocks required for service delivery (supplies, finances, HR effects, infrastructure, technology and communications, and governance including community engagement)  
• health partners supply information regarding their health activities to government and the government provides information and feedback to the church actors  
• a schedule to the policy is created which is a timetable for implementation of the recommendations in this report which are accepted by the NDoH. | NDoH Policy | NDoH Policy | Clearer articulation of partnership policy and implementation plan will strengthen relationships in the whole sector. See Interim Report for details. |
<p>| 4. Give partnership relationship management a greater focus in NDoH structure by giving the responsibility to one deputy secretary and ensure that there is adequate support to the partnership (PPAI) task force. | NDoH | As part of re-structuring | Currently, despite key partners sharing the NDoH facility, there is no regular engagement. This would elevate the importance of partnership for the sector, and increase the engagement with decision makers. |</p>
<table>
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<tr>
<td>5. Health partnership activity to be reported in the annual report to the NHB and Parliament, detailing the financing, outputs and activity to improve universal coverage.</td>
<td>Annually</td>
<td>NDoH</td>
<td>Annual reporting at the highest level will keep the issue of universal coverage and partnerships high on the NDoH and government agenda. Greater involvement and some delegation to health partners will increase the system’s capacity to take on the challenges in the NHP.</td>
</tr>
<tr>
<td>6. Enter into strategic partnerships with the umbrella bodies of provider groupings (churches, NGOs, the agriculture and extractive industries and the private providers) to increase their engagement in the planning process for the National Health Plan, and to delegate responsibility to them for the implementation of the Plan.</td>
<td>Now</td>
<td>NDoH</td>
<td>Greater involvement and some delegation to health partners will increase the system’s capacity to take on the challenges in the NHP. Better use will be made of scarce personnel in a specific area if skilled staff are routinely used across the organisational boundaries (such as between government and church facilities) in a support and mentoring role.</td>
</tr>
<tr>
<td>7. Encourage health partners to take a wider mentoring role of government services in rural areas where they have senior health expertise available or are better situated to provide mentoring because of their location.</td>
<td>When existing agreements are renewed</td>
<td>Provincial Health Authorities and Provinces, major provincial level church organisations and other rural health providers.</td>
<td>When existing agreements are renewed Better use will be made of scarce personnel in a specific area if skilled staff are routinely used across the organisational boundaries (such as between government and church facilities) in a support and mentoring role.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Organisation to carry it out</td>
<td>Timeframe</td>
<td>Assumptions</td>
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<tr>
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</tr>
<tr>
<td>8. Criteria should be included as a regulation under the Provincial Health</td>
<td>NDoH Health Reform Team.</td>
<td></td>
<td>As Provincial Health Authorities are being established, regulations should be used to provide a legal framework for health partnerships at the provincial and district levels, and this would strengthen health partnerships.</td>
</tr>
<tr>
<td>Authorities Act for considering new entrants into the health service delivery</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>field (who might partner or contract with provincial health authorities).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Health partner activity should operate inside the national, provincial</td>
<td>NDoH, PHAs, Provinces</td>
<td>Next</td>
<td>Explicit roles for all the actors within the plans and policies will lead to greater clarity and coordination of activity and better alignment towards national and provincial health sector aims.</td>
</tr>
<tr>
<td>and district health plans, policies and standards.</td>
<td></td>
<td>planning</td>
<td></td>
</tr>
<tr>
<td>10. Ensure partnership arrangements at the district level engage with</td>
<td>All provincial and district</td>
<td>Ongoing</td>
<td>Community learning centres are a current initiative of the Department of Community Development. Engaging them is an effective way to pursue community engagement in health service delivery. This initiative is just beginning and its effectiveness is not yet able to be gauged.</td>
</tr>
<tr>
<td>community learning centres.</td>
<td>health providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Public Private Partnerships for infrastructure development should be</td>
<td>NDoH senior management</td>
<td>Now</td>
<td>The senior management team needs to actively ensure that PPPs are secondary to the NHP objectives and don’t become the driver of health sector activity.</td>
</tr>
<tr>
<td>used in a restricted way due to their high cost to the health sector in the</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>future.</td>
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<tr>
<td>Recommendation</td>
<td>Organisation to carry it out</td>
<td>Timeframe</td>
<td>Assumptions</td>
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</tr>
<tr>
<td>12. Consider PPPs as an option to overcome management bottlenecks in infrastructure development, provided the PPP strengthens the capacity of PNG to manage infrastructure development in future, closely aligns with national priorities such as universal coverage, and justifies the high level of engagement that will be required from senior NDoH officials in the negotiation process.</td>
<td>NDoH senior management team</td>
<td>Now</td>
<td>Restricted use of PPP – for a full discussion of the risks involved see the Interim Report.</td>
</tr>
<tr>
<td>13. Agricultural and extractive industries with an interest in health service provision should work cooperatively with each other by forming a board to assist the government in providing direction and coordination of industry health service activities.</td>
<td>Agricultural and extractive industries</td>
<td>Now</td>
<td>Building on the Rural Enclaves network, a formal grouping would assist in building a national partnership with the NDoH for this group of actors.</td>
</tr>
<tr>
<td>14. The extractive industries should further explore the suitability of mechanisms, such as trust funds, to be used more widely to sustain health systems in remote areas once the industries leave.</td>
<td>Extractive and agricultural industries, NDoH, donors</td>
<td>Within two years</td>
<td>A review should be undertaken of the long term consequences for health sector strengthening and sustainability of current future focused funding arrangements (such as those associated with OK Tedi).</td>
</tr>
<tr>
<td>15. The NDoH should engage directly with the PNG LNG (Liquefied Natural Gas) project, to ensure health activities related to the project are consistent with and supportive of the National Health Plan.</td>
<td>PNG/ LNG and NDoH and relevant provinces</td>
<td>Now</td>
<td>Given the magnitude and timeframe of this project a planned partnership arrangement with PNG LNG specifically for health system capacity building will benefit these provinces more than fragmented ad hoc investment in health infrastructure.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Organisation to carry it out</td>
<td>Timeframe</td>
<td>Assumptions</td>
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<tr>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16. Ensure partnership arrangements include the NGOs and other civil society</td>
<td>All provincial and district</td>
<td>Ongoing</td>
<td>Stronger linkages between existing civil society actors and the formal health sector will improve community participation and delivery capacity</td>
</tr>
<tr>
<td>groups active in communities, and supports capacity building for these groups</td>
<td>health providers, donors</td>
<td></td>
<td>of the health system.</td>
</tr>
<tr>
<td>to engage with the formal health sector.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. The private sector should form a strategic partnership with the NDoH to</td>
<td>Private sector umbrella</td>
<td></td>
<td>A more formal relationship between the private sector and government will assist both partners to build towards the National Health Plan.</td>
</tr>
<tr>
<td>address areas of common interest (including regulation and accreditation of</td>
<td>organisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>providers and institutions) especially in relation to access to health activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>information.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>18. Ensure that consideration is given to a formal arrangement for the purchase</td>
<td>NDoH</td>
<td></td>
<td>A formal mechanism for purchasing services from the private sector which includes its impact on the National Health Plan will improve sector</td>
</tr>
<tr>
<td>of specific hospital services from the private for-profit sector providers.</td>
<td></td>
<td></td>
<td>performance.</td>
</tr>
</tbody>
</table>
Draft Guidelines for Contracting with Health Partners

Acknowledgement

The study team acknowledges the contribution made by the New Zealand Treasury paper Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown published in April 2009.

Future work

The study team offers these guidelines as a basis for the development of contracting guidelines for use in PNG. The team recommends that the guidelines be adapted further for the PNG situation by local experts led by the NDoH.
## Checklist for Government Health Agencies

<table>
<thead>
<tr>
<th>Question</th>
<th>Chapter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you clear about what you are trying to achieve? Does this inform your contracting or funding processes?</td>
<td>1</td>
</tr>
<tr>
<td>Is contracting with or funding a Health Partner the best way of achieving your objectives?</td>
<td>1</td>
</tr>
<tr>
<td>What is the nature of the contracting or funding relationship? Are you – Purchasing all of a service? Making a contribution to a Health Partner’s activities? Directly contracting for outcomes? Assisting an NGO to develop capacity? Making a grant?</td>
<td>1</td>
</tr>
<tr>
<td>Does the definition of the service being paid for strike the right balance between providing certainty as to what is being provided, and allowing flexibility, while avoiding unreasonable compliance cost?</td>
<td>1, 3</td>
</tr>
<tr>
<td>Has there been appropriate consultation with users, Health Partners and other stakeholders?</td>
<td>1</td>
</tr>
<tr>
<td>What sort of organisation will you be contracting with or likely to be contracting with?</td>
<td>1, 2</td>
</tr>
<tr>
<td>What is the capacity of the organisation to meet your expectations about financial accountability, data collection, clinical standards etc?</td>
<td></td>
</tr>
<tr>
<td>How will you work with local groups?</td>
<td>1, 2, 4</td>
</tr>
<tr>
<td>What incentives do the contracting or funding arrangements set up?</td>
<td>1</td>
</tr>
<tr>
<td>Do the contracting or funding arrangements provide adequate accountability for public money?</td>
<td>Introduction, 1, 3, 4</td>
</tr>
<tr>
<td>Would a grant be appropriate rather than a contract?</td>
<td>1</td>
</tr>
<tr>
<td>Do the contracting or funding arrangements allocate risk appropriately?</td>
<td>1, 3</td>
</tr>
<tr>
<td>How adequate are your own contracting policies, systems, management and staff? Are they consistent with the principles of good contract management?</td>
<td>Introduction, 1</td>
</tr>
<tr>
<td>Do other parts of Government have an interest in the contracting or funding arrangements you are involved in?</td>
<td>1</td>
</tr>
<tr>
<td>Would it be sensible for the Government Agencies involved to co-operate in managing the contracting arrangements with the NGO?</td>
<td>1</td>
</tr>
<tr>
<td>How long should the agreement be for?</td>
<td>1</td>
</tr>
<tr>
<td>Do the arrangements avoid unnecessary compliance costs for the parties?</td>
<td>1, 3, 4</td>
</tr>
<tr>
<td>Question</td>
<td>Chapter(s)</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Are the arrangements consistent with relevant regulatory requirements?</td>
<td>1</td>
</tr>
<tr>
<td>How will you identify the Health Partner you will be contracting with or funding?</td>
<td>2</td>
</tr>
<tr>
<td>Do you have an existing relationship with the Health Partner?</td>
<td>2</td>
</tr>
<tr>
<td>Do you understand the nature of the organisation you are dealing with?</td>
<td>2</td>
</tr>
<tr>
<td>Are the contracting or funding arrangements consistent with the independence of Health Partners?</td>
<td>2</td>
</tr>
<tr>
<td>Are you confident the Health Partner can meet its obligations?</td>
<td>2</td>
</tr>
<tr>
<td>In what circumstances would a tender process be appropriate?</td>
<td>2</td>
</tr>
<tr>
<td>Are you clear about your negotiating parameters including the budgetary constraint you operate under? Should the Health Partner you are negotiating with be made aware of those parameters?</td>
<td>3</td>
</tr>
<tr>
<td>Do your contract managers have adequate authority to conclude a deal?</td>
<td>3</td>
</tr>
<tr>
<td>Will the price negotiated allow for delivery to an appropriate quality of the desired time period (which may be the medium to long term)?</td>
<td>3</td>
</tr>
<tr>
<td>Have you included everything you need to in the agreement?</td>
<td>3</td>
</tr>
<tr>
<td>What is the basis for payment? Can you make payments on time according to the contract?</td>
<td>3, 4</td>
</tr>
<tr>
<td>How will a surplus be dealt with?</td>
<td>3</td>
</tr>
<tr>
<td>Is an appropriate monitoring regime in place?</td>
<td>4</td>
</tr>
<tr>
<td>Do you know how to manage the ongoing relationship with the NGO appropriately, including giving feedback on performance and reporting?</td>
<td>4</td>
</tr>
<tr>
<td>What happens if things change during a contract?</td>
<td>3, 4</td>
</tr>
<tr>
<td>What about disputes?</td>
<td>3, 4</td>
</tr>
<tr>
<td>Does your contract management system include a review and evaluation capacity? Do you know if contracting or funding arrangements are effective? Are the intended results being achieved? How well have particular contracts worked? How well does your relationship management work? Does this information feed into policy, funding and contracting decisions?</td>
<td>5</td>
</tr>
<tr>
<td>What happens at the end of a contract?</td>
<td>6</td>
</tr>
<tr>
<td>Does the Health Partner understand what happens at the end of the contract?</td>
<td>6</td>
</tr>
</tbody>
</table>
Executive Summary

These guidelines are for the Papua New Guinea Government Health Agencies as they manage the contracting and other funding arrangements with Health Partners. Government Health Agencies include the National Department of Health (NDoH), Provincial Governments and Provincial Health Authorities. The Health Partners are organizations involved in the provision of health care. They may be non Government organisations (NGOs), churches, international NGOs, industry groups or the private sector. These guidelines are aimed at contracting for the provision of services (“outputs”) with the Health Partners, or otherwise providing funding to the Health Partners, not for the routine purchase of inputs such as drugs and supplies.

The NDoH is the steward of the unified health system. The NDoH welcomes the contributions of churches and other non-governmental organisations, the private sector, industries and traditional health care providers.

The guidelines are to apply to contracting relationships with for-profit organisations as well as not-for-profit organisations, but with a particular emphasis on relationships with not-for-profit organisations. The Government has expressed a clear wish for a good working relationship with the community, church, and other health sector providers. These guidelines are intended, among other things, to assist in building this good relationship.

Government policy sets guiding principles for entering into new partnership arrangements. A Government Health Agency would have regard to these principles before entering into any new partnership or renewing existing partnerships. The Government Health Agency would make the final decision on guiding principles but these would include the following:

- There must be recognition of the stewardship and policy-setting role of government.
- The objectives of the partnership must be consistent with the objectives of the National Health Plan.
- The Health Partner must have sufficient capacity to account for government funds.
- The outcomes of the partnership must reflect the needs of recipients and users.
- The outcomes of the partnership must focus on quality.
- Both parties must act in good faith.
- Both parties must recognise autonomy and objectives of the other party.
- The partnership must contribute to universal access, equity, and sustainability.
- Priority must be given to the particular health needs of vulnerable groups such as women and children.
- The partnership must not duplicate or weaken other health services provided in the area (especially of a similar nature).
Contracting or funding arrangements can take a number of forms:

- either full or partial funding of the agreed services;
- entitlements attached to the user of a service;
- funding on the basis of outcomes achieved;
- grants (funding provided so long as certain conditions are met); or
- full or partial devolution of decisions on the allocation and use of funds to a community organisation.

This guide is intended to provide assistance to the Government Health Agency in relation to all of these contracting or funding relationships. Health Partners may also find it a useful reference. The term “contracting” is used generally throughout, although in some contexts other forms of agreement may be involved.

**Principles of Good Contract Management**

A number of principles underpin these guidelines:

- Services purchased through contracts and other types of funding relationships should contribute to the achievement of the objectives of the National Health Plan. Contracting should reflect the needs of the ultimate users or recipients of the service.
- Contracts should provide appropriate accountability for public money.
- Contracts should represent value for the public money.
- The quality of service delivery will usually be of central importance.
- The Government Health Agency should act in good faith.
- The Government Health Agency should understand the nature of the organisations they contract with.

Contracting and funding relationships with the community organisations should be consistent with the relationship the Government Health Agency seeks to have with the community and voluntary sector. This implies:

- Recognising the objectives of both parties.
- Respecting the autonomy of the church, NGO and private sector.
- Communicating in an open and timely manner.
- Working constructively together.
- Recognising the responsibilities of each party to its stakeholders.

**Contract Lifecycle**

These guidelines cover all aspects of the contract lifecycle:

1. Planning
2. Selecting a Provider
3. Negotiating the Contract
4. Managing the Contract
5. Review and Evaluation
6. Starting Over
An important issue to think about is at which stages the Health Partners you deal with should be involved in these processes. In many cases there will be advantages to involving Health Partners early in the process, at the planning stages.

**Contract Planning (Chapter 1)**

Contracting should take place within a structured contract management system. A key part of this is planning. The Government Health Agency needs to be clear about:

- Their overall objectives.
- The means they are using to achieve those objectives.
- The nature of the organisation they are likely to be dealing with, and the relationship they expect or wish to have with the organisation.
- Their own contracting policies and capability.
- How they will secure accountability for public money.
- The budget constraint they operate under.
- Risk management.

**Selecting a Provider (Chapter 2)**

The Government Health Agency can identify potential providers in a number of ways:

- Asking other Government Agencies, local Government, or other bodies.
- Asking other Health Partners, particularly umbrella groups who will have information about potential Health Partners providers.
- From published information such as accreditation or registration.
- Advertising for expressions of interest.
- Conducting tenders for services.
- From an existing provider they have a relationship with.
- Contract managers should be aware of suitable providers in their area.
- Health Partners may take the initiative to suggest services.
- Information about potential providers may be available from needs assessment or service planning.

A contract will often be one part of an ongoing relationship between the Government Health Agency and a Health Partner. Health Partners are not simply an extension of the Government. They have their own objectives and interests. The contractual relationship should not be used to prevent the Health Partner commenting on public policy matters. To the extent that Health Partners receive public money, they are, in turn, accountable for that money. They will also be accountable to their stakeholders and clients. A purchasing organisation needs to satisfy itself that a Health Partner can and does deliver the service and in a manner consistent with the values and standards the Government Health Agency expects. Ongoing relationship management may involve an element of assistance or capability development.
Negotiating the Terms of the Contract (Chapter 3)

The next step is to negotiate the contract itself. The contract sets out each party’s undertakings to the other. Negotiations will usually focus on the quality and quantity aspects of the specifications for service delivery, and the price. The price set needs to be realistic, given the quality requirements, and the likely need for ongoing delivery. Contract managers should negotiate within a clear set of parameters. It is normally in the interests of both the Government Health Agency and the Health Partner to approach negotiations in a collaborative rather than a confrontational manner. A contract can range from a document of hundreds of pages of detailed specification, to a document of a few pages. The nature of the document signed will depend on the:

- Nature of the activities or services being provided for.
- Nature of the parties to the contract and the relationship between them.
- The amount of money involved.
- The term of the contract.
- Risk and risk management – what needs to happen if things do not turn out as planned?

Managing the Contract and Monitoring (Chapter 4)

Signing the contract is only part of the Government Health Agency’s responsibilities for contract management. They are also responsible for the ongoing management of the contract once it has been signed and the relationship with the Health Partner providing the service.

This will involve:

- Monitoring (including verifying) delivery against the contract.
- Assessing the effectiveness of the services delivered.
- Approval of payment, and making payment according to the contract.
- Ongoing relationship management.
- Dealing with any differences of view with the Health Partner.
- Negotiating changes to the contract.
- In extreme cases, taking action to enforce compliance with the contract, including exercising any rights to terminate the contract.

This provides the basis for:

- Assessing whether the Health Partner has delivered what was contracted for.
- Accountability for public money.
- Paying money to the Health Partner.
- Making decisions about how to proceed at the expiry of the contract.

Review and Evaluation (Chapter 5)

Review and evaluation overlaps with monitoring, but it merits separate treatment, given that it extends further than an individual contract. Government Health Agencies must
build a reflective capacity into their contract management system. They should consider the following questions:

- Is the programme or policy being delivered by way of contracting effective?
- Does it represent value for money?
- What improvements can be made?
- How effective has the Health Partner’s contract management been?
- How have the Health Partners performed in respect of particular contracts?
- How have individual Health Partners performed against our assessment of risk?
- How has the Agency performed in respect of individual contracts?
- How effective is the Agency’s relationship management?

Starting Over (Chapter 6)

The end of a contract is an important part of the contract management cycle. Government Health Agencies need to consider what to do in the future well before the end of a contract and consult with the Health Partner. There are a number of possible approaches:

- Renegotiating the contract with the supplier or rolling it over.
- Selecting another supplier or tendering.
- Altering the scope of a service.
- Discontinuing the service.
**Introduction**

*The Government, through Government Health Agencies, provides funding to a large range of Health Partners, for a wide range of public purposes. These funding relationships are with churches, not-for-profit organisations (including local community and voluntary sector organisations) as well as industry and private sector groups. The Government has expressed a clear wish for a good working relationship with health partners, and these guidelines are intended, among other things, to help support this relationship.*

These guidelines outline some general expectations, and offer some general advice to the Government Health Agency about managing the establishment, administration and monitoring of arrangements with Health Partners to fund services (“outputs”) that support the Government’s objectives. The guidelines are not intended to apply to the routine purchase of Government Health Agency inputs (e.g. stationery or I.T. services), for which ample advice exists already and which involve straightforward commercial contracts.

The guidelines focus particular attention on relationships with not-for-profit organisations such as churches and NGOs, but will also be relevant to contractual relationships with other Health Partners. The guidelines do not contain any mandatory requirements, but Government Health Agencies should think very carefully before they decide to take a different approach, and be clear about their reasons for doing so. If a Government Health Agency chooses to take a different approach, they should explain their reasons for doing so to the Health Partners they are funding. It may be best to document these reasons to prevent misunderstandings.

All these funding arrangements involve an agreement of some kind. That agreement is usually a contract that can be legally enforced by either party (and hence the term “contracting” is used generally throughout these guidelines), but in some cases may involve a conditional grant. The agreement represents an exchange of undertakings by the parties to each provide something of value to the other, although in practice that benefit may be provided to a third party. The agreement should provide:

- Clarity about the undertaking of each party to the other.
- Certainty about the performance of those undertakings by each party.
- Justification for the payment of public money and subsequent accountability for that money.
- A clear legal underpinning to the relationship.

Contracting, however, involves more than agreeing the terms of a contract. It is important that Government Health Agencies see the contract as embedded in a contract management system or cycle that involves:

- Planning
- Selecting a provider
- Negotiating the contract
- Managing the contract and monitoring
• Review and evaluation
• Starting over

It is also important that Government Health Agencies recognise that the Government’s relationship with a Health Partner normally extends beyond the requirements of the contracting process. The PNG health system is heavily dependent on the churches for the provision of services, and the churches can be important sources of innovation, information, and useful policy and operational advice. Where relationships such as this exist, the Government Health Agency needs to see contract management in terms of supporting the wider relationship with the Health Partner.

**Principles of Good Contract and Funding Management**

A number of principles underpin these guidelines:

- Services purchased through contracts and other types of funding relationships should contribute to the achievement of the National Health Plan.
- Health Partners will similarly expect contracting arrangements to contribute to the achievement of their own objectives.

Contracting should reflect the needs of the ultimate users or recipients of the service.
Contracts should provide appropriate accountability for public money.

The information required is likely to vary depending on the amount of money involved.

Contracts should represent value for the public money.

The taxpayer should obtain the appropriate quality and quantity of service, and pay a reasonable price, for services that are effective in contributing to the achievement of the desired outcomes. The quality of service delivery will usually be of central importance.

Government Health Agencies should act in good faith.

Acting in good faith requires actively consulting Health Partners about their needs and views, considering what to do about what Health Partners suggest and providing relevant information that helps Health Partners to approach issues in an informed manner. In short, it is a “no surprises” approach which will help to build up trust.

Government Health Agencies should understand the nature of the organisations they contract with. Contracting and funding relationships with the community organisations should be consistent with the relationship the Government seeks to have with the Health Partners.

This implies:

Recognising the objectives of both parties
- Respecting the autonomy of the voluntary sector
- Communicating in an open and timely manner
- Working constructively together
- Recognising the responsibilities of each party to its stakeholders.
Chapter 1 - Planning

It is important that contracting and other funding takes place within a structured contract management system. A key part of this is planning. Government Health Agencies need to be clear about:

- Their overall objectives.
- The means to achieve those objectives.
- The population to which services are being supplied.
- The nature of the organisation the Agency is likely to be dealing with, and the relationship they have with the organisation. Is it a local community organisation? A church?
- The Agency’s own contracting policies and capability.
- How to secure accountability for public money, including direct payments by patients.
- Where responsibility will lie for all the health service building blocks.
- The budget constraint the Agency operates under, and is likely to operate under in the future.
- Risk management.

1.1 Defining Objectives

The Government Health Agency needs to be clear about what it is trying to achieve. What are the Government’s or the organisation’s objectives? These should be set by reference to Government policy or statute, and should be underpinned by an analysis of how an intervention will contribute to the objectives, including addressing the needs of those who are expected to benefit from it. This will usually involve consulting with the ultimate users or the service, and local or community organisations that have an interest and expertise in a particular issue, as well as drawing on empirical evidence and international literature.

An important part of policy analysis is assessing whether purchasing services from, or entering into a funding relationship with Health Partners is the best intervention the Government can make, in particular whether it is better or more cost effective than the direct provision of goods and services by Government Health Agencies. Other forms of intervention include:

- Direct provision of goods and services by Government Health Agencies;
- Benefits;
- Regulation;
- Taxation; and
- Publicity.

Several factors may limit the Government Health Agency’s ability to contract with Health Partners:

- Legal considerations (e.g. Parliament may assign particular responsibilities to agencies or office holders, with limited authority to delegate);
• Government policy may constrain organisations’ ability to contract;
• Convention or code of conduct requirements may constrain Government Health Agencies’ ability to contract;
• It may be difficult to contract for only part of a service, if it is an integral part of the whole service; and
• There must be a supplier or the potential supplier.

Contracting or other funding arrangements are the last step in a process of research, advice, planning and prioritising.

1.2 Defining the Service

The Government Health Agency should then decide upon and describe what it is purchasing or funding (whether that is a service or something else). This should be informed by a needs analysis that draws upon:

• The objectives sought.
• Information on the effectiveness of Government interventions (e.g. evaluations).
• Any relevant national standards or legal requirements.
• Appropriate analysis, including an assessment of the needs of the users of the service.
• An understanding of the Health Partners available to offer services.
• Consultation with ultimate users, Health Partners, potential providers, and other stakeholders. The importance of meaningful consultation within the context of policy development and needs assessment has been consistently highlighted by voluntary organisations, local community organisations and Health Partners.

The desired outcomes should inform the entire contracting process. The Government Health Agency should have a clear view of the way in which services being purchased will contribute to the achievement of the outcomes, and that should be reflected in agreements. This provides important contextual information. It will also provide a reference point for reviewing the effectiveness of the service delivery, for agreeing any changes to the contract should they be needed, and for evaluation.

The typical funding arrangement is where one or more Government Health Agencies pay a Health Partner for the provision of a set of services, often to a third party. In some cases the purchasing Agency will have a clear idea of the nature and quality of service that it wants to purchase from a Health Partner, based on a realistic and robust needs analysis, involving appropriate consultation. In such cases negotiations with the Health Partner are likely to be around the details of the service to be provided. In the absence of robust needs analysis there is a risk of a mismatch between a Government Health Agency’s views of what services are necessary, and those of the Health Partners they deal with. The Government Health Agency may purchase an existing service that provides a starting point for thinking about the desired service, although this should not constrain it from considering new ways of achieving its objectives. The Government Health Agency may also have to purchase services that comply with relevant national standards, and may also need to maintain national consistency in the delivery of services.
It will usually be sensible to develop the description of the service in consultation with Health Partners (current and potential), users, other Government Health Agencies, and other stakeholders. Many Health Partners regard consultation as a central element in their relationship with Government, including local community and voluntary sector organisations. Health Partners that provide services to their communities will often have a good understanding of the particular needs of their communities. Consultation may need to proceed at community level and services be provided at that level.

Consultation and openness are important in making policies and programmes acceptable to the public, and can help communities understand the constraints faced by Government Health Agencies. Listening to the views of stakeholders can help anticipate implementation problems, identify alternative options for providing services or activities, and can ensure that those providing the service are clear about what is being asked of them and how performance will be determined.

Consultation does not mean agreement or even negotiation, but it is more than notification. It implies providing parties with sufficient information to allow intelligent responses to be made, and the Agency entering into consultation without having finally determined its position. Government Health Agencies need to be clear that they have properly understood and taken into account the concerns of the people they have consulted. During consultation, they should take care not to be overly influenced by mobilised stakeholder groups to the detriment of groups without a strong voice. Several consultation rounds may be required. Proper consultation is likely to be the key to building a good relationship based on trust. Agencies need to manage stakeholder expectations around consultation, as while consultation helps provide information and good argument, it does not necessarily produce a decision. The amount of consultation effort should generally be proportionate to the length of the relationship and scale of services at stake. To help use resources most effectively, Government Health Agencies could, for example:

- use each others’ networks and consultation mechanisms.
- share information gathered from consultation, and share best practice on consultation.
- develop joint mechanisms to consult communities together.

Questions that may need to be discussed during consultation include:

- What outcomes are being sought?
- What is an appropriate level of service?
- Will the service be accessible to and used by the target group?
- How would Health Partners and service users prefer that the service be delivered?

In some cases the definition of the service may be developed (or the service may already be delivered) by the Health Partner itself, which proposes a set of activities that, in turn, form the basis for the contract.

There may be circumstances where contracts for blocks of related services, rather than individual services, will better meet the needs of the service users and provide for flexibility.
of service provision. This may require extensive co-operation between Government purchasers, including possibly single multi-service contracts or the use of a managing Agency to manage the ongoing relationship and contract with the Health Partner on behalf of the other Government Health Agencies. The selection of the manager should be discussed with the Health Partner concerned, and preferably proceed with the agreement of the Health Partner and service recipients if possible. The Health Partner may also wish to retain relationships with all the Government Health Agencies involved. The managing Agency selected should be the most suitable to the overall aims of the service provision.

The definition of services in the contract should reflect the key elements of the service. It will need to strike a careful balance between:

- Including enough detail to ensure there is certainty (for both the Health Partner and the Government purchaser) as to the nature and scope of the service.
- Allowing the Health Partner flexibility.

Where to strike that balance will require a judgement. The level of detail required will vary. Care must be taken to avoid compromising the effectiveness of service provision by over-prescription of its form and content. The definition of services may also be influenced by the relationship between the Health Partner and the Government Health Agency. For example, a more conservative approach to specification might be appropriate when dealing with a Health Partner without a proven track record.

The definition of the terms of the contract will usually include information on price, quality and quantity. Quality will usually be of central importance. Timing, location and client eligibility may be important aspects of quality, depending on the nature of the service. The quality specifications need to be:

- Relevant and practical in terms of the service provided.
- Readily measurable without disruption to service delivery, intrusion into confidential Health Partner-client relationships or unreasonable compliance costs.
- Cost effective in minimising risks to the purchaser and the service clients.

Maintaining a reasonable consistency of standards will require significant attention from the Government Health Agency where similar services are being provided nation-wide.

Regulatory requirements or external quality standards may define aspects of the quality standards. For example the quality of a contract for training should usually be specified by reference to the PNG national standards. Government Health Agencies should make use of any available guidelines and standards. Use should also be made of examples of best practice, and benchmarking.

An agreement that covers the delivery of outputs may include information on inputs, where:

- Inputs are an important aspect of the definition of the output or service to be provided (e.g. suitably qualified staff or process requirements).
- There is little distinction between outputs and inputs (this might occur, for
example, if the point of the exercise is to develop an organisation’s capability rather than to provide services to other parties).

- An input is particularly important (e.g. staff training).

There are risks to doing this however, notably:

- Failing to secure the desired outputs or services.
- Losing a focus on the objectives and services.
- Constraining the flexibility of the Health Partner to best manage its resources.
- Unnecessary compliance costs.

### 1.3 Funding Options

The Government uses a number of different funding arrangements, reflecting different activities that are being funded:

- either full or partial funding of the agreed services;
- entitlements attached to the user of a service;
- funding on the basis of outcomes achieved;
- grants (funding provided so long as certain conditions are met); or
- the full or partial devolution of decisions on the allocation and use of funds to a community organisation.

#### 1.3.1 Part Funding

In some cases Government Health Agencies will provide funding explicitly on the basis of making a contribution to a service or activity undertaken by a Health Partner, without any expectation that the Government health Agency will pay all the cost of the service.

Part payment for services may be appropriate where:

- the Health Partner approaches the Government Health Agency to seek assistance for an activity it already undertakes or intends to undertake. The Government health Agency contribution provides for a marginal extension only
- a contribution is agreed by both parties to be short term only
- Health Partners as part of their mission wish to contribute from their own resources
- other organisations or foundations are contributing, and
- the arrangement leaves intact the Government Health Agency’s ability to arrange for the provision of these services by Health Partners if required in the future.

Part payment is (at least in principle) distinct from the situation in which the Health Partner over-delivers on the agreed output which the Government Health Agency is paying fully or nearly fully for (e.g. by producing more of it). It is also distinct from the situation in which several Government Health Agencies pay for all of a service. It can, however, become problematic if the Government Health Agency either expects to exercise rights as if they were purchasing all of the output, or represent to other parties in their own reporting that they have secured the delivery of outputs they had only made a contribution to. The contract and reporting requirements should reflect the contributory nature of the funding.
1.3.2 Contracting for Outcomes

Usually agreements are based on the services (“outputs”) that the Health Partner agrees to provide, with outcome information providing context. It is possible to contract for outcomes directly, although this will still normally involve providing information on the services to be provided (i.e. contracting for outputs as well). This is possible where:

- The contract is for an outcome within the control of the service provider.
- The service provider Health Partner will be held accountable for the achievement of the outcome (i.e. failure to have the desired impact and achieve the outcome means the provider Health Partner does not get paid, or not paid in full).
- There is a good working relationship with a provider Health Partner with a proven track record.
- The purchasing Agency has the contractual and policy expertise to manage this type of approach.
- There is high quality information disclosure to support the contract.

Generally, Government Health Agencies and Health Partners cannot be held accountable for outcomes because of the difficulty in attributing a change in an outcome solely to the actions of the Agency or Health Partner. Contracting for outcomes is feasible if the NGO can reasonably be held accountable for the achievement of the outcome, and the meaning of “success” cannot be manipulated.

1.3.3 Paying to Develop Capacity

There are some policies where the main objective from the Government’s point of view is actually to develop the capability of the Health Partner, without any expectation that a service will be delivered. This is quite distinct from the more usual situation where a purchasing Agency may assist a supplier to enhance their capacity to deliver contracted services. In such cases the contract should be drawn up to provide clear expectations as to how the money will be spent, which may include the specification of inputs. This is described further below in Section 1.11.

1.4 Relationships

Relationship management is a key aspect of contract management. An agreement not only provides for the delivery of services in exchange for payment but also reflects and underpins a relationship between the parties. In some cases that relationship is limited to the terms of the agreement. Often, there will be a wider relationship, best served by seeking mutual respect and sufficient knowledge on the part of both Government Health Agency and Health Partner to be able to preserve each other’s interests. Many agreements between Government Health Agencies and community organisations such as churches, however, involve a much richer relationship, because:

- The relationship may exist in the absence of any contractual relationship. Such consultation can ensure that the outputs and outcomes being sought are those of interest to the Health Partners and communities, not just the Government Health Agency; that services are coordinated with those of other Government service providers; and that any issues arising about the contract can be addressed with a consultative approach.
- The relationship may continue into the medium to long term.
- Each party may expect to undertake repeat business with the other.
- The Government Health Agency may rely on a significant level of alignment between its objectives and those of the Health Partner.
- The services delivered may be difficult to specify in all respects in advance – this implies some level of discretion will rest with the supplier.

1.5 Incentives

It is important to consider the incentive effects of the agreement, and associated processes on the Health Partner, and the users or recipients of the service. How will expectations and actions affect the way people behave? The most obvious incentives are the basic terms of the contract, particularly the “rewards” (usually payment) and “sanctions” (what happens in the case of non-delivery).

There are several ways of building explicit incentives into contracts. Incentives can be linked to quantitative aspects of producing outputs. For example one can implement a mechanism where a set of outputs are all rewarded with a unitary bonus; for example for each outpatient visit a certain reward will be paid. This reward can be a top up on the regular payment mechanisms (which can be based for example on a global grant or capitation). Most often these types of arrangements need a defined set of interventions that are rewarded. The interventions that will be rewarded will necessarily depend on the services covered by the contract. In any case, a set of indicators will need to be defined; these indicators will then be followed and rewarded depending on the results achieved by the provider. The indicators used can also focus on aspects of quality of care. The difficulty with the quality rewards is to find indicators that effectively measure quality and that can be verified.

An important aspect of introducing explicit incentives in contracts is that the purchaser can effectively influence the behaviour of the provider. Therefore rewarding some interventions and some types of processes (that influence for example the quality of care or that concern the respect of standards) will guide the provider behaviour in the direction wanted by the purchaser. Building explicit incentives in contracts needs to be reflected also in the contract verification and monitoring. It is important there is a robust mechanism which allows the actors to define the actual results of the providers and which creates an obstacle for cheating and gaming the incentive mechanism.

There are a growing number of experiences, in high income countries as well as in the low income countries, of using explicit incentives in performance-based contracts or performance-based financing. There needs to be further work using this growing knowledge base in order to find suitable incentive options that will work in the PNG context.

Other aspects of the agreement and associated processes may have significant incentive effects as well, such as:
- The specification of the service.
- The duration of the contract.
• The process for selecting the Health Partner (including tendering).
• The credibility of the contract management process.
• What happens at the end of the contract.

1.6 Accountability for Public Money

Accountability for public money is central to contracting and funding arrangements in the public sector. This involves:

• Being clear why and how money is to be spent.
• Ensuring that it is spent for the purposes it was provided.
• Having reasonable assurance that the expenditure is value for money.
• Having a credible response where the expected services are not provided.
• Being transparent about all sources of income, including out of pocket payments.
• Accounting to Ministers, Parliament and the public.

Health Partners have a direct interest in effective accountability arrangements. They will accept that there must be accountability for public money. An arrangement that does not provide for adequate accountability for public money is unlikely to be durable. Health Partners themselves will also have to account to their stakeholders for their activities and the stewardship of their resources.

Generally any agreement between a Government Health Agency and a Health Partner will be a contract or conditional grant. The difference between a contract and a conditional grant lies in the mechanisms available for legal enforcement, not its length or specification. Whether or not a document or arrangement is a contract is a matter of fact (which can be tested in court). An agreement that has the elements of a contract is likely to be enforceable as one, whether it is called a “contract”, an “agreement”, a “memorandum of understanding” or something else. A contract involves:

• Contractual intention (offer and acceptance).
• Consideration (something of value, usually money, given by one party to the other in return for its performance of its part of the contract).
• Certainty of terms (it must be reasonably clear what each party has to do).
• The legal ability of the parties to contract may also be important.

Contracts offer a number of significant advantages over conditional grants:

• The law relating to contract is relatively well developed.
• They provide a range of mechanisms for enforcement to each party that are not available under a grant, such as:
• Damages (which are not limited to return of the money as with a grant).
• Requiring performance of the contractual terms.
• A contract may establish enforceable rights for beneficiaries who are not parties to the contract (i.e. recipients of services) as long as this was clearly intended when the contract was entered into.
As such, a contract provides a more reliable basis for ensuring accountability for public money and these guidelines operate on the basis that a contract will usually be the preferred mechanism. A conditional grant may, however, be enforceable to the extent that the recipient has to fulfil the conditions to receive or retain the grant. The conditions of a grant will provide the basis for accountability. In contrast to a contract it is not clear that there are any remedies for poor performance, if the recipient can claim to have met the conditions of the grant (if poorly).

All Government Health Agencies work to a budget. This should be reflected in an Agency’s contract management. In general it will be sensible for the Health Partners to be informed of this budget constraint.

1.7 Risk

Agreements will usually involve some implicit risk sharing. These risks may be in terms of:

- Outcome achievement (including unintended negative effects).
- Service delivery (both quality and quantity).
- Value for money (including waste and fraud).
- Capability (managing capability to ensure ongoing delivery. See Section 1.11)
- Fiscal risk.
- Control risk.
- Reputation or political controversy.
- Legal.

Risk may arise from the Government Health Agency’s overall contract or funding management (e.g. tendering) as much as from a particular contract or relationship with a Health Partner. The Government Health Agency needs to think about risk management as part of their contract management system, and should expect Health Partners do likewise.

In general, it will be sensible for risks to be borne by the party best placed to manage the risk. Different organisations may also have different risk preferences – some organisations are more willing to accept risk than others. Government Health Agencies should not bear all the risk, but they do need to assess the capacity of the parties they deal with to bear risks. Many community organisations may not be in as good a position to manage some risks as either commercial firms or Government Health Agencies. Expecting community organisations to bear most of the risk could lead to:

- NGOs being reluctant to sign agreements.
- The viability of Health Partners being compromised.
- Unexpected behaviour by the Health Partner as it seeks to manage its risks.

Perceptions of risk will often influence the level and nature of the monitoring undertaken by Government Health Agencies. This is described further in Section 4.1 below.
1.8 The Contracting Capability of Government Agencies

If the Government Health Agency has significant contract management responsibilities, it must treat these as part of its core business, and the staff involved must understand the processes that the Agency employs to manage contracting or other funding responsibilities. The Agency’s contract management system needs to be structured and flexible enough to manage significant shifts in Government policy. Poor quality contract management poses serious risks to the Government and the Agency.

An Agency’s contract management is dependent on:

- The quality of the systems employed:
  - Clear policies and processes for contracting or other funding responsibilities - planning, Health Partner selection (including tendering), quality assurance, relationship management, contract negotiation and drafting, and monitoring, and internal controls (e.g. one person should not be responsible for all aspects of contract management).
  - Clear ethical standards, which address conflicts of interest and promote required standards of public sector conduct.
  - Adequate recordkeeping policies, practices and systems that enable the creation and maintenance of full and accurate records of Agency decision-making and actions.

- Management capability:
  - An organisational culture committed to high quality contract management.
  - Alignment of the management and staff with the objectives of the organisation, including operating within the budget constraints and accountability requirements of the Agency.
  - Good relationship management and negotiation skills, tested by reference to results achieved in contracts and relationships.

- Clear assignment of role and responsibility to managers and staff responsible for contracting, including delegation of authority, such as:
  - The extent of managers’ ability to sign contracts.
  - The areas in which managers have discretion.
  - Which decisions are to be taken regionally and which nationally.

- Human resource capability:
  - Suitably qualified and experienced staff.
  - Access to specialist expertise, including legal, financial, contracting, policy, and cultural expertise, as well as expertise about the community and voluntary sector.
  - Training and guidance for staff, including training in dealing with community organisations where that is relevant.
  - A good understanding of the Health Partners that the Government Health Agency contracts with, and the people and communities to which services are provided.
Government Health Agencies must keep their contract management under review. This should include:

- Having a clear understanding of the cost of contract management.
- Reviewing contract management against departmental and central guidelines.
- Seeking and taking account of feedback from Health Partners and users.
- Benchmarking.

1.9 Thinking Wider than the Health Agency

A Government Agency should be aware of any Government policies or services that relate to its activities. In particular it should consult other Government Agencies that also may contract with the same Health Partners, or whose activities are important to the effectiveness of the Health Partner’s services. This is important in terms of achieving objectives, minimising compliance costs (see Section 1.12 below), and avoiding the risk of either unplanned gaps in services or the Government paying twice for the same service.

As part of the process of selecting a provider, Government Health Agencies should require a Health Partner to disclose whether or not it has applications to or is receiving funding from other Government Agencies for the same or a similar purpose. Verifying the information provided should be part of the normal contract management and monitoring activities (see Chapter 4 below). Government Heath Agencies should consider in advance how they will deal with any “double funding” and build this into their contracts (e.g. halting or altering any further payments for the service in question, or requiring the Health Partner to repay any funding received for that service). It may also be important to know about relationships between local Government and Health Partners.

Government Health Agencies may wish to jointly explore the scope for having consistent documentation, or relying on vetting or accreditation of a Health Partner by another Government Agency, taking into account any requirements specific to a particular purchaser. This may be useful, in particular, where the Government Health Agencies are dealing with the same or similar Health Partner organisations.

Government Health Agencies should consider the options to deal with situations where multiple Government Agencies contract with one Health Partner for a set of related services. These can be formal arrangements such as integrated contracts, “joined-up” and pooled funding arrangements or informal arrangements such as networks and alliances. Such arrangements can be costly to all of the parties involved. Agencies should consider, prior to participating in these types of arrangements, if the arrangement: will produce benefits that outweigh the costs for all of the parties involved.

- provides clear accountability for services or actions.
- has an agreed and understood rationale that justifies the inclusion of all participants.
- demonstrates that the outcomes for people (clients) and communities can be improved by joint action.
1.10 How Long Should the Agreement Be For?

A short-term agreement will be appropriate in some cases, such as where:

- The service or activity is only of limited duration.
- Funding will only be available for a limited period.
- The Government has announced a change of policy.
- There is uncertainty about the ability of the Health Partner to deliver.

Short-term agreements can, however, have a number of disadvantages:

- Identifying the Health Partner and negotiating a contract impose significant costs on all parties.
- They may focus attention on negotiating and signing the contract rather than service delivery.
- They can be more expensive (e.g. to cover establishment costs).
- They may cause financial uncertainty to the Health Partner.
- They may undermine the ability of the Health Partner to perform the services (e.g. if a lack of job security limits their ability to employ or retain the right staff).
- They may discourage planning, investment and innovation.
- They may undermine relationship-building objectives.

Where ongoing service delivery is required, and the Government Health Agency expects to have a medium to long-term relationship with a Health Partner, a longer-term agreement may be appropriate (e.g. 3-5 years). This is something the Agency should think about if a longer-term contract is actively sought by the Health Partner in order to better perform the service. This is a matter of judgement and negotiation, taking into account the:

- Service to be delivered.
- Views of the Health Partner that will be delivering the service.
- The track record of the Health Partner delivering the service.
- Nature of the relationship with the Health Partner.
- Life cycle of the relevant policy (has the policy been changed or is it under review?).
- Contracting capability of the Government Health Agency (limited contract management ability implies a conservative approach).
- Negotiation costs.
- Effect on value for money for the service.

A one-year appropriation does not prevent a longer contract. A number of approaches can be adopted to provide a balance between giving reasonable security to the Health Partner and protecting the Government Health Agency from risk, such as:

- Having a multi-year agreement, but negotiating the services and funding annually within that agreement. Some Health Partners may not wish to enter into a long-term contract if the prices are fixed.
- Including a review at the mid-point of the contract.
• Having a clear expectation of the agreement being renewed at the end of the year, subject to satisfactory performance, and funding being available.
• Including an explicit provision in the agreement that allows it to be terminated in the event of an appropriation not being made, Government policy changing or non-performance.

A risk government faces is ensuring long term sustainability of services. This is seen in contracting with external organisations which may be committed to PNG for a limited time, so that the contract needs to take into account how services and facilities will be maintained once the organisation has left.

It is important to be clear with the Health Partner about what the length of the contract is and the scope for renewal. This is particularly important when establishing short-term contracts of a one-off nature with Health Partners who are used to longer contracts – it is important to be clear that the contract will not be renewed so that the health partner does not anticipate that this will automatically occur.

1.11 Investing in Health Partner Capability

Capability is what an organisation needs, now and in the future, to deliver agreed services in order to achieve desired outcomes. Capability includes:

• The people in the Health Partner organisation, in terms of both the skills and competencies they bring, and the mix of individuals within it.
• The other resources the Health Partner uses to do its work (e.g. money, information, technology, fixed assets).
• The systems, processes or ways of doing things that the Health Partner uses to deploy its people and resources.
• The structures, forms and governance arrangements within which the Health Partner operates.
• The Health Partner’s culture.
• The way the Health Partner manages relationships and partnerships in order to deliver services.

There are two situations in which an investment in capability might be expected:

• An explicit Government Health Agency decision has been taken to build capability.
• Future Health Partner capability is needed in order for the Government Health Agency to continue to be able to obtain services.

It is important to note that implicit in the amount being paid by the Government Health Agency is compensation, not only for the Health Partner’s out of pocket costs in providing those services, but also for the cost of maintaining or building the capability of the Health Partner to continue to provide those services effectively in the future. Health Partners, at their discretion, are able to apply any revenue obtained from the Government under a contract for services to capability building, as long as the services are delivered as expected. This is the normal and preferred way of providing for Health Partners to obtain
the capability that they require. The Government Health Agency can normally expect Health Partners to price their service to cover the true full cost (fixed costs and variable costs, including capability maintenance costs such as depreciation).

If, however, the Government Health Agency agrees that it would be desirable to provide direct financial support (additional to any contract for the provision of services) to a Health Partner to help build its capability, then an output class appropriation is inappropriate and another type of appropriation should be used. If this support is not in the form of a loan, an appropriation for other expenses should be used.

Investing in Health Partner capability can also include encouraging and promoting good practice and appropriate standards, rather than direct financial support. For example, encouraging good employer provisions and practices to build people capability might take the form of:

- encouraging and recognising the emphasis that a Health Partner places on best employment practices within their workplace (e.g. by negotiating a provision in the contract that obliges the Health Partner to undertake its work in a best practice manner); or
- helping develop new participatory mechanisms or advice on equal opportunity policy for employees within a Health Partner’s workplace, as part of the parties’ agreed contractual arrangements.

Because the focus of encouraging good practice and appropriate standards is to build capability, it is best to develop such arrangements in consultation with the Health Partner. In some circumstances it may not be practicable for the Health Partner to implement such policies or mechanisms (e.g. very small size).

1.12 Compliance Costs

Any contract or funding management system will necessarily impose some costs on both parties to the contract, but unnecessary compliance costs should be avoided for both parties. There are a number of areas in which unnecessary compliance costs can be reduced:

- Contract duration.
- Standardised internal processes.
- “Short form” contracts that can be used for smaller contracts, reserving “long form” contracts for larger contracts. Inclusion in the agreement of detailed administrative requirements lengthens the contract with material that could just as easily be agreed outside the contracting process. This would mean that alterations to administrative requirements would not require a change to the contract.
- Standard conditions that are incorporated into all contracts (it may be sensible to discuss the development of such standard provisions with the parties the Agency regularly contracts with, since they may be ambivalent about standard provisions – welcoming any reduction in compliance costs, but wanting scope to negotiate over some of these conditions).
• Standardised reporting templates.
• Monitoring and reporting regimes that make as much use as possible of the information that Health Partners develop for their own accountability purposes. This could include, for example, information provided to accreditation, certification or licensing bodies.
• Monitoring and reporting regimes that make as much use as possible of the information that other Government Agencies that fund the Health Partner collect for their own accountability purposes.

1.13 Regulatory Considerations

The Government Health Agency must understand any regulations relevant to their contracting arrangements. These include:
• Regulations specific to their sector
• Labour regulations
• Other
Chapter 2 – Selecting a Provider

2.1 Suggested Approaches

A key step in contracting is selecting the Health Partner to deal with. A number of approaches can be adopted:

- There may be an existing provider that the Government Health Agency has a relationship with.
- Contract managers should be aware of suitable Health Partners in their area.
- Health Partners may take the initiative to suggest services or activities.
- Information about potential providers may be available from needs assessment or service planning.
- Ask other Government Agencies, local level Government, or other bodies.
- Ask other Health Partners, particularly umbrella groups who will have information about Health Partner providers.
- Published information such as accreditation or registration.
- Advertise for expressions of interest.
- Tenders for services.

The quality of the service or activity being paid for will usually be of central importance in the selection of the Health Partner.

2.2 Relationships with the Church and NGO Sector

A contract with a church or NGO will often be part of an ongoing relationship. That relationship may begin before any contract or funding agreement is in place, and may continue in the absence of any such agreement. The relationship may involve more than the service or activity being paid for. It may also mean involving the community organisation in other activities such as policy development, recognising the information and expertise that many community organisations possess. Contract management needs to be thought about as an aspect of relationship management (and vice versa).

Health Partners are not simply an extension of the Government. They have their own objectives and interests. Health Partners may be involved in activities that the Government does not wish to fund. Health Partners, in turn, may only be interested in part of a service that the Government Health Agency wishes to purchase.

Service delivery will be coloured by the Health Partner’s objectives. This will be part of what is being paid for. These objectives need to be well understood lest they undermine the relationship between the Government Health Agency and the Health Partner. It is important for Government Health Agencies to ensure Health Partners can provide services in a culturally appropriate way to ensure the services will be effective. Mainstream Health Partners dealing with particular groups may sometimes need to consider collaborative ventures with community groups.
Government Agencies should not try to use the contractual relationship to prevent the Health Partner commenting on public policy matters, including funding issues. Equally, Government Agencies should also be careful to ensure that contracts do not breach public service standards of political neutrality.

To the extent that Health Partners receive public money, they are, in turn, accountable for that money. They will also be accountable to their stakeholders and clients.

Government Agencies must consider the implications of Health Partners’ separate status. They must:

- Avoid trying to control a Health Partner’s activities, outside of the contractual rights and obligations.
- Remember that the Health Partner will not automatically give priority to the Agency’s interests or those of the Government.

2.3 Capability of the Health Partner

Government Agencies need to be confident a Health Partner can actually do what it undertakes, and in a manner consistent with the values and standards the government expects. Information to provide this assurance can come from:

- The track record of the Health Partner and the ongoing relationship.
- From sources external to the Health Partner, such as:
  - The credibility of the Health Partner with users.
  - Accreditation, licensing or certification of the Health Partner.
  - External audit.
  - Legal personality.
  - Referees, including other Government organisations.
- From the Health Partner itself, such as:
  - Financial information e.g. audited financial statements.
  - Disclosure of complaints against the Health Partner (e.g. to a relevant professional disciplinary body).
  - Evaluation of the ability of the organisation to communicate with local communities.
  - Evidence of appropriate governance and management systems and internal controls. This may include, for example, adequate segregation of duties between the governing body and management, the presence of independent trustees or directors on boards (people who are not also managers or employees of the Health Partner), having good employer practices or using independent auditors.
  - Evidence of investment in appropriate quality assurance systems and certification processes relevant to the sector.
  - Training and experience of staff.
  - Specific investigation.

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11 See Glossary
• Evidence of adequate recordkeeping policies, practices and systems.
Some of these issues can be reflected in the contract, for example:
• The size of the contract.
• How the timing of payment is structured (e.g. a cautious approach to payment might be adopted with a Health Partner without an established track record. This requires judgement - too cautious an approach may compromise the Health Partner’s viability).
• Requirements as to the Health Partner’s accreditation or solvency.
• Monitoring.
• Ongoing assistance.

In some cases the Government Health Agency may want to consider assisting a Health Partner to develop the necessary capability (see Section 1.11). This will usually only be relevant for not for profit organisations, although there may be exceptions to this. Assistance could be:
• Part of the price.
• An additional amount directed to a specific activity or input (e.g. staff training).
• Assistance in kind.

In some cases it may also be sensible to see whether there are opportunities for collaboration between Health Partners (e.g. encouraging collaborative or partnership ventures between mainstream and local providers where the mainstream provider lacks the ability to provide culturally appropriate services).

2.5 Tendering or Not?

Tendering should be an important part of a Government Health Agency’s contract management system. Tendering involves inviting people to submit a bid to deliver the good or service that the purchaser wants. Government Agencies should develop clear criteria for determining when it is appropriate to tender for services rather than using one of the other approaches listed at the beginning of this chapter. Tendering might not be necessary where:
• The supplier has specialist expertise.
• There is only one supplier (this should be periodically tested).
• The service is relatively low cost, and the costs of tendering clearly outweigh the benefits.
• The service has been recently tendered for.
• The service fits with another service already provided by one supplier (the bundle of services as a whole may subsequently be put up for tender).
• There is not time to tender (e.g. an emergency). This might happen, for example, where a contract for an essential service has to be terminated at short notice. Poor planning, by itself, is a poor excuse for not tendering.

Tendering offers a number of significant advantages. It:
• Establishes the most competitive price and terms available.
• Provides fairness between potential suppliers.
• Reduces the risk of allegations of purchaser bias or political interference.
• Can develop the market for services.
• May bring forward innovative solutions.

On the other hand it does have certain disadvantages:
• It can impose significant costs on the purchaser and the bidders, which can exceed its benefits.
• Potential providers that lack experience or capability in tendering (especially small providers) may be disadvantaged by this process. It is therefore important to have a transparent and robust process for managing tenders, and to clearly communicate expectations about tendering to potential providers. This is further discussed below in Section 2.6.
• Existing relationships may be prejudiced (including encouraging competition between organisations in the tender that will be expected to co-operate with each other in the future. This may be ameliorated, to some extent, by consultation with potential providers before the tender process, by encouraging collaboration between Health Partners, and by accepting tenders from joint ventures. It can take a significant amount of time.
• It can expose the purchaser to the risk of litigation if it is mismanaged.

Quality as well as price will be an important consideration in terms of accepting a bid. For example, if many of the users of a service are local peoples, it will often be important to ensure that a Health Partner is able to deliver the service in an appropriate manner. A very low price in a bid may raise questions about the capacity of the organisation submitting the tender to deliver the service to the necessary quality.

It is important to be clear that a tender for a particular service is not a general funding round, so as to not encourage Health Partners to send in inappropriate bids, regardless of their capacity to deliver. This places significant costs on both the NGOs and Government Agencies, and can raise unrealistic expectations.

2.6 A Tender Process

It is important to have a clear and robust process for managing tenders. A poorly managed tender can compromise relationships with the bidders, and can leave the purchaser open to legal action on the basis of either a lack of fairness, or that the tender documents represent a contract. There are a number of steps that can be taken to minimise these risks:
• A transparent process for dealing with tenders. This should include identifying in advance the criteria that will be used to evaluate tenders, and allowing adequate time for key steps.
• Make it clear that the lowest or any tender will not necessarily be accepted.
• Have clear rules for dealing with late tenders, and non-conforming tenders (automatically rejecting non-conforming tenders may rule out innovative suggestions for achieving desired objectives).

• A robust decision process, which could involve using a panel with the relevant skills.

Where many of the users of the service are local people it will be sensible to ensure that there is local representation. The panel needs to be constituted in such a way as to avoid any suggestion of a conflict of interest.

• If a tender process and negotiations result in a significantly different specification to that in the original invitation to tender, it may be necessary to allow further bidding (for at least the short-listed bidders). Agencies should take legal advice in this situation.

• Briefings for unsuccessful bidders on why their bid failed.

It is particularly important to have a way of managing the conflict of interest involved where the Government Health Agency also delivers or may deliver the service to be purchased.
Chapter 3 - Negotiating the Terms of the Contract

Some areas which may be covered in a standard partnership for health

If a decision is reached to enter a Partnership for Health, then work may begin on the preparation of the Partnership for Health Document which will be available in template form. There will be some standard clauses which must be included, but there will also be flexibility to enable big Partnership Agreements for Hospital Services and small agreements for counselling services or staffing an aid post. It may be adapted depending on the nature of the Partnership. It may be for services in an existing facility, creation of a new facility, services across a number of facilities or delegation of another function of a provincial health authority such as monitoring, etc.

Before a partnership can be signed the manner in which the following outputs are to be achieved must be set out in the agreement:

- Require incorporation or some administrative configuration which satisfies the Government Health Agency that it is dealing with an entity sufficiently well administered to enter a Partnership for Health or contract to deliver specified health services.
- How it complies with the National Health Plan and National Health Standards
- Explain how the partnership achieves a population health focus, standards of clinical care,
- Estimate numbers of people treated,
- Explain criteria for admission (i.e. does the service treat anyone, or are there some requirements etc);
- Ensure that priority is given to the particular health needs of women and children;
- How will the partnership account for government monies and monitor performance and activity standards;
- Set specific requirements for recording of key health information to be delivered to the Government Health Agency subject to requirements for privacy of health information;
- Reach agreement on charging for services and make any necessary administrative arrangements to charge for services which should be “affordable to the population served and sufficient to maintain services”.

3.1 Negotiations

Once an Agency has identified its objectives, the nature of the services it wants to purchase, the preferred provider, and is satisfied that the provider can deliver the services the next step is to negotiate the contract itself. The contract sets out each party’s undertakings to the other.

Where a provider has been selected on the basis of a tendering process, the bid and
tender documents will provide a clear basis for negotiating the details of the contract. If negotiations result in a significantly different contract specification, it may be necessary to allow re-bidding by other bidders. Government Agencies need to consider whether it is ethical to use concepts from an unsuccessful bidder in the final contract. They need to be able to explain any such apparent uses.

Negotiations will usually focus on aspects of the specifications for service delivery (particularly quality and quantity), and price. The price is likely to be a reflection of the quality requirements, but Agencies should obtain an in-depth breakdown of how the Health Partner is determining its price and review the costs for reasonableness.

Contract managers should negotiate within a clear set of negotiating parameters. This benefits both the Government Health Agency and the Health Partners, as it:

- Reduces the risk of the Government Health Agency agreeing to terms that are inconsistent with its overall objectives.
- Means that the Health Partner should be dealing with managers who can reach an agreement, rather than having to refer decisions elsewhere. Contract managers should have authority to conclude negotiations, even if they do not have authority to sign the contracts.

It is in the interests of both the Government Health Agency and the Health Partner to approach negotiations in a collaborative rather than a confrontational manner. The outcome should be a situation where there is a mutual benefit – the Government Health Agency is confident of getting the desired services for a reasonable price, the Health Partner is confident of delivering those services within the available resources.

Government Agencies must enter negotiations with a clear idea of their interests and those of the Government. The Government should actively seek value for money. At the same time, Government Agencies need to understand the interests of the Health Partner they are contracting with. Government Agencies want Health Partners to deliver services under the current contract, but also have an interest in their viability into the future and in maintaining a good relationship. Health Partners – for profit and not-for-profit - must at least cover their costs of service provision, including the cost of capital.

Purchasers want to achieve cost-effective services. They need to be aware of the risk of under-pricing the service they are purchasing. ‘Driving down’ the price could undermine the quality of service delivery and damage the capacity of the Health Partner to deliver. This is particularly an issue with small or new not for profit organisations that may have limited management and contract negotiation experience. Similarly, Government Agencies need to think about how risk is apportioned in the contract and which party is in the best position to manage particular risks. Government Agencies should avoid negotiating contracts that leave the Government holding an undue proportion of the risk.

Both parties need to be clear about whether the Government Health Agency (or several Government Agencies together) is paying for all or nearly all of the service. Alternatives include paying at full cost or for only part of the service, with other resources coming from the Health Partner or elsewhere.
It is sometimes helpful for the Government Health Agency to disclose its negotiating parameters to the provider, including any constraints they operate under such as:

- Budget – including appropriation authority.
- Law.
- Government policy.
- The need to maintain national consistency.
- The need to operate within national standards.
- The need to operate within convention or within ethical conduct requirements.

Following preliminary discussions, the Government Health Agency should prepare a draft contract as a basis for further negotiations with the Health Partner. In situations where the Government Health Agency has departed from its own contracting policies or procedures, the reasons for the variation should be recorded and the contract should outline what procedures have been put in place to mitigate any risks arising from the change, e.g. more intensive monitoring. A checklist of contents for a contract is set out below as a reminder of issues that need to be considered. This checklist does not take the place of advice from the Agency’s own legal team.

It is possible to cover all of this in a short contract. Neither the order nor the language listed needs to be used, but it is important to think about whether each of the items is clearly covered in the contract. A contract can range from a lengthy document with detailed specification, to a document of a few pages, or even an oral agreement. Oral contracts are not appropriate for Government Agencies, however, and Health Partners should be clear that a contract does not arise until a contract document has been signed. The length and nature of the document signed will depend on the nature of the activities or services being provided for, the nature of the parties to the contract and the relationship between them, and the amount of money involved.

### 3.2 Contents Checklist

It is important to think about how the contractual documentation is presented, in terms of both clarity and compliance cost. Many organisations use standard terms for parts of contracts that they do not expect to vary from contract to contract. This can reduce uncertainty and negotiating costs for both the Government Health Agency and the Health Partner. Having such standard terms annexed to, or a separate part of a contract can also significantly reduce the size of the balance of the contract.
<table>
<thead>
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<th>Item</th>
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| 1. Parties  
– who is the contract between? | Identification of the legal parties to the contract. |
| 2. Introduction/Preamble  
– what is the contract about? | • The purpose of the contract  
• This could include a discussion of the objectives/outcomes the contract is intended to contribute to (alternatively this could be in the service definition section)  
• This could include a definition of terms if necessary (or this could be an annex). |
| 3. Duration  
– how long is the contract? | Term of contract, and any related information. Could be included in the Introduction or Service Definition. |
| 4. Service Definitions  
– what is being delivered? | Scope of services to be provided, including quantity and quality. The latter may include (where relevant) specific information on:  
• Location  
• Timing  
• Client eligibility  
• Accreditation requirements  
• Skills of staff  
• Quality of premises and equipment  
• Statements on why the Health Partner is able to offer culturally appropriate services  
• Relevant regulatory requirements  
• Client satisfaction surveys  
• Purchaser reviews |
| 5. Payment  
– in return for what payment? | • What is the basis for payment?  
• A payment schedule (i.e. at what points will payments be made?).  
• Variations to payment (including the circumstances in which payments may be withheld).  
• NO PAYMENT SHOULD BE MADE BEFORE A CONTRACT IS SIGNED |
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| 6. Information and Relationship Management                          | • Any expected meetings/visits  
• Contact people  
• Information to be recorded  
• Information (including reports) to be supplied to the purchaser by the provider  
• Information (including reports) to be supplied to the provider by the purchaser  
• Reporting intervals  
• Recordkeeping policies, practices and standards  
• Procedures for *Ad hoc* reporting  
• Notification – where? How? Who?  
• Co-operation with evaluation or audit. |
| 7. Variation – what if you need to change the contents of the contract? | • What happens when the contract needs to be modified?  
• Provision for changing the terms of the contract or activating contingencies provided for in the contract  
• Process to be followed including consultation and notification. |
| 8. Disputes – what happens if the parties disagree?                  | • How disputes will be dealt with  
• Notification, consultation procedures  
• Dispute resolution (informal, mediation? arbitration?)  
• Termination of contract  
• Liability for debts  
• Compensation |
<table>
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<th>Description</th>
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| 9. General contractual obligations | Matters common to all contracts, or all contracts of a similar type entered into by the Agency. May include elements listed above. Other potential examples:  
• Consultation with local peoples is recognised in policy and processes and also occurs outside of contractual arrangements; services delivered are culturally appropriate  
• Good employer requirements (e.g. ethics and integrity; offering training and development opportunities, observance of EEO principles and opportunities).  
• Requirements to offer culturally appropriate services  
• Service delivery ethics  
• Public sector ethics and codes of conduct  
• Use of sub-contractors  
• Ownership of assets or intellectual property created (in some sectors this may need to be tailored to particular contracts)  
• Relationships with purchaser (may be covered by 6 above)  
• Confidentiality (including any privacy issues)  
• PNG law to apply  
• Linkages with other providers  
• Survival of any terms past the expiry of the contract  
• Contract for service rather than contract of service (i.e. the Health Partner or its staff do not become employees) |

See Glossary
3.3 Basis for Payment

The basis for payment for services should match (where possible) the:

- Nature and scope of the services; and
- The pattern of costs incurred by the provider.

The Agency must agree a regime for determining payment. There are a number of possibilities:

- Fee for service – a set amount paid each time a client uses a service.
- Block payments - a predetermined payment for delivery of the service.
- Cost and volume – combines aspects of fee for service and block payments.
- Paying the cost of a particular input (e.g. a staff salary).
- Hybrid payments – a combination of some of the above payments. Typically relevant for complex services or a group of services.
- Special payments – made for activities outside the normal scope of the service (e.g. contributing to policy development, providing significant amounts of information above that required for monitoring).

There are a number of ways in which the payment can be structured (see Section 4.3 below), including:

- In arrears.
- On delivery.
- By time period.
- In advance (at the beginning of the contract or before service delivery).
- At the end of the contract.

No payment should be made until the contract is signed. This is equally important for a conditional grant.

3.4 Surpluses

An important part of the overall contract management system is how to deal with any surplus that remains when the agreed outputs have been delivered. The ability of a Health Partner to retain part of any surplus can provide an important incentive to achieve efficiencies and to innovate – something always worth encouraging, including through other means, such as willingness to consider proposed innovations.

On the other hand, Government Agencies need to seek value for money, avoiding providing for large, easily earned surpluses, after all expenses including depreciation and a normal return on capital have been covered. (In this context, surpluses do not include a moderate return on capital or expenses necessary to cover infrastructure costs such as depreciation.) Similarly, Government Health Agencies should be confident, when negotiating a lower price, that this will not put service quality at risk of falling below agreed standards. Government Health Agencies will also need to keep the price under review when contracts are renegotiated in the light of knowledge acquired about costs.
and surpluses. There are a number of approaches that can be adopted in relation to a surplus:

- The Health Partner returning any surplus. This is appropriate where the surplus is due to the Health Partner under-delivering on the quantity or quality of the services.
- The Government Health Agency and the Health Partner agreeing to the provision of more of the same services.
- The Health Partner agreeing to the delivery of additional related outputs.
- It may be appropriate for the Health Partner to retain the surplus as profit. This approach relies on a robust contract management system, and good information on service delivery.
- Grant money that is not spent for the purposes originally provided should be returned to the Government Health Agency. It may be appropriate to renegotiate the conditions of a grant to reflect changing circumstances.

Deciding on the most appropriate approach to dealing with surpluses may also depend on an assessment of risk. The basis for these assessments should be documented. This may be particularly relevant when the NGO is a not for profit organisation. Government Agencies should assure themselves ahead of time that the NGO has appropriate internal controls or governance structures to ensure that any agreed surpluses are applied by the Health Partner appropriately. At the least, Agencies should verify how the surplus has been spent by the Health Partner.
Chapter 4 - Managing the Contract and Monitoring

Signing the contract is only part of its responsibilities for contract management. The Government Health Agency is also responsible for the ongoing management of:

- The contract once it has been signed, and
- The relationship with the Health Partner providing the service.

This will involve:

- Monitoring (including verifying) service delivery against the contract.
- Assessing the effectiveness of the services delivered.
- Approval of payment, and making payment according to the contract.
- Ongoing relationship management.
- Dealing with any differences of view with the Health Partner.
- Negotiating changes to the contract initiated by either party.
- In extreme cases, taking action to enforce the conditions of the contract, including exercising any rights to terminate the contract.

This provides the basis for:

- Assessing whether the Health Partner has delivered what was contracted for.
- Accountability for public money.
- Paying money to the Health Partner.
- Making decisions about how to proceed at the expiry of the contract.

4.1 Monitoring

Monitoring includes verifying that the terms and conditions under the funding agreement have been met. Monitoring will be based on:

- Information reported by the Health Partner in accordance with the contract.
- Information from other parties (e.g. surveys of users).
- The ongoing relationship with the provider.
- Reviews or audits conducted under the contract.
- Information from other sources.

Government Agencies want Health Partners to deliver services under the current contract, but will also have an interest in their viability into the future. Ideally, the information sought should provide an indication of the ongoing viability of the Health Partner, the improvements in outcomes sought, not just outputs produced, and certainly not focus mainly on inputs to the Health Partner’s activities.

Monitoring and contract management imposes costs on the purchaser and the Health Partner providing the service. There is a range of possible ways to reduce unnecessary costs, while still receiving assurance about the effective use of public money (see Section
1.6 and Section 1.12). This includes:

- Realism about the number of reports required from Health Partners.
- Performance indicators should be simple, meaningful, and relate to contracts.
- Supplying standard reporting templates to Health Partners to fill in. Then the Health Partner need not generate a report itself, and the information is in a standard form.
- Monitoring arrangements that are structured according to risk.
- Where appropriate, developing contract and capability building objectives that are consistent with the Health Partner’s own performance management system. (e.g. objectives that make use of information that the Health Partner is already collecting)

Feedback on the monitoring should be provided in a timely manner to Health Partners, to help them understand its use.

The level and nature of the monitoring undertaken by Government Health Agencies may differ according to:

- The nature of the service.
- The track record of the Health Partner.
- The amount of money involved.
- Perceptions of risk.

Some Government Agencies structure their monitoring arrangements according to assessments of risk. The basis for these assessments should be documented. This may mean focusing resources and greater attention on contracts where risk is assessed to be higher, and requiring some minimum reporting under the contract for lower risk contracts but providing for a power to do a more in-depth audit. The Government Health Agency can then audit 1 in 10 (say) such contracts, either on a random basis, or on the basis of a risk assessment or a mixture of the two. This could include an audit of the Government Health Agency’s contract management, as well as of the performance of the Health Partner.

A Government Health Agency needs to exercise informed judgement about such monitoring arrangements and where the Agency’s resources are best directed as is appropriate in their own circumstances. (See also Section 1.7)

Local community providers have often expressed the need for monitoring and reporting processes to focus more on outcomes that were collectively desired by Government Health Agencies and local communities. The outcomes reported against should also be culturally appropriate and relevant to the service provision model.

4.2 Ongoing Relationship Management

Managing the contract is part of ongoing relationship management with the Health Partner
delivering the service or otherwise in receipt of Government money. The contract will record the basic expectations each party has of the other and where the relationship is working well there will usually be no need to enforce the terms of the contract. The Health Partner is entitled to be informed in a timely manner of any concerns the Government Health Agency has about performance under the contract, and should be encouraged to provide feedback on the Government Health Agency’s performance.

The need for on-going relationship management is often paramount. The Government Health Agency should actively ensure it has sufficient understanding of the culture and language of service recipients and the Health Partners they contract with to ensure effective service provision. A good ongoing relationship and successful contract will be aided by an understanding at the outset by both Agencies and Health Partners of each other’s expectations of the way the relationship will be managed. It may be sensible to make a senior contact point known to Health Partners to help resolve difficulties that may arise. Government Agencies will often benefit from indicating a point of contact with them to assist in resolving contracting matters.

4.3 Payment

Where practicable, payments should be aligned with expected deliverables. However, this is not always possible or desirable. In some circumstances it may be appropriate to have all or the majority of payment made up front (e.g. capacity/capability building, where the contract is for relatively small amounts of money or where risk is assessed to be lower), or to pay in instalments - depending on the total amount of money involved. When structuring payments, and in particular, instalment payments, Agencies should balance the need to ensure that the Health Partner has funding so that it can deliver the service sought against the obligation to provide accountability for public money.

Full payment should not be made until final reports or information required to be provided under the terms of the contract or funding arrangement have been received and reviewed. Government Agencies should not, however, use their own poor planning as an excuse to withhold payments from Health Partners. A Health Partner satisfying its end of the contractual arrangement is entitled to be paid on time, in accordance with the payment schedule set out in its contract. Failure to pay in accordance with the payment schedule when the Health Partner has met the terms of the contract may be a breach of the contract. Failure to pay may threaten the ability of the Health Partner to continue to deliver the service.

Government Health Agencies will also need to consider in advance the implications for payment of any failure on the part of the Health Partner to meet the terms of the contract (e.g. holding over a reasonable percentage of a payment until the agreed terms are met).

No payment should be made before a contract has been signed.
If there are delays in signing a contract which compromise the delivery of an important service, then the Government purchaser should consider entering into a short term contract until the contract is signed (this could include extending an existing contract for a short period).

### 4.4 Things Change

Circumstances change. The Agency may need to consider changing the terms of the contract, and the contract should provide some scope to do this. A proposal for change could be initiated by either the Government Health Agency or the Health Partner, and will be a subject for negotiation for the parties. In considering possible changes, Government Health Agencies should think about:

- The likelihood that proposed changes will better achieve its objectives.
- The views of the provider.
- The impact on the users of the service.
- The realistic scope for change.
- Any legal issues.

The reasons for changing the contract should be documented and the resulting contract should outline what procedures have been put in place to mitigate any risks arising from the change.

### 4.5 Dealing with Disputes

It is in both parties’ interests to avoid disputes that may escalate to Ministers, the Ombudsman or the Courts. Differences of opinion arise in any relationship. Dealing constructively with such differences of opinion is a feature of a good relationship. One of the advantages that a well-constructed contract can provide is the possibility of minimising disagreements by providing a tool to deal constructively with any disagreements that arise by:

- Clearly recording the expectations that each party has of the other;
- Clearly outlining how disputes will be dealt with;
- Providing for a means of dealing with any likely areas of disagreement (e.g. using independent mediation);
- Including a process by where each party can signal to the other a desire to alter the terms of the contract;
- Recording agreed changes to the contract by annexing them to the contract.

In general, the optimal approach to dealing with differences is to deal with them promptly. This forms part of relationship management by discussion and mutual agreement. In some circumstances, outside help to might be required to deal with any dispute that the parties cannot resolve between themselves. In general both parties are likely to regard formal legal remedies are a last resort. Government Health Agencies should not, however, shrink from making use of formal remedies if necessary. Government Agencies should also bear in mind that the Health Partner is able to enforce its rights under the contract.
The contract should include clear provisions setting out the circumstances in which either party can terminate the contract.
Chapter 5 - Review and Evaluation

Review and evaluation overlaps with monitoring, but it merits separate treatment given that it extends further than an individual contract.

Government Health Agencies must build a reflective capacity into their contract management system. They need to be able to think about the following questions:

- Is the programme or policy being delivered by way of contracting effective?
- Does it represent value for money?
- What improvements can be made?
- How effective has the organisation’s contract management been?
- How have the Health Partners performed in respect of particular contracts?
- How have individual Health Partners performed against the Agency’s assessment of risk?
- How has the successful service provision contributed towards desired outcomes?
- How has the Agency performed in respect of individual contracts?
- How effective is the Agency’s relationship management?

This should be informed by:

- Information from monitoring individual contracts.
- Feedback from service users, Health Partners and other interested parties.
- Evaluation.
- Audit.
- Reviews of contract management.
- Risk assessments.
- Any other available information and analysis.

The answers to these questions should in turn feed into:

- Policy advice.
- The budget process.
- Decisions about particular contracts, relationships or services.
- The contract management system.
Chapter 6 - Starting Over

The end of a contract is an important part of the contract management cycle. Government Agencies need to consider what to do in the future well before the end of a contract. This requires returning to the planning part of the contract management cycle. There are a number of possible approaches:

- Renegotiating the contract with the supplier or rolling it over.
- Selecting another supplier or tendering.
- Altering the scope of a service.
- Continuing the service but identifying ways in which the provider could be developed further to enhance or improve service provision.
- Discontinuing the service.

The decision taken should be informed by:

- The ongoing relationship with the provider.
- Any feedback available from the users of the service.
- Monitoring of the provider’s performance.
- Evaluation of service or policy.
- Update of user/recipient needs analysis.
- Any other information available on value for money (e.g. benchmarking).
- Legal obligations.
- Changes to Government policy.
- Legislative changes.

A decision to discontinue or alter a particular policy, for example, might be taken because it had been successful and was no longer necessary or a priority, or, conversely, because of evidence that it was not effective or represented poor value for money, or because of a change to Government policy. A contract might be put up for tender because:

- The Health Partner no longer wanted to carry out the service.
- Dissatisfaction with the performance of the Health Partner (this should have been raised with the Health Partner before a final decision on the contract is made).
- A desire to test the market.
- A desire to give other potential providers an opportunity.

A contract might be re-negotiated with the Health Partner because of:

- A need to maintain continuity of supply.
- A long running relationship and satisfactory performance.
- No other suppliers being available.

The existing provider should be given ample notice of the approach that the Government Health Agency proposes to take and the Government Health Agency should ensure there has been consultation and communication about it.
Where a contract is to be varied or extended for a future period, the costs of the contract, what has been achieved or delivered to date under the contract, and what still has to be achieved/delivered should be reviewed before progressing. The actual costs of service delivery under a first contract should be checked before establishing the costs of a subsequent contract. A contract should not be rolled over to ensure continuity of supply simply because of poor planning by a Government Health Agency.
Glossary of Terms

Appropriation
The Government cannot spend any public money, or incur any expenses without the authority of Parliament. Such an authority is generally called an appropriation, and the Government and its Health Agencies must spend money (including for contracting) within the relevant appropriation.

Government
The definition of Government used in these guidelines. “Government” or “Her Majesty”
   a. Means Her Majesty the Queen in right of Papua New Guinea; and
   b. Includes all Ministers of the Government and all departments; but
   c. Does not include –
      (i) An Office or Parliament; or
      (ii) A Government entity; or
      (iii) A State enterprise named in the .........................

Government entity
Corporate bodies legally separate from the Government, but subject to a measure of control by the Government (e.g. ..............). This does not include State Owned Enterprises. They are defined by listing ..........................................., or being a subsidiary of an organisation listed.

Department
An organisation that is part of the Government

“Good employer” practices
Compliance with relevant employment relations and human rights legislation as well as fair and ethical practices, such as:
   • positive relationships with unions in the contractor’s trade or industry;
   • participatory mechanisms for employees, in addition to participation in matters such as health and safety;
   • observance of EEO principles and opportunities;
   • work/life balance policies;
   • provision of training and development opportunities; and
   • ethics and integrity.

Health partner
   • A health partner may be an NGO, a church organisation, an international NGO, an industry, a private provider or a traditional health care provider.
**Input**
A “factor of production” used to produce an output (e.g. staff time, travel, telephone calls, computer equipment or rental accommodation).

**NGO**
Non Government organisation - in this guide unless context requires otherwise the term NGO encompasses:
- Community or voluntary organisations;
- Local organisations;
- For-profit organisations where Government Health Agencies contract with them for the delivery of outputs

**Outcome**
 Defined in the as the “impacts on, or consequences for the community of the outputs or activities of the Government”.

**Output**
Goods or services produced.
Templates

Instructions for Templates

The following templates provide a standard form for simple agreements. They are most suited to relational contracts, where the parties anticipate a longer term relationship that will be guided by negotiation and discussion rather than litigation.

The clauses link to the Draft Guidelines for Contracting with Health Partners, particularly Chapters 3 and 4.

MOU between NDoH and Health Provider Umbrella Bodies (such as the CMC)

The MOU is designed to record high level agreement for cooperation between two parties to achieve a goal. It includes an action plan template that can be used if the parties agree to work together at a high level.

SHORT FORM AGREEMENT

This has been created in four different parts. It means that components can be changed without changing the whole agreement.

There are some parts of the general terms and conditions that must be modified. These are highlighted in grey. Use the checklist to see whether you have covered everything off. The General Terms and Conditions section details standard contracting requirements that will remain the same for all contracts. They provide minimum requirements for good contracting practice. You do not need to change this section.

Schedule One - Service Specification

This details what you need to think about when you are describing the service that you want to buy. The examples in the boxes provide a guide of the issues you may need to think about when drafting the service specification.

Schedule Two - Payment Schedule

This section details what you need to consider when paying for services. The examples in the boxes provide a guide to the issues you may need to think about when deciding how to pay the provider for services.
Memorandum of Understanding (MOU)

between the Papua New Guinea National Department of Health (NDoH) and XYZ

PURPOSE

NDoH and XYZ are both strongly committed to improving health outcomes for the urban poor and the rural majority in Papua New Guinea. This MOU records our intention to work together to these ends.

BACKGROUND

NDoH pays XYZ [insert annual funding] to provide [specific?] health services to the ABC population. We wish to record our high level agreement about the health and health systems outcomes we are working towards, and the expectations we have about how our organisations will work together to achieve those outcomes.

OBJECTIVES

NDoH and XYZ will work collaboratively towards the following objectives.
(Insert the high level objectives from the National Health Plan).

We anticipate that by working towards these objectives, we will improve population health outcomes, and enhance the relationship between our organisations.

GENERAL TERMS

The terms of the agreement are as follows:

Annual action plan

We will meet annually to agree a collaborative plan of action for services the NDoH funds XYZ to provide.

Each year, we will

- look at the achievements of the last year
- check that the action plan is on track
- discuss the services particularly any successes, challenges, trends and developments over the previous year and plans for the coming year.

This annual meeting will also plan the future delivery of services over a five-year time span. The action plan will detail the resources NDoH provides, and the services XYZ delivers. It will also detail resources from other sources (such as out of pocket and donor funds) that contribute to this service. The following resource categories will be included:

- Health workforce
- Financing
- Information and communication technology
• Assets and Infrastructure
• Medicines and medical supplies and technology.

The action plan will include a reporting and monitoring framework that details outputs and outcomes, so we can both track service progress and health outcomes. Output and outcome reporting will be based on the population served by this MOU.

**Relationship management meetings**

Management staff from NDoH and XYZ will meet every six months or as required to share information and review the implementation of this MOU and the action plan.

In the event of a dispute about any matters in this agreement, the management staff will work together to resolve it. If this is unsuccessful high level staff will meet and discuss the issues.

To facilitate ease of communication, we both agree to provide key contacts for operational matters, and will keep contact lists updated.

**Term**

On signing, this agreement is effective for three years unless terminated on three months’ written notice by either party.

Signed
Name ............................................
Date ............................................
Title ............................................
PNG National Department of Health

Signed
Name ............................................
Date ............................................
Title ............................................
XYZ
Action Plan
Term: [insert dates]

This collaborative action plan supports the MOU between NDoH and [party] dated [dd/mm/yy], and describes collaborative work that we will work on together over the next year.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Outcome</th>
<th>NDoH</th>
<th>Other party</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detail what will happen.</td>
<td>What does it hope to achieve?</td>
<td>Detail resources, responsibilities and milestones towards the initiative.</td>
<td>Detail resources, responsibilities and milestones towards the initiative.</td>
<td>Is there anything that will be countable e.g. 1000 children vaccinated by December 2010.</td>
</tr>
</tbody>
</table>
LETTER OF AGREEMENT FOR [SERVICES]

This letter records our agreement for [FULL LEGAL NAME SERVICE PROVIDER ORGANISATION] (you or your) to provide the [NAME OF PURCHASER ORGANISATION] (us, our or we) with the [SERVICES] described in Schedule One to this letter of agreement (“the Services”).

GENERAL CONDITIONS OF SERVICE PROVISION

The following general conditions apply in addition to the conditions in the service schedules to this Agreement.

1. The Services

You will deliver the services detailed in Schedule One to this Letter of Agreement.

2. Provision of Services

You must provide the Services and conduct your practice or business in a prompt, efficient, professional and ethical manner and consistently with:

   a. all relevant strategies issued under the [insert relevant PNG legislation]
   b. our Objectives as set out in [reference to alignment with national health and provincial health plan.]
   c. all relevant Law.
   d. all relevant clinical quality standards.

3. Reports on the services

You will provide reports detailed in Schedule One of this Letter of Agreement.

4. Payment

We will pay you [total amount over the term of the contract], in the configuration detailed in Schedule Two.

No payment will be made before the contract is signed by both of us.

5. Invoicing

Your invoice should be made out to [details of name, address and contact person of...
6. **Tax obligations**

7. **Term**

This Letter of Agreement commences on [dd/mm/yyyy] and will expire on [dd/mm/yyyy].

8. **Confidentiality and privacy**

You agree that you will not at any time disclose to any person otherwise than is necessary for this Agreement or as required by law, any information you acquire for the purposes of providing and completing the services.

9. **Professional care and diligence**

You agree to exercise all due professional care and diligence in the performance of your obligations under this Agreement in accordance with the standards of skill, care, and diligence normally practised by suitably qualified and experienced contractors in performing services of a similar nature.

You agree that if you fail to complete the services or meet the required performance measures and timelines or if you fail to exercise all due professional care and diligence in the performance of your obligations under the agreement, the fee payable under this Agreement may be abated or withheld by us.

We may require errors, omissions, defects, or faults in the services to be corrected at any time up until one month after purported completion of the services.

10. **Cultural appropriateness**

You will consult and work with local peoples and communities to ensure that services are delivered in a culturally appropriate manner.

11. **Ethical considerations**

Services will be delivered in line with generally accepted standards of service delivery ethics and within public sector ethics and codes of conduct.

12. **Service Quality Requirements**

a. **Accreditation requirements**

What minimum requirements do service providers have to meet e.g. registration with a
national body.

b. **Skills of staff**

You will ensure that clinical staff delivering services are appropriately qualified and registered with national and professional bodies.

c. **Quality of premises and equipment**

Your premises and equipment will meet national standards.

d. **Consumables and pharmaceuticals**

All clinical services will ensure that consumables and pharmaceuticals are stocked and available for use.

e. **Relevant regulatory requirements**

You agree to comply with relevant regulatory requirements for service delivery

13. **Good employer practices**

You agree to comply with relevant employment relations and human rights legislation, as well as fair and ethical practices, such as:

- positive relationships with unions in the contractor’s trade or industry;
- participatory mechanisms for employees, in addition to participation in matters such as health and safety;
- observance of equal opportunities principles;
- work/life balance policies;
- provision of training and development opportunities; and
- ethics and integrity.

14. **Notification of problems**

You must advise us promptly in writing:

a. of anything which may or is likely to materially reduce or affect your ability to provide the Services, including anything relating to any premises or equipment used by you or your key personnel;

b. if you materially fail to comply with any of your obligations in this agreement;

c. of any serious complaints or disputes which directly or indirectly relate to the provision of the Services; and

d. of any issues concerning the Services that might have high media or public interest.

You must have in place realistic and reasonable risk management processes and contingency plans to enable you to continue to provide the Services on the occurrence of any of the matters in this clause, and must provide us with details of those plans if we request them.
15. Relationship management meetings

We agree to meet every quarter to discuss your reporting and the progress of the service and any issues you may wish to discuss with us. We agree to work together in these meetings in an honest, open and constructive way.

16. Disputes

16.1 If either of us has any dispute with the other in connection with this agreement, then:

a. both of us will use our best endeavours to settle the dispute by agreement between us and act in good faith and co-operate with each other to resolve the dispute;

b. if the dispute is not settled by agreement between us within 30 days, then, unless both of us agree otherwise:
   i. full written particulars of the dispute must be promptly given to the other; and
   ii. the matter will be referred to a mediation service.

c. neither of us will initiate any litigation during the dispute resolution process outlined in paragraph b. above, unless proceedings are necessary for preserving the party’s rights; and

d. both of us will continue to comply with all our obligations in this agreement until the dispute is resolved, but payments may be withheld to the extent that they are disputed.

16.2 Clause 16.1 will not apply to any dispute:

a. concerning any renegotiation of any part of this agreement; or

b. directly or indirectly arising from any matter which has been referred to a Mediator unless the Mediator directs otherwise.

17. Information Collection

You agree to:

a. keep secure accurate records of the performance by you and your employees, agents and advisers of this agreement (Records) and make them available to us in accordance with our reasonable instructions;

b. keep proper business records and promptly complete a balance sheet, statement of income and expenditure and cashflows in accordance with accepted accountancy principles at the end of each financial year; and

c. report to us on the performance of this agreement in accordance with our reasonable instructions and if requested by us send reports direct to any governmental body in the manner we specify.
18. Audit
You and your permitted sub-contractors must allow us and our authorised agents, access on 24 hours notice to:
   a. your premises;
   b. all premises where the Records are kept; and
   c. staff, sub-contractors or other people used by you in providing the Services, and allow us to interview any staff, sub-contractors and the people you supply Services to (and their families) for the purposes of carrying out an audit of your performance and compliance with this agreement.

Our right to audit under this clause continues after this agreement ends but only to the extent that it is relevant to the period during which this agreement exists.

19. Indemnity
You shall indemnify us in respect of costs and damages associated with any legal liability that results from your acts or omissions, where those acts or omissions were not authorised by us.

20. Intellectual property
All physical and intellectual outputs produced for the purposes of providing and completing the services shall be the property of [PURCHASER NAME] (for the avoidance of doubt this includes, without limitation, all reports, papers, electronic documents (including computer software), and recordings) unless both parties agree to the issue of a licence to [insert name of contractor] for the use of research findings for the purpose publication of those finding, development of teaching curricula based on research findings, or a use which is otherwise in the public interest.

21. No assignment
You agree not to assign, delegate, or transfer your obligations under this Agreement without our specific written approval.

22. Variation
We may vary Schedule One or Two if we both agree.

23. Termination
Should we no longer require the services for any reason, you will be advised as soon as possible and will be paid for the proportion of the services provided up to when you are so advised.

Either party may give one month's notice in writing to terminate the agreement if there are serious problems with service delivery, or if either of us fails to materially meet our obligations under this agreement.
24. Entire agreement
This letter sets out the entire agreement between us, and supersedes all prior oral and written representations, understandings, arrangements or agreements.

25. Execution
To formally record your agreement to the terms and conditions set out in this letter would you please sign and date both copies of this letter, initial all pages except this page with the [name and address of the person in the purchaser’s office who will receive the agreement for signing]. The letters will be countersigned and one returned to you for your records.

Signed
Name .......................................................  Name ..........................................................
Date .........................................................  Date ............................................................
Title ..........................................................  Title ............................................................
PNG National Department of Health  XYZ
SCHEDULE ONE - SERVICE SPECIFICATION

[NAME OF SERVICE]
Example: Child and Maternal Health Services (Note the descriptions in the boxes are illustrative examples and are not the service descriptions for PNG MCH services).

1. SERVICE BACKGROUND
How did this service come about? Why was it started? What problem is it trying to fix and why is the service provider well placed to deliver the contract?

Example:
The Child and Maternal Health Services were founded to improve health outcomes for women and children in Southern Highlands by providing comprehensive maternal and child health services. Currently only 40% of women are accessing a health service, and receive health services. We wish to improve that number with this service.

2. SERVICE AIM
What does this service aim to do? Why are you funding it?

Example:
This service aims to improve child and maternal health outcomes by providing integrated child and maternal health clinics in Southern Highlands.

3. SERVICE COMPONENTS
In this section you describe what you want to buy. Scope of services to be provided, including quantity and quality. Services may be divided into different parts e.g. clinical services, health promotion. Each of the parts will describe what is expected.
Example:

2.1 Health checks programme
This service provides a programme of health and wellness based around a series of antenatal and postnatal health checks.

Services you will provide
- identify and enrol women in early pregnancy
- four antenatal checks,
- provide care during and after labour, and
- regular monthly checks of mother and child for the first year of the child’s life.

You will work with mothers to ensure that they and their babies are well, and that the babies are immunised, and opportunistically use checks to discuss nutrition and keeping well with the new mothers.

2.2 Antenatal classes
You will run at least six sessions with four classes per session for expectant mothers. The classes will cover nutrition, care, information about the birth, breastfeeding, what to expect in the first few months of the child’s life.

4. SERVICE CONDITIONS

4.1 Location
Where the services will be delivered?

Example: You will deliver services from the following sites..........

4.2 Timing
At what time of the day, week the services will be available?

Example: Services will be available from Monday - Saturday from 9am - 4pm.

4.3 Service user eligibility
Who is the service aimed at? Who is it not aimed at?

Example: This service is aimed at pregnant women and mothers of children under one year of age who live in the Southern Highlands area.
4.4 Add other relevant conditions as necessary
Specify other areas you wish to clarify e.g.:
- Number of nurses per women
- Community health workers etc
- Particular resources, or capacity of the service providers
- Fridges for vaccines
- Fees – No woman is to be charged fees for this service.

5. SERVICE REPORTING
Detail the information you want to collect. The information will let you track the reach and progress of the service and to see whether you are getting the results that you anticipated when you decided to make the investment. You may want to collect different information for different parts of the service. You need to specify how often and what you expect to see in the report and how it will be recorded and delivered to you.

Example:
On 20th January, April, July and October you will report the following quantitative information to us about your service’s progress. You will send us the information in a locked Excel spreadsheet. You will also provide a narrative reporting on any successes, challenges, trends and developments over the last quarter in a locked Word document.

Health checks
For each mother on the programme you will collect their:
- Date of birth
- Village where they live
- Clan affiliation
- Number of checks received
- Date of baby’s birth.

For each baby on the programme you will collect
- Date of birth
- Village where they live
- Ethnicity/tribal affiliation
- Number of checks received
- Number and type of immunisations received.

Antenatal classes
Number of sessions delivered in this year
Number of women enrolled in each session
Details of topics covered in each session
SCHEDULE TWO – PAYMENT SCHEDULE

After the contract is signed, we will pay you [amount in K] per annum. We will pay you [detail the monthly amount, and any conditions of payment], detailed in the table below:

<table>
<thead>
<tr>
<th>Payment mount</th>
<th>Payment date</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>K xxxx</td>
<td>Dd/mm/yyyy</td>
<td>On invoice made out to [details] And On meeting the reporting requirements</td>
</tr>
</tbody>
</table>

Example:

*After the contract is signed, we will pay you K 24,000 per annum in 12 equal monthly payments on invoice and on meeting the reporting requirements.*

<table>
<thead>
<tr>
<th>Payment amount</th>
<th>Payment date</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 5,000</td>
<td>20 January 2010</td>
<td>On invoice made out to [details] And On meeting the reporting requirements</td>
</tr>
<tr>
<td>K 5,000</td>
<td>20 February 2010</td>
<td></td>
</tr>
<tr>
<td>K 5,000</td>
<td>20 March 2010</td>
<td></td>
</tr>
<tr>
<td>K 5,000</td>
<td>20 April 2010</td>
<td></td>
</tr>
</tbody>
</table>
**SHORT FORM LETTER OF AGREEMENT CHECKLIST**

(This is not part of the contract documents)

Have you included everything you need?

<table>
<thead>
<tr>
<th>Essential elements of the Letter of Agreement that you need to check and change.</th>
<th>Clause number</th>
<th>Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>These are highlighted [in grey between square brackets] in the template. You will need to change these.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The parties - Name, address, and date of purchaser and service provider.</td>
<td>Front page</td>
<td></td>
</tr>
<tr>
<td>Payment - Total amount paid over the term of the Agreement.</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Invoicing – details of where the service provider needs to send the invoice.</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Term - dates when the contract operates</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Intellectual property – insert the purchaser name in this clause.</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Execution - name and address of the person in the purchaser’s office who will receive the Agreement for signing.</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Names of organisations in boxes for signing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>