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Is Contracting Out an Efficient Means of Delivering Health Support Services? A Case Study of A Public Hospital in Uganda

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A dissertation submitted in partial fulfilment of requirements for the award of the Degree of Masters of Social Sciences in Health Economics

Department of Economics
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2001
DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and in quotation in, this dissertation from the work, or works, of other people has been attributed, and cited and referenced.

Signature: Date:
DEDICATION

Once more this piece of work is dedicated to my father and mother who are always my inspiration.
ACKNOWLEDGEMENTS

I am greatly indebted to my supervisor Prof. Clas Rehnberg of the University of Cape Town, for his tireless and professional criticisms and advise right from the proposal development to the final production of this research report. Without his continued support I would not have been able to produce this report on my own.

The Director Mulago Hospital, Ms Alison Katarama, Mr. Sam Barasa for allowing me to conduct the study in Mulago Hospital & Complex, and for all the support they gave me during the data collection period. Am also grateful for all the information they shared with me openly.

Further, I wish to thank Mr. Micheal Okiria of Mulago Hospital for providing the cost data, which was a really challenging, task. Not forgetting Mr. Daudi Nsubuga of the Evaluation and Planning Unit of Mulago Hospital who relentlessly went through massive piles of files to get me documents relevant to my study. Mr. Sam Kiragga, Mr. Godfrey Galiwango, Ms. Rita Naiga and Ms Irene Nagawa who actively participated in the data collection.

I also want to thank the entire staff of Mulago Hospital who participated in the interviews and provided valuable information. I further thank them for all the support they gave me whenever I needed it. The list is so endless that I cannot mention each of them by name- but am really grateful.

Lastly, I would like to acknowledge my deepest gratitude to the Swedish International Development Agency for awarding me a full study scholarship, without which, I would not have been able to conduct this study nor pursue my studies at the University of Cape Town. I cannot forget to acknowledge all my lecturers in the Health Economics Unit and The School of Economics for equipping me with the knowledge and skills some of which I used to produce this report.
# TABLE OF CONTENTS

DEDICATION ...................................................................................................................... II

ACKNOWLEDGEMENTS ................................................................................................. I

LIST OF TABLES AND FIGURES ................................................................................ VI

ABSTRACT ....................................................................................................................... VII

ACRONYMS .................................................................................................................... IX

CHAPTER ONE: INTRODUCTION ................................................................................. 1

1.1 BACKGROUND ........................................................................................................ 1

1.2 Statement of the Problem ..................................................................................... 2

1.3 Objectives of the Study ......................................................................................... 4

1.4 Justification of the Study ...................................................................................... 4

1.5 Scope of the Study ................................................................................................ 5

1.6 Format of the Study .............................................................................................. 6

CHAPTER TWO: COUNTRY BACKGROUND ............................................................... 7

2.1 Socio-economic and Demographic profile ......................................................... 7

2.2 Health Policies in Uganda ................................................................................... 8

2.2.1 Health Policy in Uganda .................................................................................. 8

OBJECTIVES OF THE POLICY .................................................................................. 9

2.2.2 Health Care Financing .................................................................................... 9

2.3 Presentation of the Case Study Area: Mulago Hospital & Complex ................. 10

2.3.1 Organisation of the Services ............................................................................ 11

2.3.2 Autonomy of Mulago Hospital and Complex ................................................ 12

2.3.3 Health Reforms in the Hospital ................................................................ ...... 13

2.3.4 Contracting Out Policy in the Hospital ............................................................ 14

CHAPTER THREE: CONTRACTING OUT HEALTH RELATED SERVICES IN DEVELOPING COUNTRIES ....................................................... 18

3.1 Introduction ............................................................................................................ 18

3.1.1 Privatisation: What is it? ................................................................................ 19
3.2 Definitions, Forms and Underlying Issues of Contracting- out ........................................... 20
  3.2.1 Forms of Contracting ................................................................................................. 21
  3.2.2 Underlying Issues of Contracting Out .................................................................... 23

3.3 Empirical Studies on Contracting out of Health Related Service ........................................... 25
  3.3.1 Conclusion ............................................................................................................... 27

3.4 Hypotheses .................................................................................................................... 30

CHAPTER FOUR: CONCEPTUAL FRAMEWORK ............................................................................. 31

CHAPTER FIVE: METHODOLOGY ......................................................................................... 36

  5.1 Introduction .................................................................................................................. 36

  5.2 Study Design .............................................................................................................. 37
    5.2.1 Sampling Frame ..................................................................................................... 38
    5.2.2 Sample Design ....................................................................................................... 38
    5.2.3 Sample Size ............................................................................................................. 40
    5.2.4 Data Collection Procedures .................................................................................. 40

  5.3 Data Management and Cleaning .................................................................................. 42

  5.4 Data Analysis ............................................................................................................... 43
    5.4.1 Quality of the services .......................................................................................... 43
    5.4.2 Cost Analysis ........................................................................................................ 43

  5.5 Guidelines for Analysing Content of Contracts ............................................................ 45
    5.5.1 Contract Process and Design .............................................................................. 45
    5.5.2 Contract Implementation ....................................................................................... 46

  5.6 Limitations of the Study ............................................................................................... 47

CHAPTER SIX: RESULTS ........................................................................................................... 49

  6.1 Contracting Process ...................................................................................................... 49
    6.1.1 Cleaning Services .................................................................................................. 50
    6.1.2 Security Services .................................................................................................. 56

  6.2 Cost Analysis of the Services ...................................................................................... 59
    6.2.1 Cost Analysis for Cleaning Services .................................................................... 59
    6.2.2 Cost Analysis for Security Services .................................................................... 61

  6.3 Quality of the Services ................................................................................................ 62
    6.3.1 Cleaning Services ................................................................................................. 63
    6.3.2 Variations in Perception of Quality of Cleaning Services .................................... 63
    6.3.3 Quality of Security Services ............................................................................... 67
    6.3.4 Variations in Perceptions of Quality of Security Services .................................... 68

CHAPTER SEVEN: ANALYSIS AND DISCUSSION .................................................................... 71
7.1 Degree and Nature of Competition ......................................................... 71
7.2 Contract Design..................................................................................... 74
7.3 Contract Implementation.......................................................................... 78
7.4 Comparative Cost Analysis...................................................................... 80
7.5 Quality of the services........................................................................... 82
7.6 How Efficient is Contracting Out Health Support Services?.................. 85
7.7 Other Factors Contributing to Contract Success and Failure................. 86

CHAPTER EIGHT: POLICY IMPLICATIONS AND CONCLUSION .................. 90
8.1 Policy Implications and Recommendations........................................... 90
8.2 Conclusion ............................................................................................. 93

REFERENCES .............................................................................................. 96

APPENDIX 1A: HEALTH SECTOR BUDGET ESTIMATES 1999/00 IN BILLION
SHILLINGS .................................................................................................. 100

APPENDIX 2A: EXAMPLES OF CRIME REPORTS IN THE HOSPITAL .......... 101

APPENDIX 3A: QUALITY ASSESSMENT INTERVIEW SCHEDULE............... 102

APPENDIX 3B: COST ANALYSIS SCHEDULE CONTRACT COSTS ............. 104

APPENDIX 3C: GOVERNMENT/HOSPITAL PRODUCTION COSTS (IN-HOUSE
PROVISION OF SERVICES) ........................................................................ 105

APPENDIX 3D: CHECK LIST FOR CONTRACT DESIGN............................... 106

APPENDIX 3E: CHECK LIST FOR CONTRACT IMPLEMENTATION............... 107

APPENDIX 3F: INTERVIEW GUIDE FOR HOSPITAL ADMINISTRATORS ....... 108

APPENDIX 3G: CONTRACTORS INTERVIEW SCHEDULE............................... 109

APPENDIX 4A: ALLOCATION BASIS FOR COST OF SERVICES.................... 110

APPENDIX 5A: GUIDELINES ON NEGOTIATIONS AND EXECUTION OF
GOVERNMENT CONTRACTS ........................................................................ 113
# LIST OF TABLES AND FIGURES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Summary of the major health policies in Uganda (1999-2004)</td>
<td>9</td>
</tr>
<tr>
<td>6.1</td>
<td>Mulago Hospital's history of contracting out health support services</td>
<td>49</td>
</tr>
<tr>
<td>6.2</td>
<td>Differences in weighting system for evaluation of bids</td>
<td>52</td>
</tr>
<tr>
<td>6.3</td>
<td>Comparative cost analysis of in-house production and contracting out cleaning services</td>
<td>60</td>
</tr>
<tr>
<td>6.4</td>
<td>Comparative analysis of in-house and contracting out of security services</td>
<td>62</td>
</tr>
<tr>
<td>6.5</td>
<td>Quality assessment of structural aspects of cleaning services</td>
<td>63</td>
</tr>
<tr>
<td>6.6</td>
<td>Quality perceptions of cleaning services of different groups of respondents</td>
<td>64</td>
</tr>
<tr>
<td>6.7</td>
<td>Overall quality assessment of cleaning services</td>
<td>66</td>
</tr>
<tr>
<td>6.8</td>
<td>Quality assessment of structural aspects of security services</td>
<td>67</td>
</tr>
<tr>
<td>6.9</td>
<td>Quality perception of security services of different groups of consumers</td>
<td>68</td>
</tr>
<tr>
<td>6.10</td>
<td>Overall quality assessment of the security services</td>
<td>69</td>
</tr>
<tr>
<td>7.1</td>
<td>Summary of major findings</td>
<td>72</td>
</tr>
<tr>
<td>2.1</td>
<td>Inter-functional linkages in Mulago hospital</td>
<td>12</td>
</tr>
<tr>
<td>4.1</td>
<td>Contracting out non-clinical services and issues of efficiency</td>
<td>31</td>
</tr>
<tr>
<td>5.1</td>
<td>Multistage stratification of respondents in Mulago hospital</td>
<td>39</td>
</tr>
<tr>
<td>3.1</td>
<td>Types of contracts</td>
<td>23</td>
</tr>
</tbody>
</table>
ABSTRACT

Health reforms that advocate for more private sector involvement in the provision and financing of health services are increasingly being considered as a means of ensuring more efficient provision of health related services. Though such reforms may be designed, funded and implemented it does not imply that the conditions necessary for them to yield the intended results do exist. One such reform is contracting out. The only national referral hospital Uganda has a long history of contracting out health support services, but there is hardly any empirical evidence of the resultant efficiency gains.

To study the contractual arrangements in the hospital a theoretical framework based on what determines contract performance was used as the basis for the analysis. Several methodology approaches were used, which included in-depth structured interviews with the hospital administrator and key government officials on the entire contractual process and to establish the regulations and policies underlying the contracting out policy in the country. In addition a detailed documentary review was done for the contract design and implementation and other issues pertaining to the cleaning and security services. Cost data was obtained from the hospital’s expenditure and accounts records. Quality of the services data was collected using a quantitative interview schedule that required consumers to indicate their satisfaction with the security and cleaning services when they are provided in-house as opposed to when they are provided by contractors.

One of the major findings is that while it was cheaper to provide cleaning services through contracting out, it was actually more costly to provide security services through contracting out than in-house provision. Therefore there is no clear pattern to support the hypothesis that health support services can be provided at a lower cost than direct provision of services. This is because contract costs are a function of service complexity, contestability and management capacity. Services that are hard to specify involve uncertainty about the nature and costs of production itself, which is likely to increase total contract costs both during contract negotiations and the post contract stage.

Secondly, contractors had succeeded in providing better quality services than in-house provision. One pertinent issue of contract design is that is key to contract success is the
detailed specifications of the expected outcome in terms of both quantity and quality for this greatly eases the enforcement and monitoring process and is likely to a positive impact on the quality of services that the contractors provide, for both parties will have a clear picture of what was expected.

The study highlights a number of factors that contribute to the success of contracts: First, governments needs cost and quality information on its own services for this should be the basis upon which decisions to contract out should be made. Secondly, award and renewal of contracts requires regular and detailed evaluation of provider performance and of the market situation especially in low contestability and competition. Thirdly there is need to have incentives within the management of contracts efficient monitoring. Lastly, contract failure was attributed more to the government bureaucratic and centralised systems that often resulted in delays in awarding contracts and paying contractors.
ACRONYMS

ADB  African Development Bank
ALERT  Alert Guards and Security Systems Ltd.
CTB  Central Tender Board
GOU  Government of Uganda
GDP  Gross Domestic Product
MOH  Ministry of Health
NEC  National Enterprises Corporation
NGO  Non-Government Organisation
NOREMA  Norema Services Uganda Ltd.
ODA  Overseas Development Agency
PHC  Primary Health Care
SOE  State Owned Enterprises
UG.SH.S.  Uganda Shilling
CHAPTER ONE: INTRODUCTION

1.1 Background

Many developing countries are currently undertaking far-reaching health sector reforms, in an effort to improve and ensure efficient health services delivery. Some of these reforms are rooted in the message from financial institutions (IFIs) such as the World Bank and bilateral donors of reducing the level of government involvement in health care and promote the private sector (Bennet, McPake and Mills 1997). Although transferring services once handled by the public sector to private providers is proving to be successful in the developed countries, such reforms need to be implemented with caution in both industrialised and developing countries.

This is particularly true, given the fact that the resources required to provide and finance health care services are increasingly becoming a financial burden for most developing countries governments (Randall et al. 1993). Given the lack of insufficient resources the public sector has often been labelled inefficient where it has failed to meet the populations’ expectations. Therefore reforms advocating for more private sector involvement in the provision and financing of health services are increasingly being considered as a means of ensuring more efficient provision of health care. Though such reforms may be designed, funded and implemented it does not imply that the conditions necessary for them to yield the intended results do exist. This is because certain contextual factors that affect the consequences of reform, such as macroeconomic performance, infrastructure development, educational levels and cultural norms are beyond the influence of a Ministry of Health. As a result similar policies may have very different consequences in different environments (Kutzin 1995).

However several developing countries’ governments have gone ahead and contracted out health related services basing on the following rationale:

- Contracting out is a means of benefiting from private sector efficiency while maintaining control over what services are to be provided and to whom.
- With contracting out better quality services can be obtained at a cheaper price. It also reduces wastage and pilferage of government resources
- Contracting out offers greater flexibility to coping with changing demands,
particularly with respect to labour. It challenges the established power of organised labour and provides means to use labour more flexibly (Saltman and Von Otter 1995).

- Contracting out reduces the management load on clinical staff for they are able to concentrate more on their clinical responsibilities. It can also make the management process more transparent, facilitating the setting of objectives and holding the service provider accountable for achieving them (Mills 1997).

Despite the above advantages, the practicability of contracting out is still questionable in many developing countries. Nonetheless the language of contracting and competition, and of the division between the roles of the purchaser and provider which they require, is increasingly appearing in policy documents relating to health sector reform in developing countries (Mills 1995). Despite the increasing popularity of contracting out, (Walsh 1995; Bennet et al. 1997; and Broomberg 1994) note that there is limited empirical evidence of the impact of these reforms on health services efficiency. There is therefore need to establish the potential of such reforms in improving efficient delivery of services before developing countries governments can embark on ambitious plans of contracting out.

1.2 Statement of the Problem

Government production of health services is often criticized on the grounds that government firms are inefficient producers compared to the private sector. The contention however is that regardless of the competitiveness or efficiency of the private sector, there is unquestionably a role for the government in ensuring adequate health services (Randall et. al 1997). In Uganda the political and economic instability that rocked the country for over twenty years left a weakened public sector. The health sector like the rest of the public sector was characterised by low capacity utilisation, high operating- costs and low productivity. This meant that the meagre available public resources were being used inefficiently and service provision was inadequate and of poor quality. In response to this the Government of Uganda in 1992 instituted the Privatisation policy as one of the reforms aimed improving efficient resource allocation and service delivery (Onyaach-Olaa 1992).

As part of the piloting phase of an essential health services component, the Ministry of Health (MOH) made provision for areas of specific support that need development during the pilot phase. It was assumed that improved capacity in these areas would enhance sustainability of
the identified essential services. These areas included:

- Contracting out of services such as repairs and maintenance of vehicles, equipment and buildings.
- Contracting out specified health services, to NGOs and private providers (Maximus 1996).

Contracting out of support services in the health sector is one form of privatisation evident in Uganda’s health sector. Nearly all hospitals in Uganda have contracted out one or more non-clinical services and in future more facilities are likely to follow this trend. This is in line with the macro economic policy of privatisation, and also in line with the MOH health policy that is continually recognising the scale and importance of the private sector in the provision of health care services. Though government production of health services has often been criticised on the grounds that government firms are inefficient producers compared to private sector firms there is however no empirical evidence to show whether contracting out health support services has succeeded in improving efficiency and delivery of services in Uganda. Therefore there is need to evaluate the existing contractual arrangements for health support services in Uganda even before contracting out of clinical services can be seriously considered.

Though Uganda’s government and the Ministry of Health continue to adhere to the reform ideologies and efforts of the multilateral and bilateral agencies, it is imperative that the following policy issues are considered as far as the contracting reform policy is concerned:

- Is contracting out an efficient means of delivering health related services?
- Can contracting-out improve or interfere with the equity of delivery of health services?
- What was the rationale for the contractual arrangements in place?
- Does the government of Uganda/Ministry of Health have the capacity in terms of human skills to negotiate successful contracts?
- Is contracting out one of the reform ideologies and efforts of multilateral and bilateral agencies? Precisely is it an ideal reform for Uganda’s health sector?

Answers to all the above questions will help the Ugandan Government and more particularly the MOH determine the practicability of the contracting out policy. However, such an evaluation though important is insurmountable in this study. This study focused only on whether contracting out is an efficient means of delivering of health support services.
1.3 Objectives of the Study

The overall objective of this study is to evaluate the efficiency of contractual arrangements for support health services in Uganda. The specific objectives of the study are to:

1. Analyse the costs and quality of selected health support services that were contracted out as opposed to when services are provided in-house. Such an analysis entails answering questions like whether contractors always provide better quality services than in-house provision, what happens if contractor price/costs are too high - should public hospitals continue to contract out service? What happens if costs are increasing and yet the quality of services remains the same or deteriorates under contractual arrangements?

2. Establish what attributes make a contract successful and hence efficient. This part of the evaluation is more qualitative, in that a number of issues should be considered. For example does the negotiation process contribute to the final contract design and hence on how the contractors perform? Or is it more of the contract implementation that affects the contractors' performance? More so does the pricing of contracts have any indirect effect on the contractor performance?

1.4 Justification of the Study

The Ugandan Ministry of Health is committed to strengthening the planning, management and monitoring of health services through institutional and organizational reforms in addition to strengthening collaboration and partnership with the private sector in the national health development. It is on this premise that it is seriously considering transferring services once handled by the public sector to private providers through increased contracting out. One of the advantages in support of contracting out is that it is capable of allocating resources more efficiently by reducing or containing costs and providing better quality services. The Government of Uganda had a nine years contract with one the state owned enterprise National Enterprises Corporation (NEC) to provide cleaning services to the national referral hospital. Other public hospitals all over the country are also experimenting with contracting out cleaning, security, and laundry and catering services. Hospitals have also gone ahead and contracted out maintenance of the hospital laboratories and elevator services where they exist. Contracting out in Uganda's hospitals is more common with non-clinical services, but of recent the MOH is contemplating contracting out clinical services to private providers.
including NGOs especially in underserved areas.

The results from this study will be of particular importance to policy makers in that it will enable them to know to whether contracting out has resulted in better value for money than direct provision. The cost and quality analysis will inform policy makers of whether it is cheaper for the government to provide the services itself or to contract them out and whether there is a difference between costs and quality of providing services in-house and the costs and quality of contracting out.

Secondly this analysis will also go a long way to let policy makers know what factors might impede the success of the contracting out process and how the existing contractual arrangements could be improved. This information might also be used in the design and implementation of any future contractual arrangements.

Contracting out services that were formerly provided in-house implies a change in the role of health managers and hospital administrators for they have to monitor the performance of the contractor. Therefore this study will indirectly provide information on whether the health managers are capable of monitoring contract performance since it is assumed that monitoring is vital to how contractors perform.

Lastly, the results of this study will be particular of importance to The World Bank, and to other bilateral donors who are presently encouraging and supporting the contracting out of health related services in Uganda.

1.5 Scope of the Study

The evaluation of the relative efficiency of the contractual arrangements in Uganda was limited to the national principal referral and teaching hospital: Mulago Hospital and Complex. Mulago has a long-standing history of contracting out services and is among the first hospitals to institute the contracting out policy. It has contracted out a number of non-clinical services among which is cleaning and security services, maintenance of the diagnostic services equipment and maintenance of the elevators. However due to cost data limitations, the study was confined to evaluating the cleaning and security contractual
arrangements in the hospital.

1.6 Format of the Study

Chapter one includes the background to the study and a brief overview of the divestment of support services in the Ugandan Health Sector. It also presents the statement of the problem, objectives of the study, justification of the study and the scope of the study. The second chapter presents the country background and an overview of the case study area. The third chapter reviews contracting out of health services literature with a focus on developing countries. Chapter four presents the conceptual framework of contracting out non-clinical services and issues of efficiency. The methodology of the study that includes: data collection methods, sampling techniques and data analysis is presented in the fifth chapter. The results of the study are presented in chapter six while a detailed analysis and discussion of these results is presented in chapter seven. The final chapter includes the policy implications, recommendations and the general conclusion.
CHAPTER TWO: COUNTRY BACKGROUND

2.1 Socio-economic and Demographic profile

Uganda is a land-locked East African country, bounded by five countries: on the east by Kenya, on the north by Sudan, on the west by the Republic of Congo, on the southwest by Rwanda and on the south by Tanzania. Uganda with a population growth of 2.8% and a population of 21,143 million people has some of the poorest health status indicators in Sub Saharan Africa, (WHO 2000). Infant mortality rate is at 97 per 1000 live births while the maternal mortality ratio between 500 and 2000 per 1000 live births and fertility rate stands at 6.9. Ugandans have an average life expectancy of 42 years. The above poor indicators could be attributed to the inadequate provision and inequitable distribution of health services, high prevalence of communicable diseases, new diseases and reoccurrence of other diseases and severe poverty.¹

Prior to the years of civil strife and political turmoil that rocked the country for almost two decades during the 1970s-1980s, Uganda had a well set up health system. But the period of decline led to the collapse of social services: facilities and equipment were neglected or destroyed. In the health sector, lack of adequate drug supplies and demoralised personnel coupled with organisational and managerial problems undermined the sector’s ability to provide sufficient health care services. Currently and over the past fifteen years efforts are being made to rehabilitate the existing social infrastructure through repairs, re-equipping of facilities, retraining manpower and provision of logistical support in an effort to improve the quality of social services.

Uganda has achieved a marked real economic growth of an average 6.5% per annum for the last five years and inflation has been maintained below 10%, and per capita income is estimated at US$300 over the past five years (MOF1997). This can be attributed to some of the sound macro-economic policies like liberalisation and privatisation of the economy, which are being pursued by the government.
2.2 Health Policies in Uganda

2.2.1 Health Policy in Uganda

Through the last few decades Uganda had one of the unstable political environments. Health policies were proposed, or implied in action plans but never implemented. Fifteen years down the road Uganda has a clear health policy statement, which the Ministry of Health (MOH) revises each year but with a clear goal: to accelerate the attainment of good standard of health by all Ugandans to ensure that they live a socially and economically productive life (MOH 2001). The health policy of the Government of Uganda aims at restructuring and reorganising the health services system to suit the needs of the country. The Ugandan Government is committed to providing health for all through the primary health care strategy.

Currently with the institution of the decentralisation policy the MOH and Ministry of Local Government are directly responsible for the delivery of health services through public health institutions. The MOH directs the Ministry of Local Government in policy matters and also supervises the private sector. The MOH responsibilities have continued to change over the years shifting from direct management of the delivery of health services to new core functions that include:

- Policy formulation, setting standards and quality assurance.
- Resource mobilisation.
- Capacity development and technical support.
- Provision of nationally coordinated services.
- Monitoring and evaluation of the overall sector performance.

On the other hand the Ministry of Local Government through the district health care teams is responsible for implementation of the national health policy, planning and management of district health services, provision of disease prevention, health promotion, curative and rehabilitative service with emphasis on the minimum health care package and other national priorities.

In an effort to restore the functional capacity of the health sector the National Health Policy has continued to focus on structural and organisational reforms and the government is in the middle of an ongoing process to update and make new policies for the country. Some of the newest policies embedded in the country’s health policy document are summarised in table 1.
Table 2.1: Summary of the Major Health Policies in Uganda (1999-2004)

<table>
<thead>
<tr>
<th>Main Policy/Priority Areas of Government</th>
<th>Objectives of the Policy</th>
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<tbody>
<tr>
<td>1. Primary Health Care</td>
<td>To improve access to basic health care.</td>
</tr>
<tr>
<td>2. Decentralisation</td>
<td>To bring the management of resources closer to users To improve efficiency and effectiveness of health care services</td>
</tr>
<tr>
<td>3. Health Sub-district</td>
<td>Further decentralisation of management to lower levels. Improving equity to access.</td>
</tr>
<tr>
<td>4. Minimum health care packages</td>
<td>To identify and address priority issues in health care</td>
</tr>
<tr>
<td>5. Health Financing</td>
<td>To find alternative financing mechanisms for health care</td>
</tr>
<tr>
<td>6. Partnership with the private sector</td>
<td>To make the private sector a major partner</td>
</tr>
<tr>
<td>7. Strengthen laws and regulations</td>
<td>To review and develop relevant legal instruments to govern and regulate health and health-related activities</td>
</tr>
<tr>
<td>8. Sector Wide Approach</td>
<td>To provide effective coordination of all partners in the health sector</td>
</tr>
<tr>
<td>9. Human Resource Development</td>
<td>To address major constraints of inadequate numbers and inappropriate distribution of trained personnel To ensure increased productivity in accordance Result Oriented management</td>
</tr>
<tr>
<td>10. Community Empowerment</td>
<td>To make the community take responsibility for their own health</td>
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Some of the policies highlighted above are initiatives to contracting out health related services. Among these is decentralisation, whose objective of improving efficiency and effectiveness of health care services is in line with one of the advantages of contracting out. The MOH continues to support partnership with the private sector in the delivery of health care services by encouraging contracting out services to private providers. The strengthening of laws and regulations has implications on contracting out services, (Mills 1997) argues that regulatory environment will influence various aspects of contracting, for example it will affect the number and behaviour of private sector firms and providers who may be interested in contracts, ease of market entry and profitability.

2.2.2 Health Care Financing

Uganda’s total health care expenditure is approximately 4.7% of its GDP. Public expenditure as percentage of total expenditure on health in the year 2000 on health was 224.2 billion Uganda shillings, which is equivalent to 12.2% of the total government budget. Donor support was estimated at 24.6% (MOH 2000) but this excludes the donor contributions that
are channelled directly to NGOs. But according to the Uganda Health Bulletin of 2001 Uganda depends on donors for a large share of its total expenditure on health that is estimated to be as high as 43%\(^1\). While private expenditure on health is 44.8%, this is more in the form of out of pocket financing. Seventy percent of the government expenditure on health was for recurrent expenditure. The reallocation of the government expenditure budget\(^2\) on health was as follows: hospitals took up 38.6% (this includes Mulago Hospital, Butabika Hospital, NGO hospitals, district and referral hospitals), MOH 36.6%, PHC 12.7%, training schools 1.9%, staff allowances 9.4% and the Health Service Commission 0.8% (MOH 2000). Refer to appendix1A for the detailed health sector budget allocations. It is worth noting from appendix 1A that donor contributions are more towards capital development.

Both donors and the private sector play significant roles in Uganda’s health care financing. The private sector in Uganda consists of NGOs, private practitioners, the traditional health care system of traditional healers and midwives, and an expanding private pharmaceutical sector. The health policy recognises that the private sector is a major partner in healthcare and service delivery and is therefore committed encouraging and supporting its participation in all aspects of the national health programmes. Involving the private sector in the delivery of health services is in line with the government’s privatisation policy, which is rooted in the Economic Recovery Programme of 1987. Therefore in an effort to improve the delivery of health services the government has gone ahead and explored alternative options to improve efficiency within the public health sector such as contracting out some of the health support services to the private sector.

2.3 Presentation of the Case Study Area: Mulago Hospital & Complex.

Mulago Hospital is referred to as Uganda’s national referral, teaching and research hospital. To most Ugandans this refers to New Mulago Hospital, which they understand to have been purposely built to fulfil these functions. However, for a few especially those working in the hospital they regard Old Mulago, as an integral part of the hospital complex and indeed this was the foundation for the name “Mulago Hospital and Complex”. The 1500 bed hospital provides primary and tertiary health care. It also provides a 24-hour causality and emergency services.

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\(^1\) The total contribution of 43% from donors to the health sector includes all donor contributions channelled directly to the government and to NGOs, whether from external or internal donors.
The role of Mulago Hospital comprises of the following elements:

- Provision of inpatient and outpatient services for residents of Kampala and surrounding districts - the district role,
- Provision of specialist and referral services - the regional and national role,
- Provision of outreach services and support to Kampala primary care health units and to district hospitals and
- The national role in teaching, training and research (Kiwanuka 1998).

2.3.1 Organisation of the Services

The hospital has six directorates through which services are offered:

- Administration: this directorate includes the general administration, personnel, finance, supplies, medical records, audit and the planning and evaluation departments.
- Nursing and midwifery directorate.
- Surgery directorate incorporates all the surgical departments.
- Diagnostic and therapeutic services which comprises of clinical laboratories, x-ray, Nuclear medicine, radiotherapy, physiotherapy and occupational therapy departments.
- Maternal and Child Health Services: incorporates the departments of Obstetrics and Gynaecology, Paediatrics and Child Health and the Primary Health Care Unit.
- Medical Services incorporates the departments of Medicine, Psychiatry and Pharmacy.

The functional linkages of the hospital administration are summarised in the organisational chart presented in figure 1. From figure 1 it is clear that there is a linkage between the administrative and clinical divisions of the hospital, in that the administrative division has to oversee the clinical division as well. The hospital support services are within the Assistant Director Support Services’ jurisdiction.

With the on-going Health Services Rehabilitation Project, Mulago Hospital is making a definite and gradual improvement in its services. An assessment centre where all patients are

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2 Total reallocation of the government budget includes recurrent and development expenditure directly financed by the government.
screened was constructed under this project. This centre has gone a long way to improve on the referral system and has contributed to the decongestion of the casualty and specialised clinics of the hospital. There has been a general rehabilitation of all wards and blocks in the hospital and erection of a new security fence. The investigative directorate was also reequipped with more modern equipment.

**Figure 2.1: Inter Functional Linkages in Mulago Hospital**

2.3.2 Autonomy of Mulago Hospital and Complex

Since 1986, the Government has embarked on a comprehensive rehabilitation programme of the hospital. Before it was granted financial autonomy in 1986 Mulago Hospital was like any other hospital in Uganda managed centrally from the MOH headquarters. Its administrative functions were shared between the Director then Medical Superintendent, the Principal Nursing Officer and the Hospital Administrator each of whom had a defined area of responsibility, but with none having any executive authority. Their decisions were based on instructions, circulars and directives from the Ministry of Health. The Ministries of Public Service and Health were responsible for all staff matters including career development, discipline and welfare. While the Ministry of Finance determined all hospital budgets and expenditures while the MOH took all operational and financial decisions.
With the devolution of financial management the hospital is now required to formulate and manage its own budget, procure, store and manage its drugs and other material supplies. It has to manage its human resources although some aspects of this area remain with the Ministries of Health and Public Service. For example the Ministry of Public Service is still responsible for setting staff salary structures, recruiting and firing health personnel. Today Mulago has to plan its development and organise its services to ensure efficient and effective delivery of qualitative health care given the limited resources at its disposal. However, it is worth noting that even with the ‘financial autonomy’, the hospital is still accountable to the government Auditor General.

Though it is being continually said that Mulago Hospital is to become fully autonomous, it is almost over a decade now and no firm machinery has been put in place to institute its autonomy. In other words, the government still has a lot of control on the hospital and hence the hospital’s autonomy is partial if not only on paper! But the Cabinet has authorised the institution of an interim hospital board, which among other things will assist in preparing Mulago for the full autonomous status (MOH 2001).

2.3.3 Health Reforms in the Hospital.
In an effort to restore its past glory and in line with the National Health Policy, Mulago Hospital has and is still instituting a number of health reforms. Without adequate funding, manpower and equipment in a big complex organisation like Mulago Hospital inefficiency was bound to be evident. Furthermore with health care increasingly becoming expensive there was need to involve the communities to meet part of this cost through cost sharing - hence the user fee policy in the hospital (Kiwanuka 1998). The hospital’s recurrent expenditure budget for the financial year 1999 was approximately 2.5 billion Uganda shillings of this 1.6 billion shillings (64%) was from user fees and the government was to contribute the 1.9 billion. Donors’ contributions are not reflected in the budget, as these are more in form of capital expenditure as reflected in appendix 1A. However all revenues from the user fees is remitted to the government treasury and the hospital receives it as part of the government release through the Bank of Uganda.

Under the user-fee policy patients had to pay for all radiological services (x-ray, CT scan and
ultrasound), investigative and dental services. However, the general patients were paying less than one third of what the private patients paid (Kiwanuka 1998). Though there was no clear exemption policy those who could not totally afford to pay for the diagnostic services were exempted at the discretion of the medical personnel.

It is worth noting that the user-fee policy has always been a controversial policy since its inception in 1990 and recently in February 2001, less than a month to the Presidential elections, the government abolished user fees (cost sharing) in all its health centres with effect from March 2001. The Minister of Health stated that it was only in district, regional and national referral hospitals were patients would be given the option of paying and being served quickly or following queues for free services (New Vision Feb 17, 2001). However, such an announcement in the press is likely to have an effect on the operations of the hospital for it is anticipated that there will be a loss of revenue as a result of the society’s interpretation of the abolition of user fees policy.

Mulago Hospital pursued a public-private mix reform in 1990 in an effort to cater for clients of different socio-economic classes, in that those who could afford private services could have access to such services in the private wings of the hospital, while those who cannot afford could still enjoy the services offered in the general free wings. Secondly the financing from the government was inadequate coupled with continued loss of doctors to the private sector. The hospital administration realised that to improve the medical care quality there was need to keep the doctors in the hospital. Today Mulago operates a private wing where patients pay for all services rendered, and medical personnel who work in this section of the hospital get a top-up allowance. Some surgeons also work in the hospital and also operate their private clinics but can refer patients from their clinics to the hospital’s private wing.

2.3.4 Contracting Out Policy in the Hospital

With the approval from the Ministries of Finance and Health Mulago Hospital undertook the piloting of contracting out the grounds maintenance service in 1991. Contracting out of some of the health support services in the hospital was as a result of the Public Civil Service Reform in September 1990 that necessitated the review of staff establishments in each department of the hospital. The hospital had to ensure that its staffing levels were in line with the approved government staff establishments. This was coupled with poorly supervised,
remunerated and demoralised employees, who indirectly contributed to the unsatisfactory service delivery. It was considered that an efficient contractor could pay a living wage to a realistic number of properly supervised individuals and still charge less and provide better quality services.

Contracting out of health services to the private sector was also deemed necessary because of the continued attrition of health workers and other personnel coupled with the government ban on recruitment embedded in the Public Civil Service Reform Programme that led to a shortage in the availability of human resources for the health sector.

Further the Civil Service Reform process during 1993 also attributed to the contracting out of health support services. Some jobs were integrated that is merged into one occupation for the main reason of absorbing group employees on permanent and pension able terms. Other jobs were completely abolished while others it was recommended that they be contracted out as and when the need would arise. Among those jobs recommended to be contracted out were the cleaners/sweepers’/rubbish collectors’ jobs in large institutions like hospitals – hence the hospital had to contract out the cleaning services.

The hospital’s security services according to verbal reports from people who were serving during the time showed that the security service is as old as the hospital itself. Written information on this services particularly how it begun and how it has progressed was scarce. By 1963, Mulago Hospital was employing 48 security guards, but there was no established system of recruiting guards, however recruitment was done by the Medical Superintendent basing on the recommendations about the individual made by the head of unit. Guards were provided with uniforms that included shirts, shorts, berets and boots for easy identification. Duties of the guards included:

i) Checking and apprehending criminals who were involved in thefts of drugs, food and other supplies and patients’ property.

ii) To control entry into the hospital and wards, that is preventing visitors from entering into the hospital wards during working hours.

iii) Time keeping: guards were responsible for ringing bells when it was time for entering and leaving the wards.

However, over the years the security situation at the hospital changed with economic
degradation of the country. Though the hospital effectively required 128 guards, the department was understaffed and was by 1998/9 employing only 66 guards. This affected the deployment system in that some sensitive areas were often left unguarded like the pharmacy, stores, workshops and some exit gates of the hospital. In relation to the above problem the hospital was experiencing increasing number of break-ins and thefts of both its property (especially drugs and supplies), and that of the staff and patients. Appendix 2A highlights some types of crime the hospital experienced. Secondly guards were recruited in an adhoc manner and as a result most of them were untrained and ill equipped for the job with most of them either being school dropouts or completely illiterate). In addition, the security staff were poorly paid and were demoralised this greatly attributed to their under hand collaboration with other hospital staff in the pilferage of hospital supplies and their continued extortion of money from the public. Lastly, the management had attempted to establish a number of internal control systems that would serve as a vital mechanism for supporting the security system but often failed to maintain them or implemented them haphazardly. Most importantly in 1998 the hospital underwent substantial refurbishing and expansion, which included the fencing of the whole hospital complex and these posed challenges to the security service that was already inadequate. All in all the security services of the hospital were not up to the desired standards.

Given the above scenario the hospital decided to divest the security and cleaning services. Information from the documentary review and in-depth interviews with key hospital personnel reveals that the hospital’s rationale contracting out the services was to:

- Improve the quality and standard of services provided by the hospital through in-house provision;
- Reduce on the pilfering and wastage of hospital resources;
- Promote greater operational efficiency by use of improved management; structures and systems of monitoring and accountability;
- Reduce on the costs of providing these services; and
- Reduce on the hassles that hospital managers encounter in managing support services, hence allow them to focus more on the delivery of clinical services.

In addition contracting out of support health services is in line with the MOH implementation of government policy, which is committed to promoting greater direct participation of the private sector in the provision of hospital services and health care. Hence in 1991 the hospital
contracted out the external cleaning services on a pilot basis and later in 1993 fully contracted both the external and internal cleaning services of the hospital. Security services were contracted out in July 2000, but internal security of the hospital is still provided in-house. Apart from the security and cleaning services, the hospital has contracted out the maintenance of elevators, maintenance of laboratories, CT scan and x-rays equipment.
CHAPTER THREE: CONTRACTING OUT HEALTH RELATED SERVICES IN DEVELOPING COUNTRIES

3.1 Introduction

The relative roles of the public and private sectors in health care in developing countries have changed considerably over time (Bennet, McPake and Mills 1997). In the past the provision of health care and services was primarily the responsibility of the public sector. However from the mid 1980s there has been considerable international mobilization around the theme of smaller role of the government in health care (Bennet, McPake and Mills 1997). Public health services are not only seen as inefficient but also insufficient to meet the needs of the populations. Even the governments themselves are realising that they can no longer afford to solely provide health care services as they did in the past.

Despite government failure to provide efficient services, it is worth noting that developing countries may be implementing privatisation under pressure from the World Bank and bilateral donors. This is in conformity with (Barker 1996)’s observation that in the 1980s the IMF supported structural adjustment programmes usually contained policy recommendations related to privatisation. Sometimes these were for privatisation in the sense of change of ownership. There are number of reasons for the global alignment of the state in the provision of services. Bennet, McPake and Mills (1997) have outlined them to include:

1. The welfare optimality of a perfectly competitive market place. Under this neo-classical paradigm, a shift to the private sector ownership, in and of itself, may offer slim benefits unless market structures are conducive to competition. In a competitive market place where there are a large number of firms, all of whom individually have no influence over the price of the good or service but decide only the quantity they will produce, then welfare – maximizing outcome is predicted.

2. Political theory provides another rationale for realignment of the state. The ascendancy of neo-liberal thinking has reasserted the rights of individuals to trade and to purchase the goods and services upon which they place high priority. Thus (Adreno 1993) suggests that as an individual’s preferences, rights and values are central to most societies, private markets are also essential. In this context the global wave of democratisation, both in the former communist countries and in previously single-party states in Africa, has been an impetus to reconsidering the role of the state.
3. The fiscal situation in the developing countries has come under pressure both from greater spending commitments and declining tax bases. Shrinking government budgets and burgeoning debt-servicing commitments have meant that in some countries social services have functioned with insufficient resources available to meet operating costs. The inability to of governments to fund the operating costs of existing facilities has clearly contributed to the image of an overextended. The obvious response to such problems has been downsizing government.

4. Bennet et al. (1996) note that what would appear to be a to be a more widespread phenomenon is the pursuit of decentralization between levels of government, followed by incremental privatisation. They observe that in Venezuela for example, decentralization was associated with the widespread adoption of autonomous hospitals or hospital trusts, the establishment of private practice in government facilities, and the renting out of hospital space for non-clinical services. Mills et al. (1990) further identify privatisation as the most radical form of decentralization.

3.1.1 Privatisation: What is it?

Privatisation can simply be defined as the reduction of the role of the state in the national economies, while enhancing the scope of the private ownership and the private sector, both local and foreign. Privatisation can therefore take various forms depending on the policy options adopted by the government so as to alter the balance between the public and private sectors in the economy. The three major forms of privatisation are:

- **Divestiture** – This involves the partial sale of the government enterprises’ equity to the general public. Where capital markets are non-existent, divestiture may take the form of the total sale of the enterprise as a complete entity. It may also take the form of joint ventures where the government goes into an agreement with private individuals or firms, local and foreign partners. Due to the lack of capital markets in developing countries, joint venture is the most common form of divestiture in these countries.

- **Liberalisation or deregulation**: This mode of privatisation involves the liberalisation or deregulation of entry to activities that were restricted to the public enterprises only. The removal of restrictions on market entry is intended to increase the role of competition, and to the extent that private are successful in entering the hitherto protected markets- privatisation would have taken place even if no physical transfer of
ownership of assets would have taken place.

- **Contracting out**: This is where the provision of a good or service is transferred from the public to the private sector while the government retains the ultimate responsibility of supplying the service. The public sector finances the contract, while provision of the services is done by either a public or private institution. This type of privatisation can take the form of:
  
  i) Franchising (right to market on behalf of),
  
  ii) Contracting-out the provision of the service, and
  
  iii) Leasing or renting.

From the literature, contracting out of non-clinical services is the more common form of privatisation in the health sector in the developing countries. In Thailand contractual arrangements existed for the provision of cleaning services in hospitals. While in Papua New Guinea, cleaning, security and ground maintenance services were contracted out and in Bombay contracting out of catering and dietary services was common. A few countries in Africa have embarked on clinical contracting among them is South Africa and Zimbabwe. South Africa has several rural hospitals owned and managed by for-profit firms and contracted to a province to provide inpatient and outpatient hospital care. Zimbabwe has one example of a clinical contract, where the MOH contracted a mining company to provide clinical services in a 400-bed hospital. Senegal and Madagascar have successfully contracted out preventive nutritional services at the community level (Marek et al. 1999). Self-management in the form of autonomous hospitals is increasingly discussed in Sub-Saharan Africa, but is still a fairly infrequent phenomenon (McPake 1996 cited in Bennet, McPake and Mills 1997).

### 3.2 Definitions, Forms and Underlying Issues of Contracting-out

McPake and Hongoro (1995) define contracting as a normal market exchange of services, which is formalised in advance by issuing of a contract binding the buyer and seller to the conditions of exchange. It is often assumed that the buyer is a government agent although that may be a health unit purchasing some of the services it needs, or a more centralised body like the Ministry of Finance. The seller on the other hand may be a public or private sector institution. Kutzin (1995) on the other hand defines contracting as the use of government funds to buy health care services both clinical and non-clinical from private providers as a strategy generally intended to increase the productivity of public resources by purchasing...
gains in efficiency perceived to exist in the private sector.

Ovretveit (1995) states that contracting out is where a public service contracts out part of its work to an external organization, he further argues that contracting out is a type of ‘purchaser –provider split’ in that a public authority continues to manage and provide many direct services, while on the other hand it continues to finance the services that are directly provided by another provider (contractor). Kalule (1994) further defines contracting out as a means through which the government retains the financing role but delegates the performance role to the private sector. In all the above definitions the government finances the provision of the services, but provision is done by the private sector. However, the government can also contract a public enterprise to provide health services. From the definitions it is clear that contracting out is related to the government purchase of services from the private for-profit providers. But it is worth noting that like in the health sector the government can also purchase health services from non-government organisations (NGOs).

3.2.1 Forms of Contracting

Contracting out may be for an external organization to provide a service directly to the public for example laboratory services, or to provide a support service to a public hospital like catering, cleaning or security services. Contracting out health services takes different forms. Walsh (1995) notes that the terminology is increasingly confusing but the following terms appear to be in common use:

1. Competitive tendering (also known as market testing), where internal staff can bid for contracts in competition with private contractors, Ovretveit (1995) terms this as open contracting and notes that it is the most common model.

2. Contracting out where only private bids are allowed, and where contracts may be agreed without a competitive process (termed as ‘sole sourcing’ in the USA)

3. Internal contracting, where only internal bids are allowed: contracts may take the form of an explicit agreement between government agencies and public sector managers, or between different levels of public sector management. Such arrangements can also be termed ‘performance contracts’ (World Bank 1995 cited in Mills 1997) or ‘restricted public contracting’ (Ovretveit 1995).

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3 NGOs can be broadly defined as organisations that are ‘are not profit led and not controlled by the state’ (Green et al 1993). Unlike private for-profit providers NGOs are seen to be primarily motivated by humanitarian concern (Gilson et al.1994).
Ovretveit (1995) observes that the arguments for and against public contracting depend on which form of contracting we are referring to and also on whether we are considering contracting out non-clinical services or clinical services. The contracting process for clinical services can be as a result of closed tendering, especially in cases where the supply market for such services is limited, but could also be supplemented with performance contracts to ensure quality services. But clinical contracting especially if based on performance contracts involves a lot of monitoring which leads to increased administrative costs, not to mention that clinical contracting can be a politically sensitive issue. On the other hand open contracting usually has the advantages of encouraging new entrants, increasing competition and reducing prices (McCombs and Christianson 1987).

The advantages and disadvantages for contracting out non-clinical services will also depend on from what perspective contracting out is being analysed. For example, from the perspective of civil service employees contracting out would not be favourable as this would mean that they are likely to lose their jobs. On the contrary, from the public sector perspective contracting out may be advantageous especially if it results into cost savings and better quality services.

The type of services to be contracted out should ideally determine the reimbursement method and hence the type of contract that the purchaser will make with the contractor. In principle health managers as purchasers of health care services have a wide choice of reimbursement methods to choose from and need to be aware of the advantages and disadvantages of each. With different health services health managers may need to establish new contracts by changing the reimbursement methods to contractors. Box 3.1 summarises the different types of contracts in terms of time, volume, and detail.
Box 3.1 Types of Contracts

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Block Contract</strong></td>
<td>Similar to a budget for a defined service— an agreement to pay a sum a</td>
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<td></td>
<td>period of time (e.g. one year) in exchange for patient access to the service,</td>
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<tr>
<td></td>
<td>but number of patients (volume) and costs per patient care are not specified.</td>
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<tr>
<td><strong>Block, indicative cost and volume</strong></td>
<td>A block contract with an agreed specification of the total number of patients</td>
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<tr>
<td></td>
<td>to be treated by, e.g. a hospital, for a defined amount of money. Specification</td>
</tr>
<tr>
<td></td>
<td>is guidance—an indication.</td>
</tr>
<tr>
<td><strong>Block indicative speciality cost and volume contract</strong></td>
<td>As for 2, but an indicative contract for one or more services or specialties</td>
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<tr>
<td></td>
<td>within a provider organization.</td>
</tr>
<tr>
<td><strong>Stand-alone speciality and volume contract</strong></td>
<td>An agreement to pay $x$ for $y$ number of people to be treated by one special</td>
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<tr>
<td></td>
<td>ity (e.g. a contract with a private hospital for a service to reduce waiting</td>
</tr>
<tr>
<td></td>
<td>times).</td>
</tr>
<tr>
<td><strong>Case-mix ‘stand alone’ speciality and volume contract</strong></td>
<td>As with 4, with different payments according to severity of illness and/or</td>
</tr>
<tr>
<td></td>
<td>intensity of service e.g. high, medium and low cost categories.</td>
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<tr>
<td><strong>Single item</strong></td>
<td>An agreement to pay a set amount for a defined service to one person (or a</td>
</tr>
<tr>
<td></td>
<td>test), e.g. a single consultant episode, outpatient session, DRG/HRG</td>
</tr>
<tr>
<td></td>
<td>category payment.</td>
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</table>


The above types of contracts are not limited to clinical services but are applicable to non-clinical services as well. For example, block contracts are usually used for cleaning and ground maintenance services, where contractors are paid a monthly lump sum amount of money for a defined range of services regardless of what the output is. Block contracts have the advantage from the point of view of the purchaser of placing a cap on total contract costs unlike cost per case or per unit which may represent an open ended commitment (Mills 1997). They also tend to require less information and monitoring costs but there is usually a trade-off with the quality of services offered.

3.2.2 Underlying Issues of Contracting Out.

Failure of the public health system to offer efficient services has already been cited as one of the rationales for contracting out and increased private sector involvement in health care services provision. However, Barker (1996) argues that private hospitals sometimes appear to be efficient and cost-effective because they avoid difficult cases, which would be complex and expensive to treat (cream skimming) leaving these to the ‘inefficient’ public sector. Therefore inefficient as the public sector may be labelled often it has to continue providing such services to the populations so contracting out will not yield the desired results. The World Development Report (1993) placed considerable emphasis on the idea of public and private sectors offering complementary services. The argument is that while the public sector can continue to provide more cost-effective services, provision of less cost-effective services
could be left to the private sector.

Though contracting out may be introduced to increase efficiency, it may in fact have the effect of decreasing efficiency. For example if contract exante costs (writing a contract, finding a contractor and negotiation costs) and expost costs (accounting systems, monitoring and implementation) are too high they will result in high total contract costs. It is also worth noting that if the contracting agency (public sector) strives to minimise exante costs - in other words if not enough effort is put into writing a contract, identifying a contractor and the negotiation process, then the contract may end up not being awarded to the best contractor. This is likely to affect the quality of services offered.

Kutzin (1995) notes that one condition for contracting to yield gains in efficiency is that competition for contracts among potential suppliers exists or that, at least markets for such contracts are contestable. He adds that this implies that the potential for success, in terms of quality improvement and cost containment, is likely to be less in countries with a limited number of competing private suppliers.

Introducing contracts for services formerly provided directly by health ministries implies a change in the role and function of the latter. As Conn (1994) observes that this would mean retraining civil servants to act as contract managers and possibly also restructuring the ministries To ensure gains in efficiency from contracting services to private sector managers of contracts would need to have skills to establish contracts, evaluate bids and monitor contract performance. Kutzin (1995) notes that because the concept of efficiency includes outputs as well as costs, the skills needed for efficient contracting include the capacity to specify performance criteria and monitor progress and imposing sanctions necessary to ensure compliance.

The need for objective measurement and criteria to monitor contractor performance implies the need for information systems capable of generating relevant performance data promptly (Kutzin 1994). However, even with good systems and strong management information will not be perfect, and thus to some extent the efficiency of contracting depends on the trust between partners (McPake and Ngalande Banda 1994).
Barker (1996) notes that proponents of privatisation in health care argue that privatisation brings real benefit to all consumers by allowing the production of lower priced goods; if a free market is allowed to operate competition will force prices down. Concurring with Barker (1996) Bennet et al. (1996) argue that in the health sector privatisation policies may actually enhance equity. This is in line with the World Banks’ (1993) observation that the private sector can both bring in new resources so that the government can focus its efforts upon the essential services and may expand service to those who initially did not have them.

Further, Kutzin (1994) observes that one way that contracting can improve access to the underserved groups is to offer incentives for private providers to locate themselves in areas where government services are absent. Ministries of health can support the ability of these private providers to meet the basic needs of underserved populations by subsidising some of their resources. In Tanzania for example, the government seconds staff to mission hospitals that have been contracted to serve as district hospitals for defined geographical areas (Bennet and Ngalande- Banda 1994; Gilson et al.1994). Kutzin (1994) further observes that the value for such incentives should be less than the cost of locating government services in these areas. He further notes that if contracts serve to enhance quality, cut costs and improve access, consumers are likely to be satisfied.

3.3 **Empirical Studies on Contracting out of Health Related Service**

Mills (1995) observes that evidence on the extent of contracting out in developing country health systems is extremely limited and evaluation of its advantages and disadvantages has been virtually non-existent. The empirical studies reviewed here were done in South Africa, Thailand, Bombay, Papua New Guinea, Zimbabwe, Senegal and Madagascar.

Bhatia and Mills (1997) report that though contracting out of catering and dietary services in hospitals in Bombay was consistently more cheaper than in-house provision and that contracted out services were in general of poorer quality. They note that there was a clear earmarked trade off between cost and quality of the dietary services. Likewise in Papua New Guinea, Beracochea (1997) found out that contracting out of security and cleaning services was a more costly process than direct provision, which yielded no improvements in the quality of services offered. He notes that probably because it was an adhoc process, in that no evaluation of the costs involved was done before services were contracted resulting in no
efficiency gains. However, Tangcharoensathien (1997) notes that in Thailand there was hardly any cost differential between direct provision and contracting out of cleaning services. Contrary to Bhatia and Mills (1997) and Beracochea (1997) findings, Tangcharoensathien (1997) notes that contracted out services were of much better quality than in-house provided services.

Broomberg et al. (1997) findings on contracting out of in-patient and outpatient care services in South Africa indicate that contract costs were much lower than in-house provision. He notes that contractors were able to produce most hospital outputs at considerably lower costs than public hospitals; but lower staff costs were the main contribution to higher production among contractors. He also notes that nursing care quality was much higher in the contracted hospitals than in public hospitals. However, notable from this study was the lack of a difference between the cost of direct provision and that of contracting to the public sector due to the high profit margin of the contractors.

In Zimbabwe the MOH contracted a mining company that owned a hospital to provide clinical services to the local population. McPake and Hongoro (1995) in their study reveal that the contractor was able to offer services of at least a good quality at prices that were lower than the unit costs of the government hospital when capital costs are included. However, they note that the contract could not be considered as a success because the contractor failed to contain the total costs.

Contrary to all the above studies Marek et al. (1999) in their studies in Senegal and Madagascar do not evaluate whether contracting out is more efficient than direct provision of services. But they try to illustrate that contracting out is a feasible option for the provision of preventive services. They illustrate how both governments in Senegal and Madagascar have managed to execute the national policy against malnutrition through NGOs managed by contracted managers.

In terms of efficiency Bhatia et al. (1997) found out that contractors had much higher productivity in terms of more meals served per staff member. On the other hand Broomberg et al. (1997) used occupancy rates and turnover intervals in addition to cost and quality of services as efficiency indicators. He notes that contractor hospitals were relatively inefficient
in that they had high occupancy rates co-existing with relatively low turnover rates.

In assessing costs of in-house and contracted out services, Broomberg et al. (1997) uses the step-down cost accounting approach and compares total production costs of in-house provision with total contract costs (price paid to contractor, transaction costs incurred in establishing and maintaining contracts). Bhatia et al. (1997) also compare costs of in-house provision with contract costs, which she terms price of the contract. McPake and Hongoro (1995) use a similar methodology.

In order to assess the performance and cost of in-house and contracted out services, (Broomberg et al. 1997; Bhatia and Mills 1997; Tangcharoensathein 1997) employ cost analysis using the step-down approach. Costs for in-house provision were measured under accounting heads such as salaries, raw materials and utilities. Capital costs were estimated at their replacement value and annuitized (Bhatia and Mills 1997; Broomberg et al. 1997). But contrary to the rest Tangcharoensathein (1997) compares contract costs to a hypothetical provision of in-house services. Quality of the services in the reviewed literature is done from the consumer’s perspective depending on the service being assessed. Such consumers included nurses, patients and administrators of the hospitals. Bhatia and Mills (1997) also do a technical assessment of the quality of catering services using a 4-point likert scale.

3.3.1 Conclusion

It is evident from the literature that contracting out in developing countries is more common with non-clinical services and in hospital settings. It is only Zimbabwe, South Africa and Thailand that have explored contracting out clinical services. The limited contracting out of clinical services in developing countries can be attributed to the limited availability of private providers with sufficient experience and capacity to provide health care services on a large scale. Secondly, clinical contracting is likely to be more politically sensitive than contracting of support services (McPake and Hongoro 1995) for public medical personnel are likely to resist it and it may even require more monitoring tools. Support services may also be easier to standardise than clinical services. For example in Bombay the government hospital specified the number of meals they expected the contractor to supply, while in Papua New Guinea it was just a matter of stating the number of guards required for the security service whereas in case of cleaning services it is easy to specify the areas to be cleaned.
It is worth noting that though the specification of non-clinical services is easy, it is hard to spell out the desired quality of the service to the contractors. So it is not surprising that almost in all the studies reviewed with the exception of Marek et al.’s (1999) evaluation of contracting out prevention services in Senegal and Madagascar there was no specification of the quality indicators upon which to assess the contractors’ performance. Lack of proper quality indicators might be a constraint to monitoring the performance of contractors. In Madagascar and Senegal simple yet effective information systems were put in place with three to five indicators monitored and minimum thresholds were identified. These were used to monitor the quality and performance of the contractor (Marek et al. 1999).

All the studies reveal that contractors provided better quality services than in-house provision with the exception of dietary services in Bombay where consumers were more satisfied with the quality of meals provided in-house than those of contractors. However, there are variations in the results of the cost analyses. While in India and South Africa it was cheaper to provide services through contracting out, in Papua New Guinea contracting out of cleaning and security services was actually more costly than direct provision of the services. But in Thailand and South Africa there were hardly any cost differentials between directly provided services and those contracted out.

It is worth noting that in Thailand the cost results are based on a comparison between an estimated hypothetical in-house production cost and the actual contract cost. The researchers assumed that the in-house requirements were equal to what is specified in the contracts. For example, they assumed that the number of cleaners required for direct provision of cleaning services was equal to that specified by the hospital in the contract. Such an assumption is likely to lead to an under or over estimation of total in-house production costs. This is because in some cases hospitals may be using more resources than they require of the contractor and may be aiming at reducing their costs. Alternatively, in case of say understaffing the hospital may require the contractor to employ more staff to meet the resource gap. Therefore it is not surprising that Tangcharoensathien (1997) results show no cost differentials between direct provision and contracting out of the services.

Another point worth noting is that all the above studies refer to total contract costs. None of
the studies differentiates between exante contract costs and expost contract costs. Total contract costs have two dimensions:

- The actual prime cost of the goods or services and
- The transaction costs: but transaction costs include expost and exante costs. Exante costs would include advertising costs, lawyer fees, time spent finding contractor, writing a contract and negotiation. While expost transaction costs can include monitoring costs, implementation, setting up accounting systems. Low exante transaction costs might result in high expost costs that will in turn result in high total contract costs. The reverse can also be true, but this interdependence needs to be investigated. However, if the objective of the purchaser of services is to minimise transaction costs, this might result in compromising the quality of services as the purchaser tries to undercut exante costs (Williamson 1981).

The studies reviewed further aim at establishing the difference between the costs of providing the services in-house and contracting out the services. This implies a before and after comparison which is always prone to be affected by the environmental changes (Appleby et al. 1993) or by reorganisation of the pattern of service management or changes in service standards which are introduced at the same time as the contract. Further these costs are difficult to ascertain if the study period is long especially in developing countries where record keeping is poor. Some studies (McPake and Hongoro 1995; Bhatia and Mills 1995) avoid the before and after comparison and instead compare facilities that have contracted out services with those that still provide services in-house. But this methodology too has problems of comparability of the of health facilities chosen.

Both methodological approaches further encounter the problems of public accounting systems which rarely explicitly state the costs of particular services, let alone the transaction costs of contracting and make it difficult to identify costs in a comparable way (Walsh 1995). However, the studies reviewed try to solve the above problem by employing step-down cost analysis. This is an appropriate method for apportioning resources that serve many different departments hence taking care of costs that would not have been clearly allocated in expenditure reports. However, this method has a problem of coming up with the appropriate criteria of apportioning such costs.
Although only a partial list, the above reviewed studies yield different results regarding efficiency of contracting out health services. Hence the results cannot be generalized to any contractual arrangements for they are subject to conflicting interpretations on what determines a successful contract. Is it the nature of the contract, or the type of services being contracted out (i.e. clinical services as opposed to non-clinical services)? In conclusion the literature provides little consistency concerning the precise determinants of a successful and efficient contracting process.

3.4 Hypotheses

Based on the literature review would Uganda’s study concerning whether contracting out health support services is an efficient means of delivering these services yield similar or any different results? The hypotheses below will be used in answering this question.

1. Health support services can be provided at lower cost than direct provision of the services.

2. Contracting out provides better quality services than direct provision of health support services.

3. Certain aspects of the contract process can determine the success or failure of contractual arrangements for example:
   - The extent to which the service to be contracted out is specified in terms of quantity and quality output increases efficiency for detailed specification eases monitoring the performance of the contractor.
   - The market conditions: if the market for the service is contestable, exante costs are reduced at the contract stage and potentially post contract costs are also reduced.
   - The management capacity to monitor the contract
CHAPTER FOUR: CONCEPTUAL FRAMEWORK

An efficient contracting arrangement will be one that offers the same or better service quality but at a lower price than the one the government was incurring. However, when evaluating whether contracting out has yielded any efficiency gains it is imperative not to only consider costs and quality of the contract, but also to evaluate what is likely to affect the costs and quality of contracts. In addition the rules within the contract are vital including the monitoring processes, as is the environment within which contracting takes place including the markets supplying the goods and services (Mills 2000). Figure 1 highlights some of the issues likely to affect contract performance.

Figure 4.1: Contracting out non-clinical services and issues of efficiency
Aspects of the contract design (box 2) that are key both to the nature of contracts and their likely performance are: the specification of the service, the pricing method; the duration of the contract; and specification of sanctions of poor performance (Mills1998). The service to be provided by a contractor should be stated in terms of expected outcome in the contract document. For example in case of cleaning services, the square metres to be cleaned and or the number of times cleaning should be done can be specified in the contract. These can be used as indicators of the level of performance expected from a contractor. If a contract does not include outcome measures then monitoring and enforcement of the contract becomes difficult and this will impact on the quality of the service provided by the contractor and hence on the general overall contract performance.

Walsh (1995) proposed two basic approaches to specifying the work to be done in a contract. The first states the outcome and leaves it up to the provider to determine how the work is done. This is feasible for activities such as cleaning, but is much less easy for contracts for clinical care. The second states the methods to be used, for example a test to be done, or even just the workload, for example number of procedures. Because of the difficulty of specifying outcome, Walsh (1995) suggests that contracts will generally be a mixture of method and performance.

The level and detail in contracts will vary greatly depending on the nature of the service and ease of specification. For a service like security, it may be fairly easy to specify security in terms of quantity (number of guards) and quality (type of guards service armed or unarmed). In clinical care it may be very difficult to specify precise services and these may settled by negotiation after the contract is agreed.

A contract that clearly specifies sanctions for non-performance is likely to make the contractor ensure that he performs to the desired expectations. Walsh (1995) makes a distinction between punishment based and cooperative approaches. The former assumes that the client and contractor have different interests, and each seek to exploit the other. In such situations sanctions are required to discourage the contractor from failing to deliver. A cooperative contract on the other hand assumes that the two parties have common interests, and that events outside the contractor’s control are just likely to affect contract performance. Walsh (1995) suggests that the best solution in this case is for the client and the contractor to
work together to resolve problems. Such contracts are more likely for complex services such as clinical services, because of the difficulties of defining and checking on non-performance, whereas punishment-based approaches are more common for simpler services. Mills et al. (2000) further contends that the greater the difficulties of specifying and monitoring performance, the greater the argument for a closer relationship of co-operation between the two parties, as opposed to an arms-length relationship.

Pricing is also crucial, since it must encourage efficiency and reward good performance (World Bank 1995, cited in Mills 1996). There are many approaches to specifying the contract (bid) price, which depends on the service to be contracted and the degree of uncertainty on the workload. The mode of payment is also regarded as crucial in providing powerful incentives, which influence provider behaviour (Barnum et al. 1995). There are cases of where in the bidding process the client sets the price of the service in advance and the contractors put in bids to deliver this at the maximum standard they think is affordable. This approach may be attractive to budget-limited public organisations, since it guarantees that the cost of the contract will not exceed their budget. However, it has the likely disadvantage of discouraging bidders or attracting low quality providers if the price set is too low. In addition in the absence of good information on actual costs in either public or private sectors the price may be quite arbitrary.

The contention is that longer contracts need to include provision for changing prices. Allowing price inflation to feed its way through to the contract provides the contractor with no incentive to economise or adopt new relative prices. However excess controls on the price will encourage the contractor to cut corners and under-perform (Lalta 1993).

In addition the contract duration will affect contractor performance in that short-term contracts may increase competitive pressures among contractors and make it easier to substitute contractors who are not performing to the desired expectations. Such pressure will encourage contractors to perform more efficiently for fear of losing contracts. However, their main disadvantage is that contractors may not be committed to the delivery of services if they think that they may lose the contract in the near future. The contention is that longer contracts may be preferable in that they can stimulate bids and encourage firms to invest in service development and the specific expertise required for hospital services and to provide time for
both sides to develop skills and mutual understanding to resolve problems (Mills 2000).

The degree and nature of competition for the contracts and the type of services to be contracted (box 3) may indirectly have effect on the performance of a contract. For example in case of perfect competition where there many competitors for contracts the contracting agency in this case the public sector is likely to get the best contractors who not only be in position to deliver quality services, but also to offer services at an affordable cost. But given a monopoly market situation contractors might tend to exploit the public sector by offering services possibly at high costs, which might not match the quality of the service they may be offering. The contractor may offer low quality services but since there will be no immediate substitute then the contracting hospital would have to settle for what is offered, hence there will be no efficiency gains from contracting out. Given a competitive market situation competing suppliers may attempt to cut costs and the net result will be efficiency savings for the client who is bearing the cost. However, given a monopoly situation if the contractor available is not satisfactory then the government may decide not to contract out the services at all and may continue with in-house provision.

However, contracting without competition may be used when there is only one possible contractor or if the advantages of a close relationship with one contractor are perceived to outweigh the disadvantages of lack of competition. In the health and social services there is debate over the merits of competition versus a strategy that recognises the mutual benefits each side gains from the contract (Le Grand and Barllet 1993). This is particularly the case where the contractor is a not-for-profit service provider (Gilson 1995). This is especially true for clinical services for NGOs usually provide services on humanitarian grounds and are likely to have the same interests as the public sector when it comes to ensuring efficient and equitable distribution of health care services.

In addition the degree to which the activity being contracted for is contestable affects opportunism costs⁴ (Globerman and Vining1996). They argue further that if the market for the activity is contestable, opportunism is reduced at the contract stage and potentially at the post contract stage.

⁴ Opportunism costs arise when at least one party acts self-interestedly, but in bad faith. Opportunism costs, therefore encompass all costs associated with addressing potential or actual opportunism (Globerman and Vining 1996).
Contracting out services that used to be provided by the public sector implies that health sector managers have to manage these contracts. This implies that the efficiency gains from contracting out the services can only be attained if health sector managers have the capacity to establish contracts, negotiate contracts and monitor the performance of the contractor (box 6). The extent to which health sector managers are able to monitor the performance of the contractor and impose sanctions for non performance will greatly determine the quality of service offered by the contractor (box 5), which will be reflected in the overall contract performance. Likewise if public sector managers have the skills (box 6) to establish contracts this will also influence the design of the contract (box 2), for they will be in position to ensure that clauses for specifications of service quality are included in the contract and this will in turn determine the quality and efficiency of the contract. The competence of health sector managers will also reduce the administration costs associated with contracting out (box 7), because there will be no need to hire skilled manpower to monitor and evaluate performance of the contractors. Reduced administration costs will in turn lead to reduced contract costs (box 4) that will in turn improve the efficiency gains of contracting out (box 1) Related to managerial capacity are the administrative costs of the contracting process which must be less than the savings generated by efficiency gains form contracting, while performance remains constant (Kutzin 94).

In addition, it is worth noting that stakeholders in the policy making process might also have an indirect effect on the contract performance. If the contracting policy is implemented without proper objectives for example if it is donor driven or politically motivated, then this might be reflected in the way the contracts are designed and awarded and implemented. In other words the process and context in which the contracting out was formulated is pertinent in the analysis of contract performance.

The above analytical framework formed the basis for evaluating the relative efficiency of the contractual arrangements in this study.
CHAPTER FIVE: METHODOLOGY

5.1 Introduction

The main objective of the study was to evaluate whether contracting out was an efficient means of delivering support health services. In order to do this evaluation a comparison was made between the cost and quality of in-house provided services and some specific contracted services (i.e. security and cleaning) in Mulago Hospital - necessitating a before and after comparison. Several approaches were used among which were in-depth interviews with the hospital directors and administrators to solicit their views on the contractual process and arrangements and to get a historical perspective prior to contracting out the services. In-depth structured interviews were also conducted for the Solicitor General, Central Tender Board and Ministry of Health officials to establish the regulations and policies underlying contracting out in the country.

In addition a detailed documentary review was done for the two services that were contracted out namely cleaning and security services. This involved an analysis of the contract documents with respect to service specification, contract duration, contract prices, sanctions for non-performance and a detailed search of the hospital financial records to ascertain costs of the services. A quantitative interview schedule was used to assess the consumers' satisfaction with the quality of services. A sample of 155 consumers of the services contracted out at the hospital was interviewed, comprising of medical staff, non-medical staff and patients.

Mulago Hospital was an appropriate case study because it is one of the public hospitals with a long history of contracting out support services. The hospital also has plans of contracting out more services in future but hardly any economic evaluation has been done of the existing contractual arrangements. Mostly importantly, the hospital takes up almost 20% of the total health sector budget; therefore it is important to have an insight of how efficiently these resources are being used. The issues that were considered pertinent in this study were:

i) The costs of providing the services in-house compared to the costs of contracting out the services

ii) The quality of the services provided in-house compared to contracted out services

and lastly,

iii) Other contextual issues like the contracting process, the degree and nature of
competition, the capacity of the hospital managers to negotiate, implement and monitor contracts in addition to other external factors like policy issues in the Ugandan economy.

The sections that follow give detailed information on the methods used like: the sample design, data collection procedures, data analysis and limitations of the study.

5.2 Study Design

In order to assess the relative efficiency of contracting out as a means of delivering health support service both qualitative and quantitative data was used. Analysis was based on the government/public sector's perspective whose major concern is the difference between the costs of providing the services itself and the costs of contracting out and more so that the public sector has to ensure that such services are efficiently provided. Contract performance was assessed by making a comparison between the costs and quality of services before they were contracted out and after they were contracted out in relation to other contextual issues like the contracting process and implementation, economic and political environment. This implies a before and after comparison. For the services evaluated, the before contracting out study period was one year before the services were contracted out. For example in the case of cleaning services which were contracted out in 1991, the before study period is 1990, while for security services the before study period is 1999 because services were contracted out in 2000.

Detailed information was collected on total contract costs, public sector production costs and the quality of services. Total contract costs were categorised into exante and expost costs. Exante costs included costs of identifying a contractor like advertisement costs, legal and negotiation fees. Expost costs included the prime cost of the services, and monitoring costs. On the other hand quality of the services was assessed by the different categories of users of the hospital basing on a five point likert scale which was used to judge whether they were satisfied with the services or otherwise.

5 Legal fees were in this study considered as cost, because the government pays the Solicitor General who provides free legal services to the hospital. Negotiation costs included allowances given to staff for the total time spent identifying a contractor.
Qualitative information was solicited from the hospital administration, regarding the objectives of contracting out the services, their views about the whole contractual processes and the historical perspective of contracting out.

5.2.1 Sampling Frame

The study having been undertaken in a hospital setting it was not easy to make a sampling frame for all cadres of respondents for the retrospective analysis of the quality of the services. Three frames were required namely: the medical staff, the non-medical staff and patients. Medical staff included medical officers (doctors), nurses, midwives, laboratory technicians and pharmacists. The non-medical staff included top management and administrative staff, accounts personnel, nursing aides, clerks and any other staff available at the time. On the other hand, patients included the patients themselves, patients' attendants and patients' visitors. For example not all of the hospital workers had been in the hospital (i.e. ten years back) before the idea of contracting out the services. For the patients the numbers fluctuate between months.

Secondly since services were first contracted out ten years back it was not easy to identify respondents who could vividly recall what the situation was like before the services were contracted out. Further more the services were not contracted out at the same time. While cleaning services were contracted out over a decade ago, it is not yet a year since the security services were contracted out.

5.2.2 Sample Design

The hospital has two types of consumers of the services that were contracted out: the staff and the patients. In this respect it was assumed that these two groups of people would have different perceptions about the quality of services. The staff members were stratified into medical and non-medical staff based on the assumption that each group would have a different perception of the quality of the services. On the other hand patients were grouped to include the actual patients themselves, the patients attendants and the visitors. The figure 5.1 summarises the multistage stratification applied.
It was not easy to come up with a single suitable design of how to select respondents. This is because a respondent should have been in position to retrospectively assess services. For example the cleaning services were first contracted out ten years back whereas security services were contracted out less than a year back.

Basing on when the hospital first contracted out services, it was imperative that the final respondent of staff must have worked in the hospital for at least ten years. For the patients one had to have been to the hospital either as a patient, visitor or as an attendant and could be in position to envisage the situation before services were contracted out ten years back. This means that all the respondents had some good knowledge of Mulago Hospital. The respondents were randomly selected from the different hospital directorates and departments; on condition they met the criteria specified above.

For the in-depth interviews key informants were purposively selected from the heads of departments, hospital administrators and members of the planning and evaluation department. Their selection depended on how conversant they were with the contractual arrangements and the historical perspective of the contracting policy in the hospital. Other key informants who were also purposively selected included MOH officials, a CTB desk officer and an official from the Solicitor General’s office in addition to the managers of the contracted firms. Since all respondents were assured of confidentiality a list of the people interviewed cannot be published in this study report.
5.2.3 Sample Size

Though it would have been desirable to have a bigger sample size for the quantitative assessment of the quality of services, this was not possible for this being a retrospective study it was difficult to identify respondents who could clearly recall what the situation was before the services were contracted out. Therefore the sample size used in the quantitative analysis of the quality of the services was 160 respondents. This comprised of 40 medical staff, 40 non-medical staff and 80 patients. The sample was determined at a ratio of 1:2 (i.e. one staff member to two patients.). Qualitative information was solicited from key informants among whom included: two hospital directors, six hospital heads of departments, MOH policy makers, the solicitor general, 1 CTB official, and the two managers of the contracted firms.

5.2.4 Data Collection Procedures

The procedures followed in the data collection depended on the source and type of data required. Two types of data collection instruments were used: the first one was for the quantitative assessment of the quality of services before and after contracting out the services (refer to appendix 3A). The second instrument was a guide for the in-depth interviews combined with a checklist for the contractual arrangements (refer to appendices 3D to 3G). This section outlines the data collection procedures and the problems encountered.

Prior to the data collection, the researcher reviewed the instruments exhaustively in order to come up with an instrument that addressed all variables for the study. After the instrument was designed it was pre-tested on the different cadres of respondents. This was done to determine the suitability of the instruments in collecting the required information. The pre-testing exercise thereafter enabled the researcher to redesign the all the instruments to suit the targeted respondents and purpose.

Quality of services

Information regarding the quality of services was collected using a quantitative assessment questionnaire, which required the respondents to indicate whether they were satisfied with the services being rendered based on a five point likert scale. For the cleaning services the respondents had to assess the quality of services in terms of cleanliness of floors, walls, sinks toilets, bathrooms, verandas and corridors and waste disposal. External areas were assessed in terms of lawns, parking yards, roads, pavements drainage channels, flower gardens and roofs.
Likewise respondents were asked to assess the quality of the security services in terms of discipline of the guards, competence and trustworthiness of the guards, communication and general security. (See appendix 3A) The above variables were chosen basing on specification details provided to the contractors by the hospital. It was assumed that these would also be the same variables that the hospital would pay much detail to if it were to provide the services directly.

The quantitative instrument was administered using the face-to-face interview technique with the help of two well trained research assistants. This method though time consuming was necessary and yielded a high response rate for most respondents had to be reminded of the period before services were contracted out to be able to get their definite perception of the quality of the services.

*Cost of the services*

Since the study involved comparison of the costs of direct provision of services and contracting out, there was need to collect accurate cost data. This was collected using a cost analysis schedules outlined in appendix 3B. Cost information included hospital production costs that comprised of salaries, expenditure on consumables, utilities, supervisory costs and maintenance costs, while contract costs comprised of advertisement and negotiation costs, prime price of the contract, monitoring and evaluation costs. Cost data was derived from the hospital expenditure records accounts. However, these expenditure records captured cash outlays only implying that expenditures were generally smaller than total actual costs. Secondly, some items were generalised under accounting heads and had not been broken down to the smallest detail required of the study. This necessitated apportioning of the costs using an allocation basis based on a homogenous unit of output. For example, administrative and monitoring costs were allocated to the cleaning and security departments basing on hours spent by the staff on each activity. Likewise utility costs were apportioned to the cleaning department basing on the proportion of how much the hospital charged the contractor (1% of total utility costs). Details of this method are outlined in appendix 4A.

However, there were some difficulties encountered during the costing exercise. In the first instance as earlier stated some expenditures were not captured in the expenditure records. For example the accounting department did not have any records on cost of consumables. As a
result consumable cost estimation relied on the principal supplies officer’s assessment of the use of consumable items like soap, brooms, staff uniforms and boots in addition to his scanty records. Likewise there were no expenditure records about the contract monitoring, advertisement and negotiation costs. However, the accountant could easily recall the allowances paid to the team involved in identifying the contractors, thus monitoring costs were based on this estimate. Advertising costs were estimated basing on the market prices of advertising, while monitoring costs were apportioned on the basis of paid hours from the estimated hospital monitoring contracts budget. (See appendix 4A)

*Contract related information and other issues.*

Detailed review of the contract documents was done in addition to a checklist to gather information on contract duration, service specification, and pricing and reimbursement methods. See appendix 3C for the checklist instrument. In addition the researcher carried out in-depth structured interviews with different key hospital directors and administrators and MOH officials to establish the historical perspective of the contracting policy, objectives of contracting out and their perspectives about their capacity to negotiate and monitor contracts and what the advantages of contracting out the services were (see appendix 3E). Information about the legal framework was gathered through interviews with the Solicitor General and a CTB official. Lastly interviews were conducted with the managers of the contracted firms to establish experience of their firms and their perspectives about the contractual arrangements they had with the hospital (refer to appendix 3G).

### 5.3 Data Management and Cleaning

The quantitative data was first captured using Epiinfo 6. This was appropriate in that Epiinfo 6 is compatible with other statistical software. Data was then imported to Stata 6 for a more detailed analysis of the quality of the services. To ensure that the data is clean two sets of data were entered independently. The two files were then validated and any discrepancy resolved by going back to the original questionnaires until there was zero discrepancy. Though the initial sample size was 160 respondents, during the data cleaning, it was discovered that some respondents had more than one missing variable as a result 5 questionnaires were eliminated. However, some of the missing observations were not eliminated for respondents indicated a reason rather than a score, which was considered as important in the discussion of the results.
5.4 Data Analysis

5.4.1 Quality of the services
In order to assess the quality of the services that were contracted out and hence to evaluate whether contracting out is an efficient means of delivering health support services both quantitative and qualitative data analysis methods were employed. Analysis of the quality of services involved comparing results of exante and expost contracting out of the services using the Stata Analysis package. Assessment of the quality of the services was based on a 5-point likert scale, with 1 being “very good”, 2 “good”, 3 “Satisfactory”, 4 “poor” and 5 “very poor”. (See appendix 3A). It was further assumed that for any respondent who indicated a score of 1, 2 or 3 would be satisfied with the quality of the services being rendered, while one who indicated a score of 4 or 5 would be dissatisfied with the services. Hence further recoding was done with the score of 1-3 to represent “satisfied”, and 4-5 to represent “not satisfied”. In order to test the hypothesis that contracting out provides better quality services than direct provision of the services, two way cross tabulations with a Pearson chi-square test was done details of which are presented in chapter six.

5.4.2 Cost Analysis
A detailed cost analysis was done for both direct provision and contracting out of cleaning and security services.

Cleaning services
The hospital first contracted out cleaning services in 1990, therefore the before study period considered was 1988/89, while the after period was 1999/2000. Cost information was got from expenditure reports and from the contract documents. But recurrent expenditure reports available in the hospital did not clearly identify the specific costs of supervision and monitoring of cleaning services nor did they specify the transaction costs of contracting. In case of supervision of the services only a lump sum amount was indicated in the expenditure reports. As a result the supervision, monitoring and transaction costs had to be estimated using the allocation basis method. Basing on the primary data collected from the administrative staff it was assumed that they spend an eighth of their time on supervision and monitoring of cleaning services. Therefore an eighth of the administrative and monitoring costs was allocated to cleaning services. Details of apportioning the costs are outlined in appendix 4A. Data about the expenditure on consumables like detergents, brooms and
scrubbers was got from the records of the supplies department since the accounts department did not have up-to-date information. But some of the costs were based on the estimates given by the supplies officer.

In-house production costs of cleaning services included: salaries, consumables (cleaning agents, brooms etc...), utilities, equipment and supervisory costs (see appendix 3C). On the other hand contract costs included both ex ante and ex post costs. Ex ante costs considered in the cost analysis are: advertisement costs, legal and negotiation costs. Lawyer fees were included in the ex ante costs, for though the hospital used the free services of the solicitor general and did not directly incur any legal fees, these were considered as a cost to the government and their estimation was based on the on-going market rate of legal fees. Ex post costs on the other hand included the prime price of the services and the monitoring fees (see appendix 3B). Prime price of the services was what the hospital paid directly to the contractor to provide the services. On the other hand monitoring costs in this study are the allowances/bonus payments made to the hospital staff that are involved in the monitoring and supervision of contracts. Evaluation costs were not included because this is usually done in an ad hoc manner if at all contracts are ever evaluated. The payments made by the contractors to the hospital for water and electricity were not included in the contract costs since it is assumed that they form part of the prime price of the contract.

In order to ensure that the pre-contracting out period costs are comparable to the contracting period costs, inflation was accounted for by using the consumer price index (CPI), this formula is given below:

\[ \text{Cost}_{\text{year } n} = \left( \frac{\text{Cost}_{\text{year } n}}{\text{CPI}_{\text{year } n}} \right) \times 100 \]

Note: CPI for base year is assumed to be 100

It was not possible to obtain a price index for health care in Uganda. Secondly the study concerns non-clinical services, which usually follow CPI.

**Security Services**

Security services were contracted out in July 2000. The before study period considered in the cost analysis was 1998/99. Since the hospital only contracted out the external security
services this was dully considered in the cost analysis. Therefore there was need to estimate how much the hospital spends on the provision of external security services compared to what it pays the contractor. Likewise as for the cleaning services the apportioning of costs method was used. For example though the hospital in total employed 57 guards, only 27 guards were employed in the external security department. But the expenditure reports did not indicate such a distinction so the cost analysis involved apportioning the security costs based on the above information (see appendix 4A for details).

Total in-house production costs for security services included salaries (wages), consumables (torches, uniforms), and supervisory costs. Since the hospital employed unarmed guards there were no equipment costs for guards did not even have a baton or a whistle! Exante costs and expost costs were analysed in the same way as the cleaning contract costs were analysed (refer to appendix 4A: tableA3). The same methodology was employed to make the two study periods comparable.

5.5 Guidelines for Analysing Content of Contracts
Basing on the conceptual framework outlined in Chapter Four and the literature (Bhatia and Mills 1997; Mills 1997) contracts were analysed in terms of contract design and contract implementation. This involved a detailed review of the contract documents to ascertain the nature of the contracts, contract duration, price of the contract among others. It also involved in-depth interviews with key informants like the hospital directors and administrators, the Solicitor General and CTB officials to obtain information on the contracting process and contract implementation.

5.5.1 Contract Process and Design
In the analysis of the contract process and design the following elements were considered:

i) Bidding process: this involved analysing what type of bidding was used: whether it was a competitive, selective or closed bidding process. This also entailed establishing who is involved in the bidding process. For in some countries where there is a lot of bureaucracy bidding might be centralised and might require approval from a body like Central Tender Board as in Uganda’s case at the time of the study. Analysis of the bidding process also involved analysis of how bids were evaluated before contracts were awarded and ascertaining who was involved in
this evaluation.

ii) Service contracted: it was important to ascertain what service was contracted out since a range of services can be contracted out. In addition the entire service might not be contracted out. For example in Mulago Hospital only external security services were contracted out as opposed to the entire security services. In other instances like laboratory services the hospital can contract out the maintenance of the laboratory equipment but remain in charge of the entire operations and management of the laboratories.

iii) Service specification: for the analysis of the security and cleaning contracts it was important to note in what terms and to what detail the contracts specified the nature of the service. In case of cleaning services the contract should clearly specify the areas to be cleaned preferably in square metres. While for the security services the number of guards and type of guards should be specified.

iv) Contract duration: this involved establishing how long the contract was and whether it was a long-term or short-term contract. It was assumed in this study that a short-term contract was that of 1-2 years and that any contract of more than two years was termed as a long-term contract.

v) Pricing method: this involved analysing how prices were set and by whom. For example in this study, security services were determined on the basing on the number and type of guards required of the contractor. The analysis also involved ensuring whether the pricing method was consistent throughout the contract period and whether prices were set by the client or by the contractor, for who sets the price is also a key determinant in contract performance. Other price issues considered in the analysis were whether prices were negotiable or fixed and whether inflation was accounted for. Mills (1997) points out that longer contracts need to include provision for changing prices.

vi) Sanctions for non-performance: the analysis also considered whether the contracts included clauses about sanctions for non-performance.

5.5.2 Contract Implementation

Contract implementation analysis included:

i) Contract management

This analysis further considered who is responsible for drawing/drafting the
contract and signing the contracts. This was assumed very important in determining the capacity of the hospital personnel in managing contracts and to what extent they are fully involved in the contract implementation. Contract management analysis also involved looking at how monitoring of the performance of the contractor is done and by whom. Experience indicates that the responsibility for monitoring performance and enforcing standards needs to be clearly defined (Mills 1995).

\[ \text{i) Financing the Contract} \]

Given the different sources of income of the hospital contract analysis also established how the contracts were financed. Normally for public hospitals contracts are financed by government budgets. However, when income results from the performance of the contract, income or profit may be shared between contractor and client to encourage efficiency and maximum use (Walsh 1995).

The detailed evaluation schedule for contract implementation is attached in Appendix 3D.

5.6 Limitations of the Study

As might be expected this study had some limitations. First and foremost, the study intended to evaluate security, cleaning, elevator maintenance, CT scan and laboratory maintenance contractual arrangements. However this was not possible and the study evaluated only the cleaning and security contracts. This is because at the time of the study the hospital had just been investigated for mismanagement and fraud so it was not possible to access some cost data. This was coupled with poor record keeping within the accounts department. Secondly, the study was undertaken during the country's election period so at times it was hard to get hold of some of the key informants. Therefore the data collection took a much longer time than anticipated.

Thirdly for the quality assessment of the services it was not easy to identify respondents who could vividly recall what the services were like before they were contracted out- especially in the case of cleaning services, which had been contracted out ten years ago. As a result the targeted sample size could not be met. In relation to the above limitation in the evaluation of quality of the services, the subjective judgement of the quality of services by the different respondents is of concern especially in light of environmental changes. For example, the
hospital had just undergone a major rehabilitation and looked ‘new’, which could partially account for the high satisfaction scores for the quality of the services.

This being a before and after study it was prone to environmental changes. For instance over the ten-year period there have been changes in the hospital administration and in the way services are managed and which could account for the differences in the contractual processes and the eventual quality of services. In addition the institution of different government policies like that of decentralisation and privatisation could also have an impact on the way contracts are implemented.

Since the allocation of costs method was used in the cost analysis, some inaccuracies might have occurred as a result of the reallocation basis and estimates used. This should be taken into account in interpreting the cost results, however every effort was made to come up with the most accurate costs.
CHAPTER SIX: RESULTS

Mulago has over the years continued to contract out support health services as summarised in table 6.1. However, as earlier mentioned this study only focused on the cleaning and security services. The analysis of whether contracting out is an efficient means of delivering health support services involved the analysis of the contract process and content, a comparison of the costs of direct provision of the services with the costs of contracting out the services. A comparative analysis of the quality of the services before and after the services was also done. Lastly, cost and quality data were combined to infer the relative efficiency of contracting out support services in relation to other issues. This chapter presents details of the findings of this study.

Table 6.1 Mulago Hospital’s History of Contracting Out Health Support Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Year Contracted out</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevator maintenance and repair</td>
<td>1990</td>
<td>Service contracted out to the monopoly firm that supplied elevators. Hospital had to contract out the services since did not have technicians who could maintain and service the elevators whenever required.</td>
</tr>
<tr>
<td>External Cleaning</td>
<td>1991</td>
<td>Services contracted out on a pilot basis for two years.</td>
</tr>
<tr>
<td>External Cleaning</td>
<td>1993</td>
<td>Contract renewed for 3 years and thereafter continually with same contractor until 1999.</td>
</tr>
<tr>
<td>Internal Cleaning</td>
<td>1993</td>
<td>After being satisfied with the external cleaning contract, hospital contracted out the services for 3 years and renewed contract with same contractor up to 1999.</td>
</tr>
<tr>
<td>Preventive maintenance &amp; repair of laboratory equipment</td>
<td>June 2000</td>
<td>New computerised equipment had acquired under ADB grant and hospital did not have technicians to maintain such equipment. Suppliers have expertise and capacity to maintain and repair such equipment. Hospital assured of efficient service.</td>
</tr>
<tr>
<td>Preventive maintenance &amp; repair of CT scan and X-ray equipment</td>
<td>June 2000</td>
<td>New computerised equipment had acquired under ADB grant and hospital did not have technicians to maintain such equipment. Suppliers have expertise and capacity to maintain and repair such equipment. Hospital assured of efficient service.</td>
</tr>
<tr>
<td>Internal and external cleaning</td>
<td>July 2000</td>
<td>Contract awarded to new contractor (NOREMA) for 3 years because hospital was dissatisfied with performance of first contractor (NEC)</td>
</tr>
<tr>
<td>External Security</td>
<td>July 2000</td>
<td>Services contracted out on a pilot basis for one year. Internal security still provided in-house.</td>
</tr>
</tbody>
</table>

6.1 Contracting Process

This section presents the findings of the study regarding the contracting process in Uganda more specifically in Mulago Hospital. The findings include what tendering processes were
used in identifying the contractors in addition to how the bids were assessed. Results on features of the contracts are also presented which include among others: the way services were specified, contract durations, how contract prices were determined and sanctions for non-performance.

6.1.1 Cleaning Services

6.1.1.1 Tendering Process

Interviews with the CTB officials revealed that there are three common methods of tendering in Uganda: competitive bidding, selective bidding which can be equated to sole sourcing and prudent shopping. Competitive bidding involves openly advertising the tender and all interested firms submit their bids, which are then assessed on a uniform criterion before the contract is awarded. Selective bidding on the other hand is where the client knows the suppliers, prepares tender documents and invites the firms to bid for the contract. Prudent shopping is however used more for simple items like gloves, soap and disinfectants. The purchaser goes out and gets invoices, compares the prices and quality of the goods and purchases from the seller who offers the best price. The Attorney General provides guidelines on negotiations and execution of government contracts, which all ministries, state owned enterprises and other statutory bodies are expected to follow (refer to appendix A5).

Mulago Hospital started off with piloting the contracting out of external cleaning services in 1991 using the competitive bidding method. Advertisements were run in the newspapers and there was an enthusiastic response from twenty firms that included private and state owned firms (SOEs)\(^6\). However in 1993 the selective bidding process was used for the internal cleaning services contract. The hospital knew the supplier who happened to be the contractor who had been awarded the external cleaning contract. The hospital prepared the tender documents with the assistance of the Central Tender Board and invited the same contractor that was providing the external cleaning services to provide the internal cleaning services. This process is what Tangcharoensathien et al. (1997) refers to as closed approach, where the contract is directly arranged with one contractor and it is obviously not competitive. But in 2000, for the newly awarded cleaning contract, the hospital reverted to competitive bidding.

\(^6\) In Uganda there are 5 classes of SOEs: Class I consists of enterprises where the government has 100% shareholding of which NEC belongs. Class II are enterprises where government has majority shares, while it has minority shares in the Class III enterprises. Class IV enterprises are those enterprises that the government plans to fully privatise, while those in Class V are the ones it plans to liquidate.
Tender documents were prepared and advertisements were run in the newspapers. Each bidder had to buy the tender documents upon which to base his bid. For the cleaning services there were 7 bidders and only 3 firms were short-listed basing on the criteria outlined in the next section. In the preparation of tender documents the hospital establishes its requirements and the CTB offers the technical assistance before tender documents are made available to interested bidders but the Attorney General’s office should be full involved in this process (see appendix A5 guideline 11).

6.1.1.2 Assessment of Bids

Where the bidding process was competitive, the Mulago Hospital Tender Committee, the Central Planning Committee, together with the Infection Control & Waste Disposal Management Committees assessed each bid. Bids were assessed on the following criteria:

i) Practical test 30%. The practical test required the bidding firms especially in the case of cleaning services to physically clean areas in the hospital. After which the evaluation committees inspected the areas the firms had cleaned and awarded them marks. This also involved visiting other institutions to which the bidders were providing similar services.

ii) Technical assessment 55%. This involved analysing the bids in comparison to what was specified in the tender documents. Other aspects considered were the type of equipment the contractor intended to use, the number of staff to be employed, management of the firm, the companies’ reputation and experience among others.

iii) Financial Proposal 15%. This involved assessing how the bidders had come up with their contract price and if the pricing criteria were consistent and acceptable. This was also in relation to what the hospital was ready to pay. In addition the bidding firms capital base was also ascertained.

However, at one point in time the Mulago Hospital Administration did not agree with the Central Tender Board (CTB) on how the bids were assessed. But it is worth noting that it is CTB, which offers guidelines for assessing bids to public institutions within its jurisdiction. The CTB also approves all government contracts before they are eventually awarded. However, the CTB did not send its representative to the hospital during the evaluation of bids nor did it intervene until the hospital administration completed its evaluation and had submitted its assessment. Below is a summary of the difference in the weighting system used
by the hospital and that proposed by CTB.

Table 6.2. Differences in Weighting System for Evaluation of Bids

<table>
<thead>
<tr>
<th>Item</th>
<th>Hospital Weighting</th>
<th>CTB Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Basis of Costing</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Manpower</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Equipment</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Management of Firm</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Materials</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Experience/Reputation</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Physical Address</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Capital Base</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Referees</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

Despite the above differences the hospital stuck to its weighting system. After the above assessment the hospital passes on its recommendation to CTB for approval to award the contract.

In 1991 out of the twenty firms that bid only three were short-listed and eventually the contract was awarded to a state owned enterprise (SOE): National Enterprises Corporation (NEC). Two years later the same contractor was awarded the contract to provide internal cleaning services\(^7\) because the hospital was at that time satisfied with the services he was providing. Secondly it was the only credible firm that supposedly had monopoly of the market as confirmed by one respondent:

*‘Who could compete with NEC at that time? It was the only big firm we knew providing such services’* (Administrative staff)

It is worth noting that in 1991 the firm (NEC) that was awarded the contract had just one year’s experience and gained experience over the nine years it had the contract with the hospital. On the other hand the private firm (NOREMA) that now holds cleaning contract had two years experience in the cleaning services field.

The negotiations involved the hospital administration, representatives from the Solicitor General’s office and CTB. The Solicitor General should be fully represented in the bidding

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\(^7\) Internal cleaning refers to cleaning of the interior of the hospital buildings i.e. wards, laboratories, theatres etc. While external cleaning refers to the cleaning of the outside features of the hospital buildings and surroundings. For example, walls, roofs, flower gardens, lawns, parking yards etc.
process, preparation of terms of reference, preparation of short list of firms, bid evaluations, selection and award of contracts, negotiations and approval of contracts. The Solicitor General provides the legal backing and advises during the whole contracting process. The Commissioner Contracts and Negotiations noted that the hospital administration was relatively competent in negotiating contracts if they followed the guidelines provided.

6.1.1.3 Contract Design

Service specification

The hospital as the contracting agency clearly demarcated, mapped out and specified all the areas to be cleaned and maintained by the contractors. For external cleaning services areas to be cleaned included flower gardens, lawns, parking yards, drainage channels and roofs. While the internal areas included: floors, walls, bathrooms, sinks, corridors and waste disposal. Regarding the quality of services, the hospital provided detailed specifications to the contractor that would be used to ensure that a quality service is provided. Among these were:

i) General cleaning should be done every day between 6-8am, and a check clean should be done at 2pm and 8pm.

ii) Floors and walls and all ward surfaces should be clear of stains and blood spots.

iii) Windows and doors should be cleaned once a week.

iv) The contractor was required to provide a site supervisor with whom the hospital administration would liaise with on a day-to-day basis.

Contract Pricing

Evidence from the studies on contracting out cleaning services (Tangcharoensathien et al. 1997; Beracochea 1997) show that prime price of the services was determined on the basis of the area in square meters to be cleaned. Findings from this study show that Mulago’s case is peculiar in that for the external cleaning services pricing was based on man-hours and not squares metres, as is the experience in other countries. The hospital administrators gave two reasons for requesting the contractor to base his price on man-hours: First of all when the contractor based the price on square meters to be cleaned, it was beyond the hospital’s budget. Secondly the hospital was interested in ensuring that the contractor maintained the staff initially employed by the hospital at the ongoing wage rate and further more that the contractor did not exploit the employees.

Hence the contract price was negotiated basing on man-hours on the presumption that both
the hospital and contractors interests were met. It was agreed that the contractor provides the service at Ug. Shs.300 ($0.17)\textsuperscript{8} per man-hour and the total contract price was fixed at Ug. Shs.3, 006,000. Reimbursement for the services provided was on a monthly basis.

On the contrary to above, two years later the same contractor (NEC) was required to quantify the work to be done in terms of man-hours per square metre for floors and windows. But some areas like the toilets and bathrooms were priced in adhoc manner – not based on any specific criteria but on a lump sum block figure estimate. In addition the contractor was required to employ all the 600 employees, who were employed by the hospital when it was directly providing the services. This was politically motivated and was a means of guarding against any eventualities of lying off 600 employees.

However, six months later the contractor had to reduce the employees to 450, and three years later reduced them to 300. This was a result of the continued complaints from the hospital that the cleaners were involved in illicit activities like pilferage of drugs and supplies and soliciting bribes from patients. In addition the employees complained of being underpaid by the contractor that was clearly manifested in their lack of motivation and illicit behaviour. This situation gave an opportunity to the contractor to reduce the employees on the premise that: it was easier to manage a smaller number of employees and secondly that the contractor would be in position to increase the employees’ salaries to the desired minimum wage rate from the savings made from the staff reduction. The same pricing procedure was used ten years later in 2000 when the cleaning services were contracted out to another private firm NOREMA, but this time the contractor had the freedom to hire his own employees. The current contract price is Ug. Shs.24, 139,194. The cleaning contract could best be described as a block contract because contractors are reimbursed a lump sum amount per month regardless of their performance. From these findings it is clear that the hospital lacks a systematic pricing process.

*Contract duration*

The pilot phase of contracting out external cleaning services was initially for two years. This contract was renewed continually with the same contractor (NEC) until June 2000. The internal cleaning services contract with NEC was for three years and renewed for another

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\textsuperscript{8} Exchange rate December 2000 $1 = Shs. 1775
three years. The present contractor (NOREMA) is contracted to provide cleaning services for three years with an initial trial period of six months.

However, there was no formal contract drawn between the hospital and the first contractor (NEC) for the entire nine years' period that the contractor provided cleaning services. The only legal binding documents available were the CTB authorisation letters that indicated the contract price and who the contractor was. However, there is documented evidence that the hospital director requested the Solicitor General to draw up a formal contract. According to the NEC management there was an agreement between them and the hospital to provide cleaning services, which they termed as an "implied contract". Since there was no formal contract document neither fines nor sanctions for poor performance were ever specified nor invoked.

Contrary to the above, the new contractor (NOREMA) has a formal contract with the hospital, which spells out that either party is expected to give three months written notice to terminate the contract but no other sanctions are specified in the contract. The contract further includes clauses that allow for a written amendment of the contract and revision of the contract price if the need arises. The hospital is however not obliged to renew the contract but it can do so at its own discretion (for example if it is satisfied with the services of the contractor).

6.1.1.4 Contract Implementation
Throughout the period that the hospital has contracted out cleaning services they have been financed by public funds through the hospital budget. The in-depth interviews with a sample of hospital administrators revealed that though the contracting process is centralised the hospital is solely responsible for managing the cleaning contract. This involves developing reporting and monitoring procedures and ensuring that contractors are reimbursed as stipulated in the contracts. Contract management is the direct responsibility of the Assistant Director Support Services.

However, before the services were contracted out cleaning services were supervised and monitored by the ward managers and various task committees among which is the waste and disposal committee, the infection control committee, domestic services committee, in
addition to the supplies officer and the hospital entomologist. These same committees are still responsible for monitoring the cleaning services provided by the contractor. The ward managers are required to give a weekly performance report to the hospital administrator. All committees report directly to the Assistant Director Support Services who in turn reports to the Executive Director (see organisational chart figure 2.1). The contractor on the other hand provides a resident operations manager who is directly responsible for supervising the contractor's employees. In addition a representative from the contracted firm attends the weekly hospital management meetings where he is given a feedback on his performance.

According to the hospital planning and evaluation department evaluation of the contracts should ideally be done every six months. But as one hospital official noted that evaluation of contracts is not planned – no one knows how it will be executed, who will do it and how it will be financed. Therefore if contracts are ever evaluated it is an adhoc process.

6.1.2 Security Services

6.1.2.1 Tendering Process
The hospital first conceived the idea of contracting out security services in 1999 after realising that the direct provision of services was not only inadequate but also inefficient. However, the hospital did not contract out the entire provision of security services but decided to pilot contracting out security services by first contracting out external security services only. Unlike under direct provision of services where guards were not recruited on a competitive basis, identification of the contractor was done using the competitive tendering system. The hospital prepared the tender documents, which were submitted to CTB for approval after which advertisements inviting bidders were run in the newspapers. Bidding firms were required to purchase the tendering documents from the hospital at the cost of Ug.Shs.50,000 and submit their bids basing on the terms of reference specified in the tender documents. The hospital received five bids, which were evaluated based on the criteria outlined in section 6.1.1.2. But unlike for the cleaning services bidding firms were not required to undergo a practical test instead experience of the firms was used as a proxy for the practical test. The hospital recommended to CTB that the contract be awarded to a private security firm (Alert Guards) that had an experience of seven years, which CTB approved. Notable however is the fact that this firm did not have prior experience of guarding hospitals. Contract negotiations involved the hospital administration, representatives from the Solicitor
General's office and the CTB.

6.1.2.2 Contract Design

Security specification

The contract documents clearly specified what services were expected from the contractor that is: to guard all the gates of the hospital (i.e. provide external security services). As earlier mentioned internal security is still provided in-house. The contractor was in addition required to provide twenty four competent, duty conscious, smart, trustworthy armed and unarmed guards with radiotelephones and this was clearly specified in the contract document. In order to ensure quality security services the hospital spelt out the duties of the guards in the company's obligations and liabilities clause of the contract.

Contract Price

The security contract price was based on the number of guards to be supplied by the contractor. Armed guards were priced differently as opposed to unarmed guards. The hospital required 5-armed guards equipped with radiotelephones that were priced at Ug.Shs.250, 000 per guard per day, 5-unarmed guards with radiotelephones these were priced at Ug.Shs.230, 000 per day per guard and 14-armed guards without radiotelephones at the rate of Ug.Shs. 180,000 per guard each day. The contractor presented his price to the hospital administration that in turn presented it to the Central Tender Board for approval. An interview with the contracted firm's manager revealed that guard prices are not fixed but vary depending on the client and duration of the contract but are still a reflection of the market prices. As was the case for cleaning services contractors were reimbursed a monthly fixed block sum. Findings from this study reveal that contractors were not satisfied with the payment terms in that they are not paid promptly due to the bureaucracy in the public sector. They noted that they could provide services for as long as three months before they would be paid. However, contracts provided an allowance for the revision of the contract prices in relation to the inflation rate, which serves an incentive to contractors to be in position to provide services at new relative prices.

Contract Duration

Since this was the first time the hospital was contracting out security services, it decided to implement it as a pilot phase. As a result the security contract was short-term contract of one
year. Though the contract documents specified that a standard legal notice of one month should be given by either party to terminate the contract, no sanctions for non-performance were specified. In all instances the Solicitor General is expected to instil the sanctions if need be and should be notified if the contract is to be terminated. In-depth interviews with the hospital administrators revealed that the hospital is not obliged to renew this contract, but if the contractor’s performance is satisfactory during the pilot phase they could reconsider renewing the contract as this would reduce on the transaction costs associated with re-advertising and renegotiating contracts.

6.1.2.3 Contract Implementation

Financing of the Contract

The security services that were contracted out are financed by funds that the hospital raises through its private patients scheme. Though a public hospital, Mulago is one of those hospitals that are legally operating private health care services to patients who can afford the services. The hospital uses user charges from this scheme (but with approval from the Auditor General), to finance its activities that are not supported directly by the government budget. However, the hospital has plans of requesting the government to finance the security contract because there is the question of sustaining the security contract.

Monitoring and Evaluation of Contracts

As earlier stated monitoring of support services is a direct responsibility of the Assistant Director Support Services. Direct monitoring of the services is however done through various task forces that were strengthened when the hospital began contracting out support services. The Security Committee that comprises of the Senior Hospital Administrator, the Hospital Security Officer and some members from the management committee monitors the security contract. In addition the contractor provides a full time supervisor at the hospital to whom the guards report. The security committee is charged with the day-to-day liaison with the contractor’s site supervisor. However the in-depth interviews revealed that there was a loophole in the monitoring system: it was noted that the monitoring system was uncoordinated in that the security officer who is the man on the ground is usually by passed in that the contractor supervisor reports directly to the hospital administrator. This is likely to make the evaluation phase difficult for the person who is supposed to give the on ground
situational analysis is not actively involved in the monitoring process.

Before the services were contracted out an evaluation was done to establish what the current situation of the security services was. This being the pilot phase no evaluation of the contract has been done so far.

6.2 Cost Analysis of the Services

Costs of both in-house provision and contracting out of the cleaning and security services included the analysis of both direct costs and in-direct costs. Direct costs are the actual expenditure on goods and services purchased or the total expenditure on all resources used by the hospital to deliver the service in monetary terms. In-house production direct costs considered in the analysis included salaries and wages, expenditure on consumables (cleaning agents, uniforms, gumboots, whistles and torches), utilities, equipment, supervisory and maintenance costs.

The cost analysis of contracting out the services considered both exante and expost costs. In this study the exante costs included advertisement and negotiations costs. The hospital did not incur any lawyer fees as had been anticipated earlier because the hospital uses the services of the government Solicitor General who does all the legal work for the hospital. However such a cost should be given due consideration in the analysis of real costs as the Solicitor General is paid by the government to do such work. Therefore an estimate was made basing on market scale of legal charges for such services. Expost costs included the actual prime price of the services and the monitoring fees. The hospital did not have any record on evaluation costs, for as earlier on stated the evaluation process is not planned.

6.2.1 Cost Analysis for Cleaning Services

Table 6.3 presents an overview of the costs that the hospital incurred in the in-house production of cleaning services as compared to contracting out the services. The base year used in the cost analysis comparison is financial year 1989/90 because this is a year before services were contracted out. The contract costs are presented as fixed costs based on the 1989 prices. The costs the hospital incurred for the first cleaning contract with the SOE (NEC) are presented in column 4, while the costs for the second cleaning contract the hospital has with the private firm (NOREMA) are presented in column 5.
Table 6.3 Comparative Cost Analysis of In-house Production and Contracting Out Cleaning Services

<table>
<thead>
<tr>
<th></th>
<th>In-House Production</th>
<th>Contract Provision</th>
<th>Contract 2: NOREMA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost in Ug.Sh 1989 Prices</td>
<td>Cost in Ug.Sh Fixed at 1989 Prices</td>
<td>Cost in Ug.Sh Fixed at 1989 Prices</td>
</tr>
<tr>
<td>Item</td>
<td>Salaries 127,686,564</td>
<td>Exante Costs 682,718</td>
<td>June 1999-June 2000</td>
</tr>
<tr>
<td></td>
<td>Consumables 120,398,400</td>
<td>Advertisement 71,116</td>
<td>July 2000-June 2001</td>
</tr>
<tr>
<td></td>
<td>Utilities: Water 286,321</td>
<td>Lawyer’s fees 71,116</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equipment 2,107,564</td>
<td>Negotiation 512,039</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervisory 2,191,595</td>
<td>Total Exante Costs 1,265,874</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintenance 881,935</td>
<td>Expost Costs 1,692,573</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total 253,552,379</td>
<td>Contract Prime Price 200,395,409</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitoring 1,742,354</td>
<td>Total Expost Costs 202,137,763</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evaluation 0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Fixed Total 208,616,908</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contract Cost 203,403,636</td>
<td>210,309,480</td>
<td></td>
</tr>
</tbody>
</table>

All the costs for the direct provision of the cleaning services were obtained from the recurrent expenditure records of the hospital. However the costs for utilities, supervision and maintenance were estimated using an allocation basis approach explained in the methodology (details outlined in appendix 4A). For the contract costs, advertisement costs were based on the ongoing market prices of advertising in newspapers in relation to the number of advertisements the hospital run. Negotiation costs were derived from the allowances paid to all the hospital staff that were involved in the meetings of identifying contractors. While the monitoring fees were based on the hospital’s budget estimates. The prime price of the contracts was clearly specified in the contract documents reviewed.

The results in table 6.3 show that under direct provision of cleaning services almost 50% of total in-house production costs was spent on salaries, while 47% was spent on consumables and only 0.9% was spent on supervision. A comparison with contracting out the services reveals that the prime price of the contract (what the hospital pays directly to the contractors), takes a 98% share of the total contract costs. This is almost equally proportional to the total amount that the hospital was spending on salaries and consumables under direct provision. On average the hospital spends 0.8% of total contract costs on exante costs.

Further comparison of the in-house costs and contract costs in constant fixed prices at the 1989 nominal prices show that contracting out of the services is cheaper than in-house production.
provision. The hospital made a 20% cost saving when it contracted out the cleaning services to NEC and is currently making a 17% saving with the new contractor (i.e. Ug. Shs.50,148,742 with the first contractor and Ug. Shs. 43,242,898 with the second contractor). Notable is the fact that this analysis does not include hidden costs like the costs the government would incur in recruiting and training staff was it to directly provide cleaning services in addition to costs incurred due to lateness or non-performance. Other excluded hidden costs related to in-house provisions of services are the costs the hospital incurs in form of funeral allowances to employees.

6.2.2 Cost Analysis for Security Services

The hospital contracted out security services in July 2000 therefore the base year used in the cost analysis was financial year 1999. Contract costs are presented in constant shillings fixed at the 1999 prices. All costs for in-house provision of security services were easily obtained from the hospital’s current expenditure records, which gave total expenditure on security services. But it is worth noting that only external security services were contracted out but the expenditure records indicated the total amount spent on security; therefore the allocation method basing on number of guards was used to apportion the costs that the hospital incurred in the production of external security services (refer to appendix A4, table A3). Under direct provision of external security services the hospital did not have any equipment costs. This is because the guards employed at the time did not have any sort of equipment.
Table 6.4 Comparative Cost Analysis of In-house and Contracting Out Security Services

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost in Ug.Shs 1999</th>
<th>Contract Provision</th>
<th>Item</th>
<th>Cost in Ug.Shs Fixed at 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Year: 1999</td>
<td></td>
<td>Alert Guards Year 2000/2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>30,163,428</td>
<td>Exante Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumables</td>
<td>917,000</td>
<td>Advertisement</td>
<td>1,037,464</td>
<td></td>
</tr>
<tr>
<td>Utilities: Water</td>
<td>0</td>
<td>Lawyer's fees</td>
<td>96,061</td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td>0</td>
<td>Negotiation</td>
<td>1,248,799</td>
<td></td>
</tr>
<tr>
<td>Supervisory</td>
<td>1,663,994</td>
<td>Total Exante Costs</td>
<td>2,382,325</td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td>0</td>
<td>Expost Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32,744,422</td>
<td>Contract Prime Price</td>
<td>66,356,196</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitoring</td>
<td>3,184,438</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evaluation</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Expost Costs</td>
<td>69,540,634</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fixed Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contract Cost</td>
<td>71,922,959</td>
<td></td>
</tr>
</tbody>
</table>

Results in table 6.4 indicate that 92% of the total in-house provision costs are spent on salaries. Analysis of the contract costs shows that 92% of the total contract costs are what the hospital pays directly to the contractor for the services (prime price of the contract), while it spends 4.5% on monitoring the contract. Exante costs take up only 3.4% of the total contract costs. The analysis further reveals that the hospital is spending 91% more on supervision/monitoring of the external security services contract than what it used to spend under in-house service provision. Further comparison of in-house production costs with just the prime price of the contracts (excluding exante and monitoring costs) shows that the hospital is paying twice more for external security services than what it used to spend on in-house provision of the same services. Precisely contracting out of external security services is more expensive than in-house provision.

6.3 Quality of the Services

Quality of the services was assessed basing on the structural aspects and other indicator variables of quality that were specified by the hospital for the contractors in the delivery of each specific service. The results of the quality of the services are based on the survey of consumers’ perception of quality. Quality of services was used as the outcome measure. Shepard et al. (1998) note that patient satisfaction surveys on the service before and after divestment is one of the most efficient indicators of quality. This, along with a comparative cost analysis of the services for the similar periods would give a true indication of the effectiveness of the policy.
6.3.1 Cleaning Services

Quality of the cleaning services was assessed based on the users' perception of cleanliness of the different structural aspects of the hospital as specified in the contracts. The same structural aspects were used to assess the quality of the cleaning services when provided directly by the hospital. It was assumed that what the hospital specified in the contracts were the most pertinent structural aspects of cleanliness. Such aspects included: floors, walls, sinks, toilets, bathrooms and lawns (refer to appendix 3A for details). Respondents were made to retrospectively recall what the cleanliness situation was before services were contracted out as opposed to the current situation when services are provided by contractors.

Assessment of the quality of the cleaning services in table 6.5 indicates that the consumers were not satisfied with all indicators of the cleanliness of the hospital when services were being provided in-house. Dissatisfaction was more evident with waste disposal (75.5%) and maintenance of the drainage channels (69.7%). Since in the analysis any score for any cleanliness indicator that was between 1 and 3 was treated as satisfied and a score of 4 and 5 as dissatisfied, it is clear that the in-house provision of services was generally perceived to be unsatisfactory. Consumers were however highly satisfied with all indicators of cleanliness provided by the contractors as shown in column 4 of table 6.5.

<table>
<thead>
<tr>
<th>Variable</th>
<th>In-House Satisfied (%) (N=155)</th>
<th>Not Satisfied (%) (N=155)</th>
<th>Contract Satisfied (%) (N=155)</th>
<th>Not Satisfied (%) (N=155)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floors &amp; walls</td>
<td>46</td>
<td>54</td>
<td>93.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Sinks, toilets, bathrooms</td>
<td>24</td>
<td>76</td>
<td>93.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Verandas</td>
<td>46.5</td>
<td>53.5</td>
<td>91.6</td>
<td>8.4</td>
</tr>
<tr>
<td>Waste disposal</td>
<td>24.5</td>
<td>75.5</td>
<td>90.3</td>
<td>9.7</td>
</tr>
<tr>
<td>Lawns</td>
<td>45.8</td>
<td>54.2</td>
<td>88.4</td>
<td>11.6</td>
</tr>
<tr>
<td>Parking yards</td>
<td>51</td>
<td>49</td>
<td>92.9</td>
<td>7.1</td>
</tr>
<tr>
<td>Pavements &amp; roads</td>
<td>49</td>
<td>51</td>
<td>90.3</td>
<td>9.7</td>
</tr>
<tr>
<td>Drainage channels</td>
<td>30.3</td>
<td>69.7</td>
<td>88.4</td>
<td>11.6</td>
</tr>
<tr>
<td>Flower gardens</td>
<td>45.2</td>
<td>54.8</td>
<td>84.5</td>
<td>15.5</td>
</tr>
<tr>
<td>Roofs</td>
<td>42</td>
<td>58</td>
<td>84.5</td>
<td>15.5</td>
</tr>
</tbody>
</table>

6.3.2 Variations in Perception of Quality of Cleaning Services

Three groups of consumers of the cleaning services in the hospital were used to assess the
quality of the cleaning services. These were the medical staff, non-medical staff and patients and this choice of consumers is in line with similar studies done elsewhere ((Tangcharoensathien 1997; Bhatia and Mills 1997). It was assumed that these three groups of users would have different perceptions about the quality of the cleaning services. The results in table 6.6 summarise the variations in the consumers' perception of quality of cleaning services when provided in-house as compared to when they are provided by contractors.

Table 6.6: Quality Perceptions of Cleaning Services of the Different Groups of Respondents

<table>
<thead>
<tr>
<th></th>
<th>In-house</th>
<th>Provision</th>
<th>Contractor</th>
<th>Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical</td>
<td>Non-Medical</td>
<td>Patients</td>
<td>Medical</td>
</tr>
<tr>
<td>Satisfied</td>
<td>23%</td>
<td>30%</td>
<td>36%</td>
<td>Satisfied</td>
</tr>
<tr>
<td>Not Satisfied</td>
<td>61%</td>
<td>64%</td>
<td>64%</td>
<td>Not Satisfied</td>
</tr>
<tr>
<td>Indifferent (For other reasons)</td>
<td>16%</td>
<td>6%</td>
<td>6%</td>
<td>Indifferent (For other reasons)</td>
</tr>
</tbody>
</table>

It is evident that all the majority of the users of the hospital were not satisfied with the in-house provision of cleaning services that is 61% medical staff and 64% for both non-medical and patients. Both medical and non-medical staff contended that the low quality of in-house provided cleaning services was due to:

First and foremost, the cleaners were demoralised for they were poorly paid and lacked the proper cleaning equipment, this was coupled with the poor supervision. In addition it was not uncommon to find cleaners involved in clinical activities where they could solicit bribes from patients hence abandoning their duties. Another reason was that the health sector was allocated limited resources and as a result there were major delays in repairing the sewage and water system.

However, the staff who were indifferent about in-house provision of services argued that the government could not be blamed wholly for the poor services for the whole health sector system had broken down. This was supported one medical respondent who said:

'Due to the civil strife in the 80s, all systems were broken down and it was no different in the hospital- little could be done.' (Medical staff)
Others argued that they could not solely say that they were dissatisfied with the in-house provision of cleaning services because the external areas of the hospital were extremely clean but that it was hard to maintain the cleanliness of the internal areas of the hospital with a totally broken down water system.

The majority of staff and patients interviewed expressed satisfaction with the services provided by the contractors when compared to the in-house provision. But they were some reservations noted by the respondents who were indifferent. They noted that the high output of quality of cleaning services could not all be attributed to the contractors because the hospital had just undergone a substantial refurbishing and renovation so most areas looked new. They argued that some credit should be given to the government for renovating the hospital otherwise the contractors would also have not been able to attain the high standard of cleanliness’ if they had been contracted in the 80s when the hospital was in a state of disrepair.

‘Long time ago when government cleaners were cleaning the hospital, the roads and pavements were clean though not renovated. These days they just appear clean because they are renovated.’ (Doctor)

But there was a general consensus that the hospital was currently very clean as compared to the 80s when the government was providing the services.

Since the hospital has had two contractors since it contracted out cleaning services, this study also tried to make comparison between these two contractors (NEC and NOREMA). The study also tried to establish why the contractor (NEC) who had the contract for almost nine years eventually lost the contract. The staff interviewed observed that NEC had poor management and were just interested in the money and not the job they were contracted to do. The NEC employees were constantly involved in clinical activities and solicited bribes from patients in addition to their conniving with other hospital staff in pilfering hospital supplies. Contrary to the above, it was revealed that NOREMA was committed to the job and actually had full time supervisors and a manager at the hospital. In addition the staff noted that NEC did not have any experience prior to being awarded the cleaning contract so there was no way they could offer high quality services.

However, despite the better services that NOREMA is offering the dissatisfied patients
pointed out that the female cleaners were rather harsh to the patients as evidenced by some respondents:

'There are two sides of NO REMA: there are cleaners who are doing a very good job and those who clean but are very harsh to the patients, they cannot explain to patients that it is time to clean but just splash water on us.' (Patient)

'The women cleaners are harsh and impatient with the patients probably the men should do this job- they can never back at you.' (Patient)

'The wards are very clean although some of the female cleaners do not cooperate with patients, they tend to be harsh.' (Patient)

Further it was noted that though NO REMA was doing a good job some areas of the hospital were neglected. For example in the casualty the cleanliness was below standard and it was not uncommon to see spills of blood and overflowing waste bins. In addition the external areas were not as clean as the internal areas of the hospital. However, the hospital administration pointed out that NEC had actually tried their best for they had found the hospital in a state of disrepair and had started from scratch unlike NO REMA who had been awarded the contract when the hospital had just been renovated.

Table 6.7: Overall Quality Assessment of Cleaning Services

<table>
<thead>
<tr>
<th>Cleaning all Combined Before Contracting out</th>
<th>Cleaning all Combined After Contracting out</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>1</td>
<td>41</td>
</tr>
<tr>
<td>97.56</td>
<td>2.44</td>
<td>100</td>
</tr>
<tr>
<td>Not Satisfied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>4</td>
<td>94</td>
</tr>
<tr>
<td>95.74</td>
<td>4.26</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>135</td>
</tr>
<tr>
<td>130</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>96.3</td>
<td>3.7</td>
<td></td>
</tr>
</tbody>
</table>

In order to test the hypothesis that contracting out provides better quality services than direct provision of services and to get an overall perception about the quality of cleaning services, all variables in table 6.5 were combined into one variable and a Pearson chi square test using Intercooled Stata 6 was done. The results are presented in table 6.7.

The results above show that 95.74% of the respondents who were not satisfied with the in-house provision of cleaning services were satisfied with the contractor provided services. And 4.26% of the respondents who were not satisfied with in-house provided services were
also not satisfied with contractor provided services. This association is not significant at the 5% level of significance (Pr = 0.607); therefore we cannot reject the null hypothesis. Despite the variations in perceptions of the quality of the cleaning services it is clear that contractors are offering a better quality service than the government.

6.3.3 Quality of Security Services

Security services were also assessed basing on the specifications of the kinds of guards and services the hospital expected the contractor to provide. These included discipline of the guards, competence of the guards, the ability of the guards to communicate with people coming into the hospital and the general security. It was assumed that these are the pertinent variables that the hospital would consider when evaluating the quality of the security services whether they are provided in-house or by contractors.

Table 6.8 Quality Assessments of Structural Aspects of Security Services.

<table>
<thead>
<tr>
<th>Variable</th>
<th>In-house</th>
<th>In-house</th>
<th>Contractor</th>
<th>Contractor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfied (%)</td>
<td>Not Satisfied (%)</td>
<td>Satisfied (%)</td>
<td>Not Satisfied (%)</td>
</tr>
<tr>
<td>Discipline</td>
<td>42.5</td>
<td>57.5</td>
<td>82.6</td>
<td>17.4</td>
</tr>
<tr>
<td>Competence</td>
<td>45.1</td>
<td>54.9</td>
<td>86.5</td>
<td>13.5</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>29.7</td>
<td>70.3</td>
<td>75.5</td>
<td>24.5</td>
</tr>
<tr>
<td>Communication</td>
<td>38.7</td>
<td>61.3</td>
<td>83.3</td>
<td>16.7</td>
</tr>
<tr>
<td>General Security</td>
<td>35.5</td>
<td>64.5</td>
<td>88.4</td>
<td>11.6</td>
</tr>
</tbody>
</table>

Table 6.8 shows the comparison of the quality of in-house and contracted out security services as perceived by the consumers basing on the different quality indicator variables. In general the majority consumers were not satisfied with the in-house security services as indicated in the third column of table 10. Consumers were more dissatisfied with the trustworthiness of the guards (70.3%) and general security (64.5%). They actually pointed out that the guards were very corrupt and would always ask for bribes before letting in anybody into the hospital. However, regarding the poor general security it was noted that at that time the hospital fence was in shambles and in many areas the fence was completely down coupled with the inadequate number of guards. So it was not surprising that the hospital was experiencing a number of thefts of its property and that of the patients. On the other hand the consumers indicated a high satisfaction with the security services provided by the contractor. Consumers were more satisfied with the general security (88.4%), followed by
competence (86.5%) and communication (83.3%). Definitely with a newly erected fence and deployment of armed guards at almost every entrance to the hospital general security was bound to improve. The contracted guards were commended for having better communication skills in that they can speak English because they are better educated than the guards who were employed by the government.

6.3.4 Variations in Perceptions of Quality of Security Services

Like for cleaning services three groups of consumers of the security services in the hospital were interviewed in the assessment of the quality of the security services provided in-house and by contractors. These were the medical staff, non-medical staff and patients. It was assumed that these different categories of consumers would have different perceptions about the quality of the security services- these are presented in table 6.9

| Table 6.9: Quality Perceptions of Security Services of Different Groups of Consumers |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| In-house | Provision | Contractor | Provision | |
|          | Medical    | Non-Medical | Patients  | Medical    | Non-Medical | Patients  |
| Satisfied | 26%        | 47%         | 30%       | Satisfied  | 79%         | 66%       | 96%       |
| Not Satisfied | 63%        | 47%         | 69%       | Not Satisfied | 19%         | 23%       | 3%        |
| Indifferent (For other reasons) | 11%        | 6%          | 1%        | Indifferent (For other reasons) | 2%          | 11%       | 1%        |

While only 26% of the medical staff interviewed were satisfied with in-house provided security services, 47% of non-medical staff were satisfied with the services as compared to 30% of the patients. On the other hand 63% of the medical staff were not satisfied with the in-house security services as compared to 47% and 69% of the non-medical and patients respectively. Respondents who were indifferent about the security services argued that there is no way the hospital could provide a better security service without enough support and resources from the government to employ more competent guards. Others noted that whether the services are provided in-house or by contractors, all guards are corrupt.

'Guards are guards it doesn't matter who employs them, they all take bribes and will always treat you like a criminal if you don't bribe them.' (Patient)

'All guards are rude and don't listen' (Medical staff)

However, there was a high satisfaction rate with the services provided by the contractor with
90% of the patients satisfied with security services as compared to 79% and 66% medical staff and non-medical staff respectively. Reasons being that the contracted guards are more competent, listen and are easily identifiable. Secondly the fact that the guards know that they can easily be fired strive to perform to the expectations of their employer. However, there were some reservations in that the improved security services were due to the newly erected fence that was part of the hospital renovations.

While 23% of the non-medical staff was dissatisfied with the contractor, only 19% and 3% of the medical and patients respectively were dissatisfied with the security services provided by the contractor. Patients noted that the contracted guards mistreated them and were harsh and not sympathetic. Some respondents clearly summed it up:

'Aler~ guards mistreat us, they are harsh and guard the hospital gate like it is an army quarter guard gate.' (Patient)

'These new guards have poor public relations, they need to be sensitised about the people they are handling- we are patients and this is our hospital.' (Patient)

'Aler~ guards have no respect for the hospital staff- everyday I have to explain at length to them where am going. Imagine I have worked in this hospital for over 20 years and am mishandled by a mere guard at the hospital gate....' (Medical staff)

However, some hospital staff felt that contracting out the security services was just a costly exercise especially since the government was not directly financing the contract. They were of the view that the in-house guards would have just been motivated, offered more training and reequipped. They argued that with a new and stronger fence the hospital did not need armed guards.

Combining all the variables in table 6.9 and testing the null hypothesis using Stata 6, obtained the results presented in table 6.10.

Table 6.10: Overall Quality Assessment of the Security Services

<table>
<thead>
<tr>
<th>Security all Combined Before Contracting out</th>
<th>Security all Combined After Contracting out</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>79.59</td>
<td>100</td>
</tr>
<tr>
<td>79.59</td>
<td>20.41</td>
<td></td>
</tr>
<tr>
<td>Not Satisfied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>8</td>
<td>94</td>
</tr>
<tr>
<td>91.49</td>
<td>8.51</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>125</td>
<td>18</td>
<td>135</td>
</tr>
<tr>
<td>87.41</td>
<td>12.59</td>
<td></td>
</tr>
</tbody>
</table>

Pearson chi²(1) = 4.1437 Pr = 0.042
91.49% of the respondents who were not satisfied with the direct provision of external security services were satisfied with the services after they were contracted out. This compared to only 8.51% respondents who were not satisfied with the services association is not significant the 5% level of significance and we can reject the null hypothesis that contracting out provides better quality services than direct provision of the services, but we cannot reject the null hypothesis at the 10% level of significance. One hospital administrator noted that with the contractors in place he is receiving less reports of theft. He recommended that contractors should be treated as partners in business not as competitors.

The results presented in the foregoing sections indicate that contractors succeeded in providing better quality services than in-house provision in both the cleaning and security services. In the assessment of the quality of the services, the impact of subjective judgement of the respondents is of concern. But at the same time the consumers’ views are considered important in the design and development of policies like contracting out. The results further reveal that it was cheaper to provide cleaning services using contractors than in-house provision. However the security services provided by the contractors are more expensive than in-house provided services. It is worth noting that due to the poor expenditure and accounts records at the hospital it was not possible to get capital costs involved in provision of in-house services, therefore this should be taken into consideration when interpreting the cost results presented.
CHAPTER SEVEN: ANALYSIS AND DISCUSSION

The major objective of this study was to evaluate whether contracting out is an efficient means of delivering health support services, which entailed a comparative analysis of the costs and quality of two selected health support services namely cleaning and security when they were directly provided and when they were contracted out. Efficiency gains from contracting out services were based on whether contractors were economically efficient in that better quality services were provided at lower costs than public provision in relation to other confounding factors. The study also tried to establish what attributes make a contract successful and hence efficient.

This chapter presents some of the major findings about contract design and implementation that are summarised in table 7.1, followed by a detailed analysis and discussion of the findings.

7.1 Degree and Nature of Competition

The contractual arrangements studied resulted from both direct negotiation and competitive tendering processes. The first internal cleaning contract the hospital had with NEC is an example of a directly negotiated contract, while the current cleaning and security contractual arrangements evidence a competitive tendering process. Though the government through the CTB and Solicitor general encourages competitive tendering, which is also the most widely advocated form of tendering, the few bids that the hospital received for the contracts (seven bids for security contract and five for the cleaning contract) evidences the limited number of competing private suppliers in the market. This also partially explains why in 1993 the hospital had to award the internal cleaning contract to NEC based on selective bidding (direct negotiation). Though the contention is that selective bidding minimises monitoring costs and contract failure is likely to be lower since already experienced firms are pre-selected to bid (Mills 97), this was not the case with the NEC cleaning services contract. NEC hardly had any experience in cleaning prior to its being contracted and just gained experience over the years it had the contract. This, coupled with the fact that its employees were constantly involved in illicit activities also explains its continued deteriorating performance over the years and the eventual failure of the whole contract. Noteworthy is the fact that low contestability for the services being contracted raises different issues in the contract and post
contract phases.

Table: 7.1 Summary of the major findings

<table>
<thead>
<tr>
<th>Service</th>
<th>External Cleaning</th>
<th>Internal Cleaning</th>
<th>Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tendering process</td>
<td>First contract was partially competitive⁹ Second contract purely competitive</td>
<td>First contract-sole sourcing. Second contract purely competitive, advertisements in newspapers, 7 bidders</td>
<td>Competitive, advertisements in newspapers 5 bidders</td>
</tr>
<tr>
<td>Specification of work load</td>
<td>Man hrs worked (depends on minimum wage) Detailed Quality specifications provided</td>
<td>Man-hours per square meter worked- some areas arbitrary priced Detailed Quality specifications provided</td>
<td>Number of guards Quality specifications embedded in company’s obligations</td>
</tr>
<tr>
<td>Price setting Type of Contract</td>
<td>Contractor presents his price- Hospital present’s price to CTB. Fixed, but can be revised if need arises Block contract -Mthly payment</td>
<td>Contractor sets price- Hospital. Presents to CTB. Fixed, but can be revised if need arises Block contract -Mthly payment</td>
<td>Contractor sets price based on per guard employed. Fixed, but can be revised if need arises Block contract -Mthly payment</td>
</tr>
<tr>
<td>Duration</td>
<td>Initial pilot phase of 2 years Continuously renewed with same contractor for 8 years</td>
<td>3 years</td>
<td>1 year-pilot phase</td>
</tr>
<tr>
<td>Sanctions</td>
<td>No formal contract with first contractor. Though there is a formal contract with new contractor, no sanctions are specified in contract documents</td>
<td>3 months notice to terminate- sanctions not spelt out. Solicitor General expected to instil sanctions if any.</td>
<td>1 month’s notice (std legal notice) to terminate. Sanctions not spelt out. Solicitor General instil sanctions</td>
</tr>
<tr>
<td>Financing</td>
<td>Govt/MOH</td>
<td>Govt/MOH</td>
<td>Private from user fees funds</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Infection Control&amp; Waste Management Committee, Core Mgt &amp; Mgt Committees</td>
<td>Infection Control&amp; Waste Management Committee, Core Mgt &amp; Mgt Committees</td>
<td>Hospital Security Committee assisted by Core Mgt &amp; Mgt Committees</td>
</tr>
<tr>
<td>Evaluation</td>
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<td>Costs of Services</td>
<td>Contractors cheaper than in house provision</td>
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<td>Quality of services</td>
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Globerman (1996) notes that during contract negotiations a potential contractor in a market with limited contestability is tempted to offer services at a price above marginal cost or average cost in circumstances where the average cost is declining for the demanded good. At the post contract stage, low contestability increases the risk of opportunism and associated

⁹ Though there were 20 bidders, majority of bidders were not well established- NEC was the only well known and established firm at the time. Thus bidding was more of a formality.
costs facing the purchaser, because a contractor cannot be quickly replaced and there is heightened risk of contract breach externalities. This is exactly what the hospital experienced with NEC, for it assumed that this firm had monopoly of the market and it did not take any initiative to test the market for new entrants hence it continued to renew that contract for nine consecutive years even when it was evident that the contractor’s performance was poor.

The low number of bidders is also attributable to the fact that private firms are sceptical about government contracts because they are usually indefinite delays in payments due to the bureaucratic system, which requires all government payments to be cleared by the auditor General’s office. In fact one contract manager contended to this observation in that as much as he was required to provide a timely and quality service, his firm had not been paid for the past two months during the period of the study. Secondly the hospital administrators and CTB officials noted that public sector institutions often have budget constraints and have to balance their needs with the available resources. This implies that they usually have to negotiate with the prospective contractors to offer them prices that are usually lower than the average market prices; this definitely discourages the number of eligible bidders. This implies further that the eventual contractor is more of one who offers the lowest price but not necessarily the best performer.

Another notable finding is that at the time of this study the tendering process in Uganda was highly bureaucratic and centralised, with the CTB having to approve all tender documents and all contract awards. This study revealed that such centralised and bureaucratic processes often led to delays in awarding contracts to would be contractors, which affected the delivery of services. For example the NEC contract to provide cleaning services was effectively ending in December 1999. The hospital re-advertised the tender in September 1999 after informing the CTB of their intentions to renew the contract. But the new contract was not awarded until July 2000. Therefore NEC continued to provide cleaning services beyond the contract period during this transition period, which explains why the cleaning services were quite unsatisfactory during this period for NEC was not obliged to provide these services but was doing so on humanitarian grounds. Further, the fact that at the time of the study NEC had not been paid its services shows that the hospital acted opportunistically during the transition period because it has never met its obligation to the contractor.
The study reveals that the hospital had a systematic system of evaluating bids based on guidelines provided by CTB. However, the discrepancy that arose between the hospital and CTB about the evaluation process used in rewarding the cleaning contract to a new contractor was actually due to the fact that some CTB officials and politicians wanted NEC to maintain the contract despite the fact that the hospital had shown its dissatisfaction with NEC’s performance. Though not explicitly stated, but this points to corruption among the key actors in the contracting process, which also partially explains why NEC’s contract was renewed continually over the nine years without ever re-advertising or evaluating the contract. Corruption is not only unique to Uganda’s case study but has also been cited in Papua New Guinea and Thailand (Beracochea 1997; Tangcharoensathien et al. 1997) were contracting at times was an adhoc process for politicians were promised kick-backs and resulted in poor contract performance.

However, notable is the fact the hospital stuck to its evaluation system and managed to resist other political actors’ influence, which shows that the hospital knew what it wanted in a contractor and was actively involved in the contracting process, which it tried to ensure that it was not flawed and was transparent as possible. The involvement of the different hospital committee members in the tendering process shows that contracting was a planned and organized process.

To sum up the degree and nature of competition was considered to be low which had an impact on the type of contractors that were awarded the contracts; specifically contractors had little or no experience and actually gained experience on the job. Secondly, the limited contestability meant that contracts were renewed with the same contractors even in circumstances where their performance was unsatisfactory.

7.2 Contract Design
Contract design is one of the conditions cited by Mills (1997) as contributing to successful contract performance. Of particular importance is the way services that are to be provided are specified, the price of the contract and sanctions for non-performance. Results from this study reveal that the hospital had no difficulty in specifying the expected output to the contractors: cleaning services were specified in terms of areas to be cleaned, while security services were specified in terms of number of guards to be provided by the contractors.
Contrary to Mills' (1997) observations that quality specifications were rare in contractual arrangements of services in developing countries, the results from this study further reveal that quality specifications were pertinently considered in the contracting process. The hospital provided the contractors with detailed quality specifications, which even included what should be cleaned, the type of cleaning agents to be used and when cleaning should be done. Likewise for security services, the type of guards, what they are expected to do and their characteristics were too explicitly provided to the contractors. The detailed quality specification is partly attributable to the fact that the hospital received technical assistance from ODA consultants who provided the hospital administration with contract design guidelines, which were duly followed and implemented. The security contract also clearly spelled out the expected outcome in the company’s obligations and liabilities, which are binding in that the contractor has to ensure that he meets these obligations most of which were actually quality indicators.

\textit{Pricing/Payment Methods}

Another contract design issue is the pricing and payment method for it determines what type of contract exists between the purchaser and the provider of services and also has implications on the costs and quality of the services. For the contractual arrangements in this study contractors proposed the prices of the services to the hospital basing on market rates, which in turn were presented to CTB for approval. Notable however is the pricing procedure used to determine contract prices. Considering the cleaning services contract it is evident that there was lack of consistency in the pricing method. For instance, while the external cleaning services were priced in man-hours, some areas for the internal cleaning services were priced in terms of square metres, while others were priced in an ad hoc manner. The hospital used the open tendering method in comparison to its budget to determine the contract prices.

Under direct provision of the cleaning and security services the hospital operated annual budgets for these services, which were revised incrementally every other year regardless of each department’s performance. This definitely provided little or no incentive for these departments to increase their efficiency. For example employees were assured of receiving their monthly payments for there were no fines for their absenteeism or non-performance,
which partially accounts for some of the failures of direct provision.

One worth noting similarity between direct provision and contracting out of both cleaning and security services revealed in this study lies in the reimbursement methods. Contractors are reimbursed a fixed amount every month regardless of their output or performance. Block contracts which are the same as a budget for a defined service under direct provision, seem advantageous to the hospital because they require less information in terms of how much work was done, by whom, and when. Secondly, block contracts make the budgeting process easy and predictable since the hospital knows exactly what it is to spend on contracted services annually.

Despite these advantages this method of reimbursement raises the issue of whether the government is actually getting value for its money. For instance for the security contract the hospital pays for twenty four guards each day, but the hospital did not have daily nor monthly records about the number of guards supplied by the contractor apart from what is stated in the contract documents. This means that there might be days when the contractor supplies fewer guards, but with such a loophole in the monitoring process coupled with the fact that contract documents do not specify any fines or sanctions, the government continues to pay the block sum (Ug.Shs 16,699,671 per month) even when fewer guards would have been supplied. This study further reveals that though the contractor (NEC) who had the cleaning contract for nine years was providing a better service than in-house production he eventually became inefficient in that over the years the quality of cleaning services he was providing deteriorated. This is a good example of one of the major disadvantages of block contracts in that they offer contractors few incentives for efficiency or to increase on the quality of services since contractors are always assured of getting reimbursed regardless of their output.

**Contract Duration**

Contract durations also affect contract performance in that for instance long-term contract as opposed to short-term contracts tend to give contractors assurance and stability but contractor performance in the long run will also be dependant on how well the contract is monitored. All the contractual arrangements studied were short-term contracts of two to three years for cleaning services and one year for security services. Despite the fact that short-term contracts usually involve higher transaction costs in terms of re-advertising and re-tendering, the
hospital had to take precautions as far as the security contract was concerned for this was the first time the hospital was contracting out such services, hence the one year contract was a pilot phase that would enable the hospital determine the efficiency of contracting out the services. Secondly short-term contracts have an advantage of increasing competitiveness among contractors and hence increasing efficiency. The contract managers who were interviewed revealed that they were working hard to ensure that their contracts are renewed, which is in support with the foregoing observation.

A notable disadvantage of long-term contracts is that they tend to lead to inefficiency because contractors tend to feel indispensable. This was actually the case with the cleaning contract with NEC. Indeed the NEC contract can be defined as a loose contract that was based on a long-term relationship that Mills (2000) argues is likely to reduce incentives for efficiency. Some hospital managers preferred long-term contracts especially if the contractor was performing to expectations. They argued that this reduces the administrative costs in terms of re-advertising, re-tendering and reorienting the new contractor. Probably this could be one of the reasons why the hospital kept on renewing its cleaning contract with the government SOE: NEC.

Finally the last issue to be discussed regarding contract design is sanctions for non-performance. Contracts for both cleaning and security services just specified notification to terminate contracts but no sanctions for non-performance were specified in either contract documents. This is rather contradictory because when the Solicitor General was interviewed he readily knew all the possible sanctions other than termination, but did not include them in the contracts nor did he legally advise the hospital on this aspect. In other words the hospital continues to pay the contractors the full contract sum even in circumstances where it could possibly fine them. This is very similar to when services were being provided in-house, in that even when an employee’s salary would have been cut due to non-performance, this is never the case for there are no clear regulations on this matter.

In summary, under contract design it is important to have detailed specifications of the expected outcome in terms of both quantity and quality for this greatly eases the enforcement and monitoring process and is likely to a positive impact on the quality of services that the contractors provide, for both parties will have a clear picture of what was expected. However
as much it is ideal to have detailed specifications, hospital managers and other key actors should bear in mind that detail has its costs and that all eventualities cannot be covered in a contract, more so contracts should used as a framework to develop a conducive purchaser-provider relationship. Noteworthy is that the more complex the service to be contracted the harder it would be to specify, measure and monitor and the higher the transaction costs of the contract. Secondly it is pertinent to have systematic pricing methods for each particular service because this does not only make budgeting easy in that total contract costs are predictable, but also reduces opportunism costs for the contracting agency will be aware of what costs are involved. Thirdly, it is imperative to note that there is likely to be a trade-off between minimising administrative costs and efficiency gains from long-term contracts but no generalizations can be made on the cost effectiveness of short-term or long-term contracts for both have their associated costs. Lastly contracts should explicitly include sanctions for non-performance, though sanctions may never be instilled their inclusion can be one of the tools to ensure that contractors do not fail to perform.

7.3 Contract Implementation

Another pertinent element conducive for successful contracting cited by Mills (1997) is the way the contract is implemented, that is the way the contract is managed, financed and monitored. Though results about the contracting process indicate that it is a highly centralised and bureaucratic process, management of the contracts is fully decentralised with the hospital having to decide who manages the contract. In her analysis of contracts in developing countries Mills (1997) notes that contracts rarely included sufficient specifications or allocation of responsibilities to allow contract performance to be monitored. However, Mulago's case is different and commendable when it comes to contract implementation, in that even at the hospital level it has decentralized the management and monitoring of the contractual arrangements. Results from this study show that the hospital has in place monitoring teams/task forces comprising of different hospital staff that are directly responsible for monitoring the contracts.

Experience with the first cleaning contract reveals that the monitoring teams were not so vigilant as reflected by the contractors' employees who were constantly involved in other activities beyond their jurisdiction. This could be attributed to two factors: first of all it was the first time the hospital was contracting out support services, so probably the hospital
managers did not know what was expected of them. Secondly like in most public institutions most of the health personnel were demoralised and de-motivated with little or no interest in their work.

However, learning from past experience the hospital managed to strengthen the monitoring process. Contractors are required to provide a permanent resident supervisor at the hospital who is responsible for all aspects of contract activities. In addition the ward managers oversee the day-day cleanliness of their areas and are required to fill monitoring forms on a weekly basis about the state of cleanliness of their wards, which they submit to the hospital administrator. The hospital administrator liaises with the contractor's supervisor and gives him a feedback on the overall performance. In addition the hospital has introduced cleanliness' competitions among wards, which is actually an indirect monitoring tool for the entire staff end up ensuring that their wards are clean. This monitoring system is not so different from that of in-house provision of services except that ward managers were actually directly responsible for supervising the cleaners on top of their other clinical duties unlike under contracting out where the contractor is directly responsible for the supervision of the employees. The clear specification of responsibilities and effective monitoring of contractors has greatly contributed to the high quality of cleaning services.

Contrary to the above it was observed that monitoring of the security contract was uncoordinated and there was no clear specification of responsibilities. The contractors directly reported to the hospital administrator and the hospital security staff on the ground was hardly involved in the supervision. As a result the hospital security department appeared to be demoralised, which eventually is likely to be reflected in contractor performance for a number of flaws observed among contract guards are ignored. But one interesting observation is that the security department was from the beginning against contracting out the security services and the hospital security officer probably now has less authority which partly explains the apathy of the security department.

The government through the hospital budget has directly financed the cleaning contract over all the years. However the security contract is privately financed by the hospital through user fee funds. This poses an issue of sustainability of the security contract especially during this time when the government has just abolished user fees in government health units (New
Vision 17, 2000). Secondly this may imply that currently the hospital is foregoing some activities that it used to finance through user fees to be able to meet the contract costs. But the fact that the contracting out security services is just being piloted probably the evaluation process at the end of the phase might offer more options to this problem.

To sum up contracting out services does not mean that all responsibility should be shifted to the contractors, because one major reason for public sector inefficiency is the lack of supervision. It is important that health managers where the contracting takes place are actively involved in the daily monitoring of contracts because quality control requires proper contract monitoring, which in turn requires that responsibilities are clearly spelt out. In addition to ensure increased efficiency there should be coordination among all actors involved the contract process in the entire health care system otherwise un-coordination among the key actors is likely to manifest itself in inefficient contract performance.

7.4 Comparative Cost Analysis

Cleaning Services

This evaluation was done from a public sector perspective whose major concern is whether contractors are able to provide services at lower costs. The cost analysis results clearly demonstrate that contractors were able to provide cleaning services at a lower cost than when services were provided in-house by the government. The hospital made a cost saving of 17% when it contracted out the services to NEC and was making a saving of 20.4 % with current contractor (NOREMA). Of utmost importance and worth discussion is what contributes to the cost differentials between in-house production and contract production of services.

First of all usually for political reasons public health facilities tend to be overstaffed and hence a biggest part of their expenditure attributed to salaries. In Mulago’s case for example salaries took up 50% of total in-house production costs for cleaning services. It used to employ approximately six hundred employees as compared to half the number that the contractors employ. Though contractors could not reveal their exact expenditure on salaries, it was evident from the discussions with the contract managers that contractors target cheap labour but also try to employ a minimal number of staff. Contractors also revealed that they invest in equipment that makes production of services easy and fast and also requires less labour. In contrast the public sector was relying more on labour intensive methods of
production that is evidenced in the 0.8% expenditure on equipment as compared to 50% on salaries.

Secondly the cost analysis shows that consumables account for 47% of in-house production costs; this is attributable to the fact that the hospital used to experience a lot of pilferage of hospital supplies due to poor controls. This can contribute to the cost variations between in-house production and contract provision because unlike the public sector, contractors tend to have tight controls on their supplies and hence can minimise consumable costs.

Further from the cost analysis of cleaning services, the hospital spends on average only 0.7% on exante costs (advertisement, lawyers fees and negotiation) and only 1.2% of total contract costs on monitoring. Such low administrative costs have enabled the hospital to minimise total contract costs. The low monitoring costs can be explained by the fact that the hospital has not hired any extra technical personnel to monitor the contracts but instead pays a minimal allowance to the health personnel involved in the monitoring of services.

Security Services

External security services in the hospital were contracted out through a competitive tendering process. But contrary to theoretical arguments that suggest that competitive bidding by the private-for-profit private sector firms for a specified output generally guarantees that the product will be produced at the lowest costs (Randall et al. 1993; Tirole 1998), contracted external security services in Mulago are actually being provided at more than twice the cost they were under in-house provision (i.e. Ug Shs.66, 356,195 excluding exante and monitoring costs as compared to Ug Shs. 32,744,422). This wide cost differential can be further evidenced using the average price of each guard under the two kinds of provision. While the external security services were provided in-house at an average of Shs. 101,063 per month, the contractors provide each guard at an average of Shs.239, 850 per month.

However, the hospital had made an evaluation prior to contracting out the external security services. The evaluation report (Unpublished) included a comparison of prices of potential bidders but it did not include costs of direct provision of the services, hence failed to compare the costs involved in the alternative options of provision. Though the contention in the effectiveness of contracting out the security services may be that the contractor is providing
the hospital with a totally different service in that contractor guards are more educated and better equipped (guards have radio-telephones, and some are armed, unlike under in-house guards who were uneducated and had no form of equipment), provision of security services by the contractor at more than twice the cost of in-house provision is definitely not a cost-effective alternative unless this cost is offset by a markedly improvement in quality of services.

7.5 Quality of the services

Cleaning Services

Though it is difficult to assess all aspects pertaining to quality of cleaning services a comparison between some structural aspects of quality can give an indication of the state of the services. In this case some aspects of structural quality based on the subjective perception of the consumers are quite clear. Notable is the poor state of cleanliness of the sinks, bathrooms and toilets and waste disposal under in-house provision as compared to contract provided services, which is reflected by the 76% of the respondents who were dissatisfied with the services (see table 6.5). This can be explained by the fact that before services were contracted out, the entire water and sewerage system was literally broken down compared to the current situation where the systems have been repaired and are functional, so maintenance of cleanliness was difficult.

The results further demonstrate that contractors were able to provide better quality services than in-house provision. The probable explanation for variations in quality of services is that at the time when the cleaning services were contracted out, public sector employees were indifferent, disinterested and demoralised not to mention that they were poorly supervised. This apathy could be attributed to the lack of incentives to motivate the employees. On the other hand, though contractors may not give any direct incentives but the fact that employees know that they can be hired and fired at any time is an indirect incentive for them to ensure that they are efficient. Secondly contractors have a comparative advantage over hospitals in that they are contracted to provide services which are they are specialised in.

The results in table 6.7 clearly show that contractors have succeeded in providing better quality services than direct provision. However at the 10% level of significance, these results do not support the hypothesis that contractors provide better quality services than in-house
provision as evidenced by the variations in perceptions of the quality of the cleaning services (table 6.6). In other words not all the quality improvement in cleaning services can be attributable to contractors. A strong contention is that the government could not be wholly blamed for the poor services because during the 80s most of the health sector systems were broken down unlike currently where there is great effort to rehabilitate the system. Secondly the high quality of cleanliness is also attributable to the fact that the entire hospital has just undergone a major refurbishment and renovation, so it looks 'new' - which credit should be given to the government. Otherwise even the contractors would not have been in position to attain such a high rate of cleanliness had they been contracted in the 80s when the hospital was in a state of disrepair.

Further, it was noted that some aspects of quality for contract provided services were poor, among which was the cleanliness of the casualty ward that often had overflowing bins and spills of blood. There was also major concern about the politeness of the female cleaners who were characterised as harsh to patients. Hence as much as the contracting out apparently has resulted in better quality services, other institutional and environmental factors external to the contractual arrangements are also influential.

Security Services

Quality of external security services was assessed based on the characteristics of guards in addition to general security, which were used as quality indicators. Still quality of the services was analysed from the subjective perspective of the respondents. There was great dissatisfaction with the trustworthiness of in-house guards. The explanation for this dissatisfaction was that in-house guards were corrupt and used to solicit bribes from people coming into the hospital in addition to conniving with hospital staff to pilfer hospital property, drugs and supplies. However, it is worth noting that trustworthiness of contractor guards still had the lowest rate of satisfaction among respondents (75.5% see table 6.6). This can be explained by the respondents' observation that whether services are provided by contractors or in-house, all guards are corrupt and take bribes. From the satisfaction scores (tables 6.6 & 6.7), it seems that contractors have succeeded in providing better quality security services than in-house production. This is because given the comparative advantage that the contractor has over the hospital it is expected that they would provide better services. Secondly the contracted guards are more educated and more equipped than the in-house
guards. While under direct provision the hospital employed twenty-seven guards who were hardly educated and had no form of equipment, the contractor provides twenty-four educated and well-equipped guards. However, as McPake and Hongoro (1995) contend that it will never be clear whether input differences reflect efficiency rather than quality differences.

Further analysis of the quality of services shows that not all the improvement in quality of security services is attributable to contractors. This is evidenced by the significant results in table 6.10, with a Pr = 0.042, which does support the hypothesis at the 5% significant level that contractors provide better quality services than in-house provision. The probable explanation for this result is that when the hospital was undergoing renovation under the ADB project a new fence was erected hence strengthening the security system. Further there were reservations about how the contracted guards handled patients and visitors to the hospital. This group of respondents showed preference for in-house guards in that contract guards were rude and mistreated them and guarded the hospital like it was an army quarters. This observation is similar to Beracochea (1997) findings in Papua New Guinea where patients complained about the rudeness of contractor guards. This could be further attributed to the fact that though the contracted firm has seven years experience this was actually the first time it was guarding a hospital and guards had not been fully sensitised about the group of people they were handling, which has definite implications on the quality of the contractor's service and performance.

To sum up, no generalizations can be made whether contractors always succeed in providing services at lower costs than in-house provision. This is because while it was cheaper to provide cleaning services by contractors, it was actually more expensive to provide security services through contractors. In cases of where the objective of contracting out services is to make cost saving it is important for contracting agencies to always first make proper cost comparisons between the directly provided services and would be contractor services. This is because choosing a contractor basing on the lowest bidder does not imply that the same contractor will provide services more cheaply because contract costs include more than just the prime costs of the services. Other costs include exante costs, monitoring and evaluation costs all of which should be considered before a final decision to contract out the services is done.
Contractors seem to have succeeded in providing better quality services than in-house provision. This improvement in quality is attributable to the fact that the services contracted out were not so complex so which made it easy to specify, measure and monitor output. However, the regression results do not support the foregoing hypothesis and therefore no generalizations can be made that contractors will always provide better quality services than direct provision. This is because contract performance is also influenced by economic, political and environmental factors.

7.6 How Efficient is Contracting Out Health Support Services?

Measurement of efficiency is quite a challenging exercise, which requires the combination of cost and quality data to infer the extent of efficiency. The major concern of the public sector is which provider produces a given volume of service at the lowest cost. Therefore to consider contractors who provide better quality of services to be more efficient without considering the costs involved would lead to wrong conclusions.

A combined analysis of the cost and quality data shows that contractors are more efficient producers of cleaning services than direct provision in that the contractors succeeded in raising the quality of cleaning services by providing a better service and at a lower cost than in-house provision.

Other efficiency gains from contracting out the cleaning services is that hospital managers were relieved from the daily direct supervision of cleaning of the hospital and have more time to concentrate on other hospital activities. However, this does not mean that hospital managers solely transferred all their responsibilities to the contractor because they are actually actively involved in the monitoring process. The markedly successful contractor performance is also attributable to the fact the hospital provided explicit specifications of outcomes in terms of quality and quantity that eased the monitoring process.

Prior to contracting out cleaning services the hospital was incurring high consumable costs because there was a lot of pilferage and wastage of hospital supplies by the cleaners and other staff, which was partly due to poor accountability and control systems. Though there might still be pilferage of other hospital supplies, but with the contractor providing cleaning consumables the hospital has been able to minimise costs which were due pilferage of
cleaning consumables. The hospital’s cost for protective clothing has also reduced since the contractor is responsible for providing these to its employees - hence an efficiency gain from contracting out the services.

Further, contracting out of both cleaning and security services has also resulted in the decrease of the hospital’s wage bill because the contractors are solely responsible for hiring and paying their employees, which is definitely an efficiency gain. From the in-depth interviews with hospital administrators it was revealed that the hospital used to incur indirect costs in terms funeral and other emergency allowances that were given to in-house employees in the cleaning department. Though there was no available expenditure data on the exact amount of such allowances, it is clear that with the contracting out services the hospital has further been able to minimise such indirect costs attributable to direct provision of the services.

However, though the contracted security firm seemed to be providing a better quality service than in-house provision, a combination the quality and cost results yields inconsistent conclusions regarding the efficiency gains from contracting out these services. Notable is the finding that the contractor is providing the external security services at more than twice the cost they were provided at under direct provision. The great increase in cost of the services coupled with the significant results from the quality analysis that do not support the hypothesis that contracting out provides better quality services than direct provision make contracting out security services an inefficient process. This is so especially since the main objective of contracting out the services was to improve the quality of the services but also at the same time to minimise costs associated with the provision of these services. However, from the evaluation report of in-house security services (unpublished) it is apparent that that the hospital made a conscious decision to contract out external security services because its overriding objective was to expand and improve the entire external security services. This objective, coupled with the high rate of satisfaction with the quality of services provided by the contractor seems to offset the costs.

7.7 Other Factors Contributing to Contract Success and Failure

The level to which various responsibilities for contracting are assigned appears to be of considerable importance to the success of service contracts (Bennet and Mills1997). Ghana
and Papua New Guinea offer examples of contract failure resulting from contracts being agreed centrally and hospitals not being involved in the negotiations, which meant that contracts were weakly specified and impossible to enforce at the local level (Beracochea 1997; Mills and Bennet 1997; Mills 2000). However, in Mulago Hospital the active involvement of the hospital administration in the entire contracting process for the newly established security and cleaning resulted into comprehensive contracts that include most detail regarding contract specificity, implementation and clear monitoring responsibilities, that a key to contract success. The CTB and Solicitor General can be regarded as more of regulatory institutions of the government who ensure that the hospital follows the laid down guidelines but the actual management and implementation of the contracts is the sole responsibility of the hospital (see appendix A5: 3,15). This has increased the hospital autonomy in decision-making that acted as an operational incentive to hospital managers to ensure efficient functioning of contracts. The detailed contracts especially as far as cleaning services specificity is concerned are also partly attributable to the technical assistance the hospital received from ODA.

In relation to the above is the capacity of the hospital managers to negotiate, implement and monitor contracts. This study shows that Mulago’s administrators have the required capacity to implement and monitor contracts. This resulted in lower administrative costs since the hospital did not have to hire technical staff for these tasks. However, the managers are not competent enough in contract negotiation but this is counteracted by the technical support they receive from both the CTB and Solicitor General.

Though the level of private sector development is often cited as a potential barrier to contracting in developing countries (Bennet and Mills 1997) this is not the case in Uganda. This is because contracting out stems out of the macro-economic policy of privatisation that is fully supported by the GoU. Therefore the few number of bids for both the security and cleaning contracts are more of a sign of the lack of competition that exists for government contracts than barriers to entry, due to the associated delays in payments by the government. However, since these are non-clinical services that do not require the contractors to invest a lot of capital, there is potential for contestability. Greater contestability can also be encouraged by governmental behaviour. First the government can ensure that contracts are as small as possible and consistent with minimum efficient scale of production of the contractor.
(Globerman et al. 1996). For example in this case study, one firm can be contracted for internal cleaning while another is contracted for external cleaning however it must be noted that this will raise ex-ante costs for it tends to be harder to monitor a large number of small contracts rather than one large contract.

One major factor that led to the failure of the cleaning contract between Mulago Hospital and NEC was the failure of the Solicitor General to draw up a formal contract between the two parties. Drawing up a contract is beyond the hospital’s capacity and more so the bureaucratic guidelines do not allow a public institution to use private legal services (see appendix A5: 12). So throughout the entire nine-year period NEC was providing services based on the CTB authority letter and mutual trust; therefore it was hard for the hospital to effectively enforce performance checks. Mills (2000) notes that such loose contracts based on long-term relationships are likely to reduce incentives for efficiency.

One interesting feature about the first cleaning contract that the hospital had with the SOE was that the contractor had to take on all the employees that the hospital initially employed. The probable explanation is more of political than economical because the government could not afford ‘making headlines’ of lying off 600 workers at a go! The results of this conditionality were soon evidenced among others by the hospital complaints about contractor employees being involved in illicit activities like extorting money from patients, manning drug cupboards which led to increased pilferage of drugs and sundries not to mention the deteriorating quality of contractor’s provided services. This left the contractor with only one solution: to make the hard decision that the government had failed to make. Such contract problems that include staff redundancies are not unique to Uganda. Mills (2000) cites an example in India where the Department of Health had attempted to contract out laundry services in a hospital but discovered that it could not lay off existing staff nor was the contractor ready to employ them and the staff were also not willing to be employed by the contractor so the government abandoned the plan to contract the services. It is clear that such external political effects resulting from fear of opposition are likely to manifest themselves in poor contract performance. Therefore in situations were contracting out services might involve staff redundancies, contracting out of services should provide for greater flexibility in personnel management generally associated with the private sector including ability to hire and fire rapidly and to employ temporary staff (Bennet and Mills 1997).
Both the security and cleaning contractual arrangements are a result of an immediate solution to the inefficient in-house provision of services. It is worth pointing out that there is no comprehensive evaluation that was done of these services prior to contracting them out. This required adequate and up-to-date cost and quality data that was lacking due to the poor management and information systems. Bennet and Mills (1997) contend that adequate information systems are key to successful contracting and that governments and public health institutions need information on their own services because this helps them to decide which services to contract out and to negotiate more effectively with contractors.

Lastly, the success of the contractual arrangements can also be attributed to the government of Uganda that has gone a long way to rehabilitate all sectors of the economy. Mulago Hospital had at the time of the study just undergone a major refurbishment, which involved erecting a new fence hence strengthening and improving the general security of the hospital. In addition the entire hospital looks new, which also partially accounts for the improved cleanliness of the hospital. Finally, because reform is a dynamic process, not a once and for all event; the key capacity is being able to learn from successes and failures (Bennet and Mills 1997). Mulago Hospital seems to be borrowing a leaf from other countries experiences hence the marked success of the contractual arrangements, so should all other public health institutions that are planning to contract out some of their services.
CHAPTER EIGHT: POLICY IMPLICATIONS AND CONCLUSION

8.1 Policy Implications and Recommendations

The foregoing discussion and analysis of the results raises a number of policy implications that would be pertinent in any future contractual arrangements and which would probably improve the existing contracts in public health facilities. First of all, much as block contracts result in low transaction costs policy makers should be aware of their few incentives for efficiency or for raising quality, for as much as the goal is to minimise costs of providing health support services, this should not be traded off with the quality as an output measure. This is because paying contractors a block sum of money for services is no different from a public sector budget for a given service however block contracts were the norm for all the contractual arrangements in the hospital. Ideally policy makers have a wide choice of payment methods to choose from depending on the type of service and the ease of specification of the service before they can decide on any definite contractual payment arrangement. For example a payment method that may work well for a non-clinical service may not apply to clinical services.

So for different contracts health managers can establish different payment procedures but bearing in mind the advantages and disadvantages of each. For example in case of security services the monthly contract price was based on number of guards the contractor was expected to supply each day. Therefore other than reimbursing the contractor a fixed amount per month, the hospital can do the reimbursement based on guards employed per day—definitely this requires the hospital to keep a daily record of the guards implying more monitoring costs, but it ensures that the government pays for exactly what it gets.

The way the cleaning contract kept on being renewed with the same contractor for several years raises some issues for concern. Renewal of contracts should be based on performance of the contractor as well as evaluation of the supply market. Though the argument is that developed countries do not have a developed market for competing private suppliers, one aspect that should be considered is that they are usually new entrants into the market if they are no barriers to entry. This implies that hospitals can opt for short term bound contracts and be more vigilant in re-advertising tenders for the provision of services so as to allow new entrants to bid for contracts. This is in line with Kutzin (1995) assertion that if the goal of
contracting is to improve efficiency and quality through the use of market forces, the key macro condition that must be fulfilled is that the market to supply the contracted service is contestable, otherwise contracting will be essentially equivalent to granting a monopoly. If there is low contestability this increases the potential for opportunism because the MOH/government cannot easily replace the contractor. Usually the markets for non-clinical services like cleaning and security are contestable because producers can easily switch to the production of these services without sinking large upfront costs. In addition a number of firms have the basic capacity to supply such services even if they are currently not doing so.

The tendering and contracting process in Uganda was partially characterised by centralized and bureaucratic tendencies with the Central Tender Board and Solicitor General having to approve all tender documents and award of contracts. This bureaucracy often led to delays in awarding contracts and had effects on the way contracts were implemented. For example CTB gave authority to Mulago Hospital to renew the NEC contract for three more years in January 1997 for a contract meant to end in June 1996.

Such bureaucratic failures call for the need to devolve the tendering process to much lower levels like the public health facilities where the contracting takes place. However, devolving the tendering process to hospitals would require some new skills from health managers if this process were to be enhanced. However, the fact that Mulago Hospital already has a hospital tendering committee and was actively involved in the whole contracting process seems to suggest that the hospital has some capacity to handle the tendering/contracting process. Therefore if hospital managers are given more training in drafting tender documents, evaluation of bids and negotiation skills, the hospital will be able to solve some of the loopholes in the contracting process.

Delays in paying contractors are another consequence of bureaucratic government procedures. This leaves the hospital in a weak position to fully question contractor performance if the contractors have not been dully paid; it also partially explains why private suppliers are reluctant to bid for government contracts. There is therefore need for the government meet payments as stipulated in the contracts.

The finding that the security contract is being financed privately by the hospital through
funds from user fees raises concern about the sustainability of the security contract. Mills (1997) notes that in poor countries if governments cannot afford to fund direct provision adequately, it is highly unlikely that contracting is the solution. In the same contention there is more to sustainability of contracts than just financing because public sector inefficiency at times is as a result of management failure. Therefore it is important to consider sustainability of contracting in both terms of financial and management capacity.

Though the hospital succeeded in instituting a systematic monitoring system of contracts there are no penalties for poor performance in place. Sanctions are required to discourage the contractor from failing to deliver (Walsh 1995). Therefore contract documents should be revised to specify penalties, sanctions and the circumstances under which such penalties are likely to be applied. Possible penalties could include withholding payments, fines and the worst-case scenario: revoking contracts. The hospital should further be given full legal backing and support by the Solicitor General should a need arise to instil any of the penalties or sanctions.

The finding that the evaluation of both direct provision and contracts is not a planned process was evident in the lack of complete service cost information upon which bids should have been evaluated. The hospital administrators were not knowledgeable of their own costs under in-house provision and further no provider performance data was available to support the need to contract out services or to renew already existing contracts. It is worth emphasising that evaluation is part of the planning and contracting cycle and should be the basis upon which providers should be identified - be it in-house provision or contractors. Therefore evaluation should not be an adhoc process but should be part of the contracting process and contracting should be done as part of the entire health institution's planning process (see appendix A6). Without a proper and documented evaluation process it becomes hard to assess whether contracting out is the most efficient option as opposed to direct provision. It is therefore recommended that the hospital improve its information systems, which will enable it keep track of its own production costs and contractor performance data. It should then use this data at the end of a clearly stipulated period within the hospital's planning cycle to evaluate contractor performance before it can decide on either renewing or re-advertising contracts. If the hospital is contemplating to contract out new services, the decision to contract out the services should be based on a through evaluation using of its own production
costs and performance against that of potential contractors. The contention might be that the hospital does not have the capacity to do such evaluation but it already has an evaluation and planning department with competent staff that seemed to be unexploited.

8.2 Conclusion

This was a case study of a national referral hospital in Uganda, which is the only one of its kind in the country. Therefore a number of its features and scope may not be comparable to other hospitals in the country. Therefore the findings from this study cannot be generalised to the country as a whole but the fact that this hospital has long standing experience with contracting out non-clinical services some of the findings and recommendations from this study could be of pertinent use to other government health institutions who have already contracted out or are planning to contract out similar services.

The cost analysis was quite a challenging exercise especially given the fact that due to inadequate and incomplete hospital information some allocation formula had to be established based on some valid assumptions so as to estimate some costs like: the utility costs, equipment, supervisory and monitoring costs. The comparative cost analysis results from this study are not different from those of earlier studies reviewed in the literature (Bhatia 1997; Beracochea1997; and Tangcharoensathien1997) that showed variations, in that while for some services contractors managed to provide services more cheaply direct provision, for other services the opposite was true. Likewise in this study while it was cheaper to provide cleaning services through contracting out, it was actually more costly to provide security services through contracting out than in-house provision. Therefore there is no clear pattern to support the hypothesis that health support services can be provided at a lower cost than direct provision of services. This is because contract costs are a function of service complexity, contestability and management capacity. Services that are hard to specify involve uncertainty about the nature and costs of production itself, which is likely to increase total contract costs both during contract negotiations and after the contract has been implemented for there might arise a need to revise the contract. Further if the market for service is contestable opportunism costs are reduced at the contract stage and at the post contract stage. Lastly, the capacity of the government and MOH to negotiate, evaluate and
monitor contracts will reduce administrative costs and hence total contract costs. Therefore the economic and institutional context within which the contracts are implemented can determine the total contract costs.

While contractors seemed to have succeeded in providing better quality services than in-house provision, it is worth pointing out that quality, as an indicator of contractor performance is a function of degree of competition, service specification and management capacity to monitor performance. It has been established from this study that competition for provision of services tends to increase pressure among contractors to increase their performance for fear of being replaced hence increasing quality of services. Detailed service specification in terms of quantity and quality measures, ensures that both parties are explicitly aware of what is expected and hence try to keep to these expectations. Lastly, the ability of health managers to monitor the performance of the contractor will be reflected in contract performance.

The hospital administration was fully involved in the monitoring of contracts and this further explains the improved quality of services. Those who are involved in the monitoring process are given allowances that are incentives for them to ensure that contractors perform. Therefore within the management capacity for contracts there must be an element of bonus incentives to enable health managers to monitor contracts in an efficient way because one failure of in-house provision is the lack of supervision due to the total absence of incentives to motivate supervisors.

Despite the effort the hospital has put in monitoring the contracts, the importance of evaluation is once again emphasised. Evaluation of both direct production of services and costs of potential contractors should be the basis upon which judgement should be made whether services should be contracted out. The same information should also be used to evaluate bids. But this greatly calls for the improvement of information systems in the hospital to be able to generate adequate and accurate cost and provider performance data, in addition to information about its own production costs.

Lastly it should be noted that in Uganda contracting out is a result of a macro-economic policies of privatisation. The government through the MOH is therefore in full support of the
contracting out programmes. At a macro level therefore it is imperative to consider how well developed the market for competing private suppliers is because this provides a potential for improvements in quality of the services and cost containment. Since contracts are implemented at the micro level (that is at the health facilities) this means that there might be need to build up the managerial and administrative capacity at this levels to ensure successful contracting processes and implementation. This may require the retraining of administrative staff to prepare them to take up additional responsibilities. However this has cost implications which the government should consider before it takes on ambitious plans of contracting out health related services.

In addition contracts need to be reviewed to include explicit sanctions or penalties for non-performance to ensure contractor compliance. There is also need to consider other methods of payments other than block contracts though this should be done in relation to the advantages and disadvantages of each mode of payment, but it is worth pointing out that block contracts have few incentives for efficiency.

The success or failure of a contract is quite unpredictable, but from this study it is quite clear that contract performance is more than just a function of cost reduction and quality improvement, but that it also depends on the market conditions, contract design and the capacity of health personnel to negotiate, evaluate and monitor contracts. This study has also established other factors that may determine contract success which were not a priori assumed. Among these is the coordination among the key actors in the contracting process, explicit specification of monitoring responsibilities and the existence of incentives within the monitoring process. Lastly the economic, institutional and political environment is also likely to affect contract performance.
References


Gilson, L. et al. (1995) 'Should governments in Low and middle Income Countries Contract


Countries: Bureaucratic versus Market Approaches.’ PHP Departmental Publication No.17, London School of Hygiene and Tropical Medicine.


98


Appendix 1A: Health Sector Budget Estimates 1999/00 In Billion Shillings
1US$=1500 Ug.Shs.

<table>
<thead>
<tr>
<th>Programmes</th>
<th>Total Recurrent (wage + non-wage)</th>
<th>Domestic Development</th>
<th>Total</th>
<th>% Allocated to Health</th>
</tr>
</thead>
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<tr>
<td>Health HQs</td>
<td>11.48</td>
<td>12.02</td>
<td>23.5</td>
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</tr>
<tr>
<td>Butabika Hospital</td>
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<td>0.15</td>
<td>1.68</td>
<td></td>
</tr>
<tr>
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<td>11.7</td>
<td>1.95</td>
<td>13.65</td>
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</tr>
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<td>PHC Conditional Grant</td>
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<td>12.36</td>
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<td>NGO Hospitals/PHC</td>
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<td>1.85</td>
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<td>District Hospitals</td>
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<td>Referral Hospitals</td>
<td>3.99</td>
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<td>3.99</td>
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<td>District Lunch Allowance</td>
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<td>9.18</td>
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<tr>
<td>Health Service Commission</td>
<td>0.654</td>
<td>0.12</td>
<td>0.774</td>
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<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>68.774</strong></td>
<td><strong>14.24</strong></td>
<td><strong>83.014</strong></td>
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<td>Development Budget</td>
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<td>Donor</td>
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<tr>
<td>Health HQs</td>
<td>110.2725</td>
<td>12.02</td>
<td>122.2925</td>
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<tr>
<td>Mulago Hospital Complex</td>
<td>16.7925</td>
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<td>18.7425</td>
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<tr>
<td>Butabika Hospital</td>
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<td>0.15</td>
<td>0.15</td>
<td></td>
</tr>
<tr>
<td>Health Service Commission</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>127.06875</strong></td>
<td><strong>14.12</strong></td>
<td><strong>141.18875</strong></td>
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</tr>
<tr>
<td>Grand Total (Health Sector)</td>
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<td></td>
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<tr>
<td>Total GoU Recurrent Budget</td>
<td><strong>1132.1</strong></td>
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</tr>
<tr>
<td>Total GoU Budget</td>
<td><strong>1836.4</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total GoU Donors Support</td>
<td><strong>516.45</strong></td>
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</tr>
</tbody>
</table>

**Footnote:**
The Grand total includes both recurrent and development expenditure from both the GoU and donor contributions.

Appendix 2A: Examples Of Crime Reports In The Hospital

<table>
<thead>
<tr>
<th>SD NOS.</th>
<th>NATURE OF REPORTS</th>
<th>REMARKS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/8/97</td>
<td>Theft of drugs by a one Kasega Harriet</td>
<td>Handled over to Police but no reports have been received Yet</td>
<td>8/8/97</td>
</tr>
<tr>
<td>2/16/97</td>
<td>Theft of drugs by one Kyeyune Godfrey</td>
<td>Handled over to Police and case is pending in court</td>
<td>16/5/97</td>
</tr>
<tr>
<td>3/12/97</td>
<td>Attempted electrocution of children of Musabiru G. of Catering Dept. by a one</td>
<td>Disciplinary action is pending 25/8/97</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Namara Sam of Workshop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/3/97</td>
<td>Extortion of money from a one Andama Annet by a one Dr. Apio at .H.D.</td>
<td>The case is pending disciplinary 3/11/97</td>
<td></td>
</tr>
<tr>
<td>2/18/97</td>
<td>Three goats belonging to a one Ntahondi were arrested grazing in the hospital illegally</td>
<td>They were returned to the owner 18/11/97 after caution</td>
<td></td>
</tr>
<tr>
<td>3/20/97</td>
<td>Theft case of a manhole cover from Mwanamugimu</td>
<td>Investigation continues</td>
<td>20/11/97</td>
</tr>
<tr>
<td>4/20/97</td>
<td>Attempt breakage into Main Theatre by unknown person who escaped</td>
<td>Investigation continues</td>
<td>3/12/97</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/21/97</td>
<td>Loss of a money purse by a one Dr. Chirwa Elizabeth</td>
<td>Investigation continues</td>
<td>21/11/97</td>
</tr>
<tr>
<td>6/29/97</td>
<td>Burglary breakage and theft from Rwandeme’s residence</td>
<td>Investigation continues</td>
<td>28/11/97</td>
</tr>
<tr>
<td>7/29/97</td>
<td>Theft of patients properties In ward 1C by an unknown person</td>
<td>Investigation continues</td>
<td>28/11/97</td>
</tr>
<tr>
<td>2/2/97</td>
<td>Theft of a man haul cover from Dental Clinic</td>
<td>Investigation continues</td>
<td>1/12/97</td>
</tr>
<tr>
<td>3/23/97</td>
<td>Theft of drugs and sundries by one Namusisi Alice Alias Robina Alias Namayanja</td>
<td>Reported to Police charged in court and remanded in Luzira</td>
<td>23/12/97</td>
</tr>
</tbody>
</table>

101
Appendix 3A: Quality Assessment Interview Schedule

This study aims at evaluating the existing contractual arrangements in public hospitals in Uganda. In order to assist in this process, we would be grateful if you could take time to respond to the questions below. In particular please give your opinion about the quality of the services. Your answers will be treated with utmost confidentiality.

Thank-you.

Department ..............................................................
Cadre .................................................................
Other Medical ........................................................
Non-medical (state title) ...........................................

Please could you rank the quality of the following services when provided by the government (in-house) and when provided by contractors?

Government (in-house provision)

<table>
<thead>
<tr>
<th>Service</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cleaning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal areas:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Floors, walls</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>ii) Sinks, toilets, bathrooms</td>
<td></td>
<td></td>
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<tr>
<td>iii) Verandas, corridors</td>
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<tr>
<td>iv) Waste disposal</td>
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<tr>
<td>External areas:</td>
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<td></td>
<td></td>
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<tr>
<td>i) Lawns (are they well maintained)</td>
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<tr>
<td>ii) Parking yards</td>
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<td></td>
<td></td>
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<tr>
<td>iii) Roads and Pavements</td>
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<tr>
<td>iv) Drainage channels</td>
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<tr>
<td>v) Flower gardens</td>
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<tr>
<td>vi) Roofs (free of unwanted plants and litter)</td>
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<tr>
<td><strong>External Security</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>i) Discipline of guards</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ii) Competence of guards (alertness)</td>
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<td></td>
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<tr>
<td>iii) Trustworthiness of guards</td>
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<tr>
<td>iv) Communication</td>
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<td></td>
</tr>
<tr>
<td>v) General Security</td>
<td></td>
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</tr>
</tbody>
</table>

Score guide: 1=Very good 2=good 3=Satisfactory 4=Poor 5=Very Poor

Comments: __________________________________________________________________________________________

__________________________________________________________________________________________

102
## Contractor Provided Services

<table>
<thead>
<tr>
<th>Service</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cleaning</strong></td>
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<tr>
<td>Internal areas:</td>
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<td></td>
</tr>
<tr>
<td>i) Floors, walls</td>
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<tr>
<td>ii) Sinks, toilets, bathrooms</td>
<td></td>
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<tr>
<td>iii) Verandas, corridors</td>
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<tr>
<td>iv) Waste disposal</td>
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<tr>
<td>External areas:</td>
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<td>i) Lawns (are they well maintained)</td>
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<tr>
<td>ii) Parking yards</td>
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<tr>
<td>iii) Roads and Pavements</td>
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<td></td>
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<tr>
<td>iv) Drainage channels</td>
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<tr>
<td>v) Flower gardens</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>vi) Roofs (free of unwanted plants and litter)</td>
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<td><strong>External Security</strong></td>
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</tr>
<tr>
<td>i) Discipline of guards</td>
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<tr>
<td>iii) Trustworthiness of guards</td>
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<tr>
<td>iv) Communication</td>
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<tr>
<td>v) General Security</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Score guide:**
- 1 = Very good
- 2 = good
- 3 = Satisfactory
- 4 = Poor
- 5 = Very Poor

**Comments:**

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103
### Appendix 3B: Cost Analysis Schedule Contract Costs

Financial Year

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<tr>
<th>Exante Costs</th>
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<th>Expost Costs</th>
<th>Cost in Uganda Shillings</th>
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<tr>
<td>Advertisement</td>
<td>Prime price of services/goods</td>
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<td></td>
</tr>
<tr>
<td>Lawyer fees</td>
<td>Monitoring fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meetings (identifying contractor)</td>
<td>Accounting systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negotiation (in proportion of time spent)</td>
<td>Evaluation costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Contract Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: some of the above costs may require taking consideration of time spent by administrators supervising, monitoring contracts and percentage time calculated in proportion to monthly salary.
# Appendix 3C: Government/Hospital Production Costs (In-House Provision Of Services)

Financial Year

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost in Uganda Shillings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries (wages)</td>
<td></td>
</tr>
<tr>
<td>Raw materials (cleaning agents etc..)</td>
<td></td>
</tr>
<tr>
<td>Utilities:</td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td></td>
</tr>
<tr>
<td>Gas</td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
</tr>
<tr>
<td>Supervisory costs (in proportion to staff time)</td>
<td></td>
</tr>
</tbody>
</table>

Notes:

Floor space in square metres

Department floor space:

------------------------------------------------------------------

Time spent on supervision administrative staff:

------------------------------------------------------------------

------------------------------------------------------------------

------------------------------------------------------------------
Appendix 3D: Check List For Contract Design

Name of Hospital: ..............................................................................................................
Level of Hospital (Tertiary, district etc.): .................................................................
Contracting Agency: .................................................................................................
Contractor: .................................................................................................................

<table>
<thead>
<tr>
<th>Service contracted out</th>
<th>Service specification (sq metres, meals served, etc…)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract Duration (state form what period to end period)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the pricing/ reimbursement method?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Who sets the price?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Are prices negotiable, fixes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Are sanctions for poor performance specified/breach of contract?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTES:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

__________________________________________________________________________
### Appendix 3E: Check List For Contract Implementation

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is responsible for drawing/drafting the contract?</td>
<td></td>
</tr>
<tr>
<td>How many bidders were there?</td>
<td></td>
</tr>
<tr>
<td>What were the selection criteria for the contractor?</td>
<td></td>
</tr>
<tr>
<td>Who monitors the contract?</td>
<td></td>
</tr>
<tr>
<td>How is the contract financed?</td>
<td></td>
</tr>
<tr>
<td>What are the evaluation criteria?</td>
<td></td>
</tr>
</tbody>
</table>

**NOTES:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

______
Appendix 3F: Interview Guide For Hospital Administrators

This study aims at evaluating the existing contractual arrangements in public hospitals in Uganda. In order to assist in this process, we would be grateful if you could take time to respond to the questions below. Your answers will be treated with utmost confidentiality.

Thank-you.

Title.................................................................

Department.............................................................

1. Brief background that led to contracting-out the services

2. What were the objectives for contracting-out the services?

3. Involvement in the negotiation and contracting process. Do you think you have the capacity to draft/negotiate contracts?

4. How is monitoring of contract done and how often is it done? What is your role in the monitoring of support services? Any problems related to the management/monitoring of contractors as opposed to in-house provision?

5. What have been the advantages of contracting out the services? Do you think contracting-out has achieved its intended objectives? Any Indicators

6. What have been the disadvantages of contracting out the services?
Appendix 3G: Contractors Interview Schedule

This study aims at evaluating the existing contractual arrangements in public hospitals in Uganda. In order to assist in this process, we would be grateful if you could take time to respond to the questions below. Your answers will be treated with utmost confidentiality.

Thank-you.

Date: ........................................
Name of Firm ...........................................................
Title of Respondent ..................................................

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long have you had the contract with Mulago Hospital?</td>
<td></td>
</tr>
<tr>
<td>How many competitors were there for the same contract?</td>
<td></td>
</tr>
<tr>
<td>Does the firm have any prior experience in the service that it is currently providing – how long was the experience</td>
<td></td>
</tr>
<tr>
<td>What costs did the firm incur during the contracting process? – stamp fees, legal charges, tender fees, etc…</td>
<td></td>
</tr>
<tr>
<td>Start-up costs</td>
<td></td>
</tr>
<tr>
<td>What facilities does the hospital provide and at what rates?</td>
<td></td>
</tr>
<tr>
<td>What concessions does the hospital provide to the firm?</td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the contractual arrangement?</td>
<td></td>
</tr>
<tr>
<td>Why?</td>
<td></td>
</tr>
<tr>
<td>Comments if any.</td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 4A

Table A2: Allocation Basis for to Cleaning Services

<table>
<thead>
<tr>
<th>Cost Centre</th>
<th>Direct Cost(Ug.Sh.s.)</th>
<th>Allocation Basis*</th>
<th>Cost</th>
<th>Allocation Basis*</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries(wages)</td>
<td>127,686,564</td>
<td>100%</td>
<td>127,686,564</td>
<td>100%</td>
<td>127,686,564</td>
</tr>
<tr>
<td>Consumables</td>
<td>120,398,400</td>
<td>100%</td>
<td>120,398,400</td>
<td>100%</td>
<td>120,398,400</td>
</tr>
<tr>
<td>Water**</td>
<td>28,632,147</td>
<td>1%</td>
<td>286,321</td>
<td>1%</td>
<td>286,321</td>
</tr>
<tr>
<td>Supervisory***</td>
<td>17,532,756</td>
<td>12.50%</td>
<td>2,191,595</td>
<td>12.50%</td>
<td>2,191,595</td>
</tr>
<tr>
<td>Equipment</td>
<td>2,107,564</td>
<td>100%</td>
<td>2,107,564</td>
<td>100%</td>
<td>2,107,564</td>
</tr>
<tr>
<td>Maintenance****</td>
<td>7,055,475</td>
<td>12.5%</td>
<td>881,934</td>
<td>12.5%</td>
<td>881,934</td>
</tr>
<tr>
<td><strong>Total in nominal values</strong></td>
<td></td>
<td></td>
<td>253,552,378</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### In- house Production Costs (1989)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Advertisement</td>
<td>960,000</td>
<td>960,000</td>
<td>1,080,000</td>
</tr>
<tr>
<td>Lawyer fees</td>
<td>100,000</td>
<td>100,000</td>
<td>100,000</td>
</tr>
<tr>
<td>Negotiation</td>
<td>720,000</td>
<td>720,000</td>
<td>1,200,000</td>
</tr>
<tr>
<td>Prime Price of contract</td>
<td>281,784,720</td>
<td>281,784,720</td>
<td>289,670,328</td>
</tr>
<tr>
<td>Monitoring fees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Inflection Control &amp; Waste</td>
<td>575,000</td>
<td>575,000</td>
<td>1,800,000</td>
</tr>
<tr>
<td>ii) Management and Core Management</td>
<td>15,000,000</td>
<td>1,875,000</td>
<td>12.50%</td>
</tr>
<tr>
<td>Total Contract Costs(nominal values)</td>
<td>286,014,720</td>
<td></td>
<td>295,725,328</td>
</tr>
</tbody>
</table>

*Allocation basis was based on availability of data.

Costs that are 100% allocated to cleaning were easily obtained from the expenditure records as expenditure to cleaning.

**Contractors are charged 1% for water, this was used as allocation basis for water costs under in-house production.

***Basing on Drummond et al.(1998) and Shepard et al. 1998 staff time spent on supervising in-house services and monitoring of contracts was allocated using administrative data. Managers were asked how many hours they used to spend supervising in-house provided services and what time theye spent monitoring contracts. From the interviews with supervisory staff, it was found out that on average staff spent one hour out of the eight working hours supervising in-house provided services or monitoring contracts. This was used as the basis to prorate the supervisory and monitoring costs to cleaning services.

Maintenance Cost: allocated on the based on percentage of supervisory costs (see Shepard et al 1998).
### Table A3: Allocation Basis for External Security Services

#### In-house Production Costs (1999)

<table>
<thead>
<tr>
<th>Cost Centre</th>
<th>Allocation Basis*</th>
<th>Cost Allocated (Ug.shs.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries (wages)**</td>
<td>63,678,348</td>
<td>30,163,428</td>
</tr>
<tr>
<td>Consumables</td>
<td>917,000</td>
<td>917,000</td>
</tr>
<tr>
<td>Supervisory***</td>
<td>3,327,888</td>
<td>1,663,944</td>
</tr>
<tr>
<td><strong>Total in nominal values</strong></td>
<td></td>
<td>32,744,372</td>
</tr>
</tbody>
</table>

#### Contract Costs (2000)

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (Ug.shs.)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advertisement</td>
<td>1,080,000</td>
<td></td>
</tr>
<tr>
<td>Lawyer fees</td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Negotiation</td>
<td>1,300,000</td>
<td></td>
</tr>
<tr>
<td>Prime Price of contract</td>
<td>69,076,800</td>
<td></td>
</tr>
<tr>
<td>Monitoring fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Security Committee</td>
<td>1,440,000</td>
<td>100%</td>
</tr>
<tr>
<td>ii) Management and Core Management</td>
<td>15,000,000</td>
<td>12.50%</td>
</tr>
<tr>
<td><strong>Total Contract Costs (nominal values)</strong></td>
<td></td>
<td>74,871,800</td>
</tr>
</tbody>
</table>

#### Notes

* Allocation basis was determined based on interviews and available data.
** The hospital contracted out only external security services, were only twenty-seven guards were employed.
*** Supervisory Costs: These were allocated basing on the time the Security officer spent supervising in-house external security provision, which from the interviews wast 50% of his time.

#### Contract Costs

1. Advertisement costs: these were not available from the expenditure records therefore they were determined at the market rate of advertising at that time and on the number of advertisement the hospital run.
2. Lawyer fees: Though the hospital employed the free services of the Solicitor General-this is an economic cost for the government pays the Solicitor General to offer these services. This cost was estimated based on the scale of fees recommended...
for such services in the Statutory Instruments (1996)

3. Negotiation Costs: estimated based on the allowances given to staff members involved in identification of a contractor
and the negotiation process. 13 staff members were involved and each received Shs.100

4. Monitoring Costs
The hospital was in the process of paying allowances to the staff members involved in the monitoring of contracts. Monitoring costs
were estimated using the proposed budget estimates for committees in the hospital.
Monitoring of contracts involves the Management and Core Management Committee in addition to the Infection Control &
Waste Management Committee and Security Committee. Both the Security and Infection & Waste Management Committee members
receive a definite allowance hence all of it is allocated to the Monitoring costs. However, the Management and Core Management
Committee members spent on average an eighth of their time on monitoring of contracts which is equivalent to 12.5%

Fixing Costs.
Costs in Tables A2 and A3 are in nominal values. But in order to make the costs in the different years comparable, contract costs
were fixed using the CPI see Pg.45.
Appendix 5A: Guidelines On Negotiations And Execution Of Government Contracts

1. In these guidelines the word “contract” means an Agreement, Memorandum of Understanding, Letters of Intent, Guarantees, and any other similar or analogous document to which the Government or Government owned institution is a party.

2. These guidelines shall apply to all procurement contracts involving donor funding and to all contracts from locally funded resources whose total value exceeds fifty million shillings (shillings 50,000,000/=).

3. Ministries, parastatal organisations and other statutory bodies are responsible for the initiation, conception, preparation and implementation of policy decisions relating to the procurement of goods and services.

4. Ministers may sign communications addressed to the Attorney General regarding matters relating to contracts.

5. Permanent Secretaries or officers duly authorised by the respective Permanent Secretaries, Chairmen of Boards and Managing Directors or General Managers of Corporations or Parastatals, Chairmen of Commissions and Heads of other Public Institutions may sign communications addressed to the Solicitor General regarding advice on matters relating to contracts.

6. All Ministries, Public Institutions, bidders, suppliers or contractors must observe the highest standards of ethics during selection and execution of contracts.

7. All Ministries and Public Institutions must promote the integrity, confidentiality, fairness and equitable treatment of all bidders, suppliers or contractors.

8. Bidders who interfere with any of the procedures relating to the procurement process shall be disqualified and blacklisted.

9. Proposals for award of contracts shall be rejected if bidders engage in corrupt practices in competing for the contracts in question.

10. Evaluation of bids must be done transparently by competent personnel. This is a very important stage in the making of contracts.

11. Unless otherwise waived by the Attorney General or the Solicitor General, the Attorney General’s chambers shall be fully involved and represented at the following stages of the bidding process; preparation of terms of reference, preparation of short list of firms, determination of the selection procedure and criteria for evaluation, bid evaluations, selection and award of contract, negotiations and approval of contract.

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11 Parastatal organisations are equivalent to State Owned Enterprises.
12. Unless otherwise waived by the Attorney General or by the Solicitor General final copies of the contract to be executed shall be prepared by the Attorney General’s chambers.

13. Every contract shall not be concluded or executed without clearance from the Attorney General or from the Solicitor General.

14. Unless otherwise waived by the Attorney General or by the Solicitor General, a State Attorney from the Attorney General’s chambers shall be present at the contract signing ceremony.

15. Except where otherwise required by any law, contracts must be signed by the respective Permanent Secretaries, Board Chairmen, Chairmen of Commissions or Heads of other Public Institutions.

16. The signed copy of each contract shall be deposited with the Solicitor General.

17. Each implementing Ministry or Agency of Government shall maintain a performance evaluation of individuals and firms that execute the contract obligations. Firms and individuals found incompetent should be blacklisted.
Appendix 6A: The Contracting Cycle In The Context Of A Long- Term Planning Cycle

Purpose

Planning and Contracting Cycles

Ongoing Tasks

Planning Cycle

Needs assessment

Effectiveness Research

Priority option Appraisal

Contracting Cycle

Provider performance data

Evaluation

Selection

Negotiation


1 Poverty is recognised to be the underlying cause of the poor health situation in the country. Poverty among the population remains high with an annual GNP per capita of US$300 and approximately 46% of the people living in absolute poverty. (1995/6 Monitoring Survey, Ministry of Finance, Planning and Economic Development)