RESULTS FOR DEVELOPMENT

Insight Health Advisors

ACCESS health international

Contracting out of basic health services in São Paulo (Brazil)

Secondary Case Study[1]

Daniela Gutiérrez (Results for Development)

June 2021

[1] This case study was developed using evidence from the following sources:

Coelho VS and Greve J. 2016. As Organizações Sociais de Saúde e o Desempenho do SUS: Um Estudo sobre a Atenção Básica em São Paulo. DADOS – Revista de Ciências Sociais, 57(3), 867-901.

Greve J and Coelho VS. 2017. Evaluating the impact of contracting out basic health care services in the state of São Paulo, Brazil. Health policy and planning, 32(7), 923–933.

Context

Since 1989, Brazilians have had the right to free health care at all levels of complexity (primary, secondary, and tertiary) through the publicly funded health care system, or Sistema Único de Saúde (SUS). As a result, key health indicators have improved significantly in Brazil over the past 30 years; however the public sector continues to face issues in the coverage, quality, and efficiency of provision of primary health care (PHC) services (Greve and Coelho 2017). In the 1990s, the SUS began implementing the Family Health Strategy (FHS), a community-based program to deliver PHC services. To implement the FHS, municipalities began to contract with pre-certified nonprofit or non-governmental organizations (NGOs) to operate within the public sector for the delivery of health care services at public facilities (Coelho and Greve 2016). In Brazil, this contracting strategy was largely motivated by the hard budget constraint legislation passed in 2000—the Fiscal Responsibility Law (FRL)—which stated that municipalities could not spend more than 60% of their current net revenue on active or inactive public sector staff (Coelho and Greve 2016). Although the contracting was initially catalyzed by the FRL, it quickly became apparent that contracting out had the potential to improve the delivery of PHC services provided by the SUS to its users. The FHS sought to increase the rates of utilization of PHC services for SUS users with the ultimate goal of improving key infant and child health indicators and reducing hospitalization rates for preventable diseases.

In the state of São Paulo, contracting arrangements between the public sector (Municipal Health Secretariats or MHS) and the private sector (NGOs) as part of the FHS began in the municipality of São Paulo in 2001 and expanded to 318 out of 644 municipalities starting in 2004. Public authorities from the municipalities engaged health personnel or NGOs through indirect contracting. In indirect contracting with NGOs, NGOs supplied health personnel to provide PHC services in basic health units through *convenios,* or loose contracts or NGOs supplied health personnel or management services to operate a basic health unit through performance-related contracts where duties were specified in a mutually agreed action plan (Greve and Coelho 2017). It is important to note that in São Paulo, the municipalities vary considerably in size, organization, capacity, and economic status and therefore the contracting strategy was implemented differently in each municipality. These contracting efforts are ongoing in the state of São Paulo.

This case study explores the implementation and results of contracting out of basic health services in São Paulo, including whether and how it achieved its intended outcomes and the factors that may have helped or hindered the effectiveness of this public-private engagement (PPE). The case study centers mainly on findings from an evaluation of the impact of implementing a contracting out strategy on health and health care use in 101 out of the 645 municipalities[2] in the state, which used data from 2005-2012 (Greve and Coelho 2017).

The remainder of the case study is organized into the following sections: Methods; Results; Key Success Factors; and Discussion.

[2] In 2011, 206/645 municipalities were contracting PHC services but only 101 "treatment" municipalities had >10% of employees on external contracts.

Methods

This case study is one of six developed for the Strengthening Mixed Health Systems (SMHS) project that presents analysis from existing evaluations of public-private engagements for health and new interviews and review of the data. The secondary case data collection and analysis for all six cases uses both existing research and supplemental primary data collection to answer the questions: (1) is there evidence that this public-private engagement (PPE) is associated with improved outcomes, and (2) what factors are associated with helping and/or hindering the success of the engagement. After identifying the PPEs for these case studies, we undertook a structured search of the literature to compile existing peer-reviewed and grey literature about the PPE that would help us to answer the above questions. In addition, we attempted to interview researchers of PPE evaluations and PPE implementers/partners, when they could be identified, to collect supplementary data on the two questions. The resulting documents and transcripts were then coded and analyzed using a set of closed codes centering on four themes: PPE context and background, theory of change, process evaluation results (activities, outputs, and outcomes), and helping/hindering factors. The qualitative analysis of the process evaluation results and factors coding is presented in the Results section of the case study. For the factor coding specifically, we utilized a set of codes designed based on the PPE Factor Ecosystem that was developed as part of the SMHS project; a description of the ten factors is included in Box 1.

Box 1. PPE Factor Ecosystem

The factors presented in the Results were developed as part of a systematic evidence review conducted by the research team. This review surfaced common factors in the published literature that were cited as playing a role in either helping or hurting the success of PPEs, resulting in the development of a new ecosystem framework. The factors in the ecosystem include Environmental, Structural, and Engagement factors, specifically:

- Environmental – shaping the environment in which a PPE operates (including political, financial, legal and organizational).
- Structural – defining the architecture of a PPE (including engagement models, formality, and resources for engagement).
- Will to engage - the intention, interest, or commitment of individual PPE actor and their institutions to enter and sustain the engagement.
- Trust - the belief that the opposite sector is acting in good faith and has the goodwill and integrity to effectively participate in an engagement.
- Mutual understanding – the understanding of the opposite sector's capacities, motivations, resources, and role in the health system.
- Communication – the process and approach used by sector partners to exchange information and participate in dialogue.
- Engagement rationale – the basis of and motivation for the engagement.
- Technical and managerial capacities – the capacities of PPE actors related to the technical area of PPE focus as well as project management and joint leadership.
- Accountability – the process and approach used by sector partners to hold one another accountable for carrying out their roles and responsibilities in the PPE.
- Other – while the above types represent factors that emerged from the literature, we allowed for open coding of factors that arose in evaluations, documentation or interviews of the focus PPE that did not otherwise fit into the above categories.

For this case study on the contracting out of basic health services in São Paulo, a total of 2 articles were identified, reviewed, and coded. An interview with a key informant researcher was conducted using a structured interview protocol. A transcript of this interview was coded using the same set of closed codes centered around key themes. A limitation to note is that no interviews with implementers from the public or private sector were obtained. It is important to note the limitation that existing studies may not have sought to explicitly measure factors; as such, those identified through the coding of existing evaluations may not provide a fully representative view of the factors that influenced the effectiveness or lack thereof of the engagement.

Results

Unlike some PPEs, the contracting out of basic health care services in São Paulo was not a structured program or cohesive policy with clear objectives and guidance for public and private actors involved. The municipalities engaging with NGOs were all very different and implemented different contracting modalities. This made efforts to evaluate the outcomes from this PPE challenging, and ultimately alternative explanations for the findings cannot be ruled out.

An evaluation of the contracting out of basic health services in São Paulo by Greve and Coelho (2017) found that when controlling for municipality fixed effects, contracting out led to an increase in PHC appointments by approximately 1 appointment per SUS user per year. However, the authors acknowledged that the increase might also reflect the transition to a more accurate reporting system. The study also found that contracting out led to a reduction in hospitalizations for preventable diseases. Finally, while evidence suggests contracting out led to positive effects on health and health care supply, it had no significant impact on infant and child mortality (Greve and Coelho 2017).

A separate mixed-methods study by the same two authors (Coelho and Greve 2016) on four municipalities that engaged in indirect contracting in São Paulo (Mogi das Cruzes, Suzano, São Bernardo do Campo, and Embu) found that only one reached the Ministry of Health (MOH) guideline of 2-3 basic health care consultations per patient per year. In addition, only two of the municipalities managed to reach MOH goals of 90% of live births with 7 or more prenatal consultations and infant mortality rates of below 10 per 1,000 live births (Coelho and Greve 2016).

Anecdotal evidence also points to two additional unintended outcomes of the contracting efforts. One was that contracting improved transparency within the public sector because, once NGOs were put in charge of managing the basic health units, there was more clarity on how much each unit was spending; this had not previously been the case. A second unintended outcome was the improved flexibility of public sector actors to manage human resources for health. Basic health units faced cumbersome hiring processes for civil servants before the contracting strategy began, but contracting external personnel allowed them to fill human resource gaps more quickly and efficiently (SMHS key informant interviews 2020).

Overall, existing evidence on contracting out points to some improvement in the delivery of PHC services provided by the SUS to its users but did not point to any significant effects on child mortality.

Key Success Factors

The available evidence highlights several factors that may have helped or hindered the effective implementation of contracting out strategy in São Paulo. These included factors related to the political context; the contracting mechanisms; technical and managerial capacities of the MHS and NGOs; and accountability mechanisms.

Environmental factors. Political and organizational factors hindered and helped this PPE to achieve its intended outcomes in several ways. MHS managers indicated that the contracting of NGOs faced political resistance from civil servant unions that pressured health councils and the government. In addition, there was a lack of clarity in the organization of the basic health units. Some units had specialist providers, while FHS basic health units had both general providers and specialists. This created confusion among the managers and SUS users because, although they were all basic health units, they employed different types of health workers and followed different rules of use (Coelho and Greve 2016). Alternatively, political competition at the municipal level helped the implementation of this PPE because municipalities had elections every four years and mayoral candidates wanted to stand out from their opponents by promoting PPE to respond to the population's demand for the improvement of services (SMHS key informant interviews 2020).

Structural factors. Although contracting modalities varied among municipalities, anecdotal evidence found that two features of contracting supported the positive effects of the contracting out strategy on the increase in PHC appointments per SUS user. First, indirect contracting allowed for greater flexibility in hiring personnel, allowing managers to circumvent the limits often imposed on the public sector for hiring. This facilitated the hiring of new professionals, either when basic health units were being opened or expanded, when the professionals' performance was not satisfactory, or when there was high turnover of these professionals. Second, health care providers linked to indirect contracts had more incentive to accurately report on services they provided because their contracts stipulated achieving pre-defined goals (Coelho and Greve 2016; Greve and Coelho 2017). This was the case in the municipalities of Mogi das Cruzes and Suzano which implemented management contracts with NGOs to encourage a culture of evaluation that, according to public sector managers, should improve provider performance (Coelho and Greve 2016).

Engagement factors

The engagement between the public and private sector actors in the contracting out of basic health care services in São Paulo was unique in that the private sector was not hired in the traditional sense; instead, NGOs were contracted by the public sector to provide health or management services within the public sector.

Engagement rationale and communication. Communication mechanisms were different in each municipality and were dependent on the contracting modality. In Mogi das Cruzes, where management contracts were implemented, the NGO Cejam was responsible to regularly bring the MHS supervisors and the basic health unit managers and teams together to create a shared vision of the units and address problems together (Coelho and Greve 2016). Evidence from Embu and São Bernardo do Campo where health personnel were contracted from NGOs showed that the municipalities invested in biweekly meetings between MHS managers and the managers from the basic health units. During these meetings, they worked through existing problems and shared experiences about potential solutions to address them.

Technical and managerial capacities. Several factors related to the capacities of the public and private sector impacted the effectiveness of this PPE as well. First, many of the NGOs that the municipalities contracted with were experienced in basic management or service provision and had been working in those municipalities for years before the contracting out strategy began. This previous experience gave the public sector the confidence to want to engage with them. However, in poorer areas, NGOs often had less experience delivering services, which resulted in implementation issues (SMHS key informant interviews 2020). On the public sector side, Mogi das Cruzes and Suzano municipalities engaged in competitive bidding processes for the management contracts which ultimately created more managerial tasks of defining goals, establishing indicators, and creating meeting agendas to evaluate the progress and performance of the contracted NGOs (Coelho and Greve 2016). In smaller municipalities, MHS managers were not trained on contracting processes and thus lacked the capacity to develop, manage, evaluate, and plan for contracts. Some managers indicated even being discouraged from contracting with NGOs because it was an involved and bureaucratic process to oversee and manage the contracts internally (SMHS key informant interviews 2020).

Accountability. One aspect that helped the contracting in municipalities was the use of accountability mechanisms. At the time, Brazil's national data systems were well-developed and implemented in all municipalities so there was information available on the number of consultations and number of basic health units. For example, all basic health units in the municipalities studied used the Primary Care Information System (SIAB), which allowed the units to record and report on the services provided to the MHS and flag any discrepancies or under performance. However, there was little evidence that these systems were being used to frequently evaluate the units. Facilities in all four municipalities studied, however, invested in improving the information, planning, and evaluation mechanisms because these outputs were used to monitor contracts, plan future goals, and create incentives. In São Bernardo, these data were not published to avoid emphasizing that the relationship between the MHS and the units should be mediated by the definition of goals and evaluations (Coelho and Greve 2016).

Discussion

The evidence explored in this case study indicates mixed success for the contracting out of basic health care services in São Paulo. While contracting out may have led to an increase in PHC appointments by approximately 1 appointment per SUS user per year and reduced hospitalizations for preventable disease, there is no evidence that it had an effect on infant or child mortality. Though this PPE faced political resistance from health unions and small municipalities lacked training on contracting processes, evidence shows that the most successful experiences benefited from existing NGO technical experience, strong information and monitoring systems, and effective communication mechanisms within the basic health units.

The contracting out of basic health care services in São Paulo offers several insights about PPEs in health. Foremost are lessons related to the interdependency between these factors. Structural factors related to the design of this PPE—particularly the contracting mechanism used— had a significant impact on the capacities of the public sector to effectively manage competitive bidding processes and monitor contracts. The use of contracts also led to improved accountability because goals and outputs included in the contract incentivized providers to accurately report on service delivery and use the available monitoring mechanisms. Additionally, engagement factors between the MHS and NGO managers—particularly the shared vision about the objectives of the system—also had an impact on the frequency and quality of the communication between the actors.

Finally, this case study suggests that the effectiveness of the contracting model is highly dependent on the capacity of both the public sector to manage contracts and of the NGOs to deliver services. Small municipalities may need capacity building in managing contracts and better connections to experienced NGO service providers to effectively implement the model.

References

Coelho VS and Greve J. 2016. As Organizações Sociais de Saúde e o Desempenho do SUS: Um Estudo sobre a Atenção Básica em São Paulo. *DADOS – Revista de Ciências Sociais*, 57(3), 867-901.

Greve J and Coelho VS. 2017. Evaluating the impact of contracting out basic health care services in the state of São Paulo, Brazil. *Health policy and planning*, *32*(7), 923–933.

This case study is one of a series of six secondary cases written for the Strengthening Mixed Health Systems program, analyzing the factors helping and hindering the effectiveness of public-private engagements for health in low- and middle-income countries. All case studies, as well as a report presenting cross-cutting findings, can be found on the Strengthening Mixed Health Systems project website.

The Strengthening Mixed Health Systems project is supported by funding from Merck, through Merck for Mothers, the company's global initiative to help create a world where no woman has to die while giving life. Merck for Mothers is known as MSD for Mothers outside the United States and Canada.

RESULTS FOR DEVELOPMENT