



Draft

# Islamic Republic of Iran

## The role of contractual arrangements in improving health sector performance



**World Health  
Organization**

Regional Office for the Eastern Mediterranean

## **ABBREVIATIONS**

1. MOH/MOHME: Ministry of Health/Ministry of Health and Medical Education
2. UHSR: Unit of Health Sector Reform
3. SSO: Social Security Organization
4. MSIO: Medical Services Insurance Organization
5. ICCU: Intensive/Cardiac Care Unit
6. GDP: Gross Domestic Product
7. PBO/MPO: Plan and Budget Organization/Management and Planning Organization
8. TQM: Total Quality Management
9. TUMS: Teheran Medical Sciences University
10. MUMS: Meshed Medical Sciences University

## **INTRODUCTION**

Financing health care is a critical concern for rich and poor countries alike, as health care systems account for about 9% of global production. Developing countries face particularly serious challenges as they attempt to improve the well-being of their populations, achieve economic development objectives, and integrate themselves with the global economy. Health care financing is a particular concern for these developing countries, which account for about 84% of the world's population and around 93% of its disease burden, but only 18% of its income and 11% of its health expenditure (Schieber, 1997).

Rebuilding of financial resources is a major component of health sector reform policies. In this respect, the adoption of market-based performance approaches in health care service provision, in other words, marketization and privatization, were supposed to be a panacea. Arguments in favour of the use of market incentives in health care may be summarized as follows:

Contracting/outsourcing may increase competition among health care providers;  
Increased provider competition may increase technical efficiency on the supply side and therefore allocative efficiency within the system;  
Contractual relationships enhance efficiency on the purchaser and provider sides via the incentive structure inherent in the contract;  
The contracting process itself may promote transparency in trading and decentralization of managerial responsibility, both of which may have beneficial effects on efficiency (Palmer N, 2000).

Even where there is competition, there is no evidence that the private sector invariably provides greater efficiency or quality (Witter et al, 2000). For example, in the United States of America, competitive markets have been shown to have higher costs, more duplication of services, longer length of stay, and higher staff ratios than non-competitive markets. In the national health service, implementation of purchaser-provider split and quasi-market policies in the public sector have not yet been successfully evaluated. However, there are no generalized findings from studies conducted in health sector and health financing reform, therefore, the applicability of these assumptions to health care services, especially in developing countries, must be questioned. Indeed, attempts to translate such points of view into practice have highlighted several questionable assumptions, particularly that:

Enough potential providers exist to enable the creation of provider competition;  
Provider competition, without any change on the purchasing side, can enhance efficiency;  
The benefits of introducing market incentives outweigh the costs of their implementation and maintenance;  
Government has adequate capacity to enter into and manage contractual relationships with the private sector (Palmer, N. 2000).

Effective utilization of resources seems to be central in health sector reform. Internal market competition introduced in the United Kingdom and New Zealand, and managed care competition implemented in the United States of America, are known as two major strategies

in this respect. However, none of them have been fully adopted for the purpose of reform in health care markets of the Islamic Republic of Iran.

The objectives of the study were to identify:

types of care for contracting,  
the way of choosing contract counterparts,  
methods of payment for their services, and dealing with problems arising during the period of contract,  
evaluation of contract counterparts' performance,  
conditions in which nullification or renewing of contracts are met,  
financial risk-bearing by contract counterparts,  
effects and outcomes of contracts in terms of cost containment, increasing access and improving quality,  
characteristics of the group who is responsible for management, implementation and evaluation of contracting out in each medical sciences university.

## **2. APPROACH AND METHODOLOGY**

For the purpose of data collection from medical sciences universities, a questionnaire was developed including both closed and open-ended questions. The questionnaire was based on lists of questions provided by WHO with regard to the study. The type of services contracted, conditions for renewing or nullifying contracts, ways of conflict management between contract parties, selecting/choosing counterparts, and strength and weakness' of contractual arrangements in practice, as well as wider social and organizational environment, were determined as the questions of the study (Annex 1).

An attempt has been made to send the questionnaires to the universities of medical sciences through Health Sector Reform Unit of the Ministry of Health and Medical Education, but it failed. Parallel to this attempt, a request submitted to "Health Economics and Program Budget" office of the Ministry of Health and Medical Education, to facilitate and help data collection process. It was also unsuccessful.

Personal relations and direct contacts with officials of universities were the last option to data collection. The questionnaire was mailed to Tabriz, Teheran, Meshed, Lorestan, and Uromieh, medical sciences universities to be filled and returned. Contact information was also provided for question and requests for clarification by the respondents.

To expand on information provided by the universities, semi-structured interviews were conducted with officials in Ministry of Health and Medical Education and universities, both individually and in small groups. The questionnaire was considered as a framework for interviews. Collected data were analysed qualitatively and quantitatively.

## **OVERVIEW OF THE IRANIAN HEALTH SYSTEM**

The health system in the Islamic Republic of Iran is structured into three levels. Specialty and super-specialty curative services are located and delivered at the upper level, mainly in mega cities and urban areas. The bottom two levels belong to primary health care services, and their activities cover rural, deprived, and remote areas' populations as well as the urban poor.

The health system is highly centralized, and almost all decisions regarding general goals, policies and allocation of resources are made at the central level by the Ministry of Health and Medical Education. The Ministry has the legal authority to oversee, license and regulate the activities of the private health sector (Mehriar et al, 2004).

Primary health care services are basically delivered by the public sector and are almost free of charge, particularly for the poor. Upper-level services (specialty and super-specialty curative services), are the area in which private sector plays a distinctive role. There are about 123 well-equipped, urban-centred, private delivering specialty and super-specialty service hospitals in the Islamic Republic of Iran.

Emergency, curative, diagnostic and pharmaceutical services are delivered by private hospital. Although there is a tariff schedule for health care services determined by High Council of Medical Services Insurance (headed by the Minister of Health and Medical Education), the private sector does not apply it consistently. Among these hospitals, almost all practise fee-for-service payment and charge their patients according to their own fee schedules. Regulation and monitoring of private sector performance are not as effective as expected. The well-known physicians and specialists of the public sector work in the private sector as well. Nursing and technical staff of private hospitals also come mainly from the public sector. There is not a clear division between public and private sectors with regard to health care service delivery in the Islamic Republic of Iran, creating confusion in the area of public-private partnership. The overlapping of human resource functions can affect quality of care, effectiveness of regulations and management of services on the whole. The issue of public sector resources exploitation by the private sector remains to be studied.

The private sector, due partly to its inherent for-profit orientation and partly to poor organizational behaviour of public sector, does not participate actively in providing and delivering primary health care services. Private hospitals also do not show keenness to contract with the Ministry of Health and Medical Education, because of low tariffs, extra paperwork and delays in payment.

Structurally, and apart from the private sector, there are other organizations and institutions which play a leading role in health care management of Islamic Republic of Iran, in terms of policy-making, tariff-setting, and service provision and delivery. The Social Security Organization (SSO) and Armed Forces Health Services Insurance are examples. Moreover, charity organizations, which focus mainly on outpatient services, Imam Khomeini Relief Committee, which serves mainly the poor, and several units of health care delivery

affiliated with banks, municipalities, and other organizations further complicate the system, and perhaps make it less efficient.

Table 1 shows the number and types of hospitals in terms of the sectors to which they belong.

**Table 1. Number and types of hospitals**

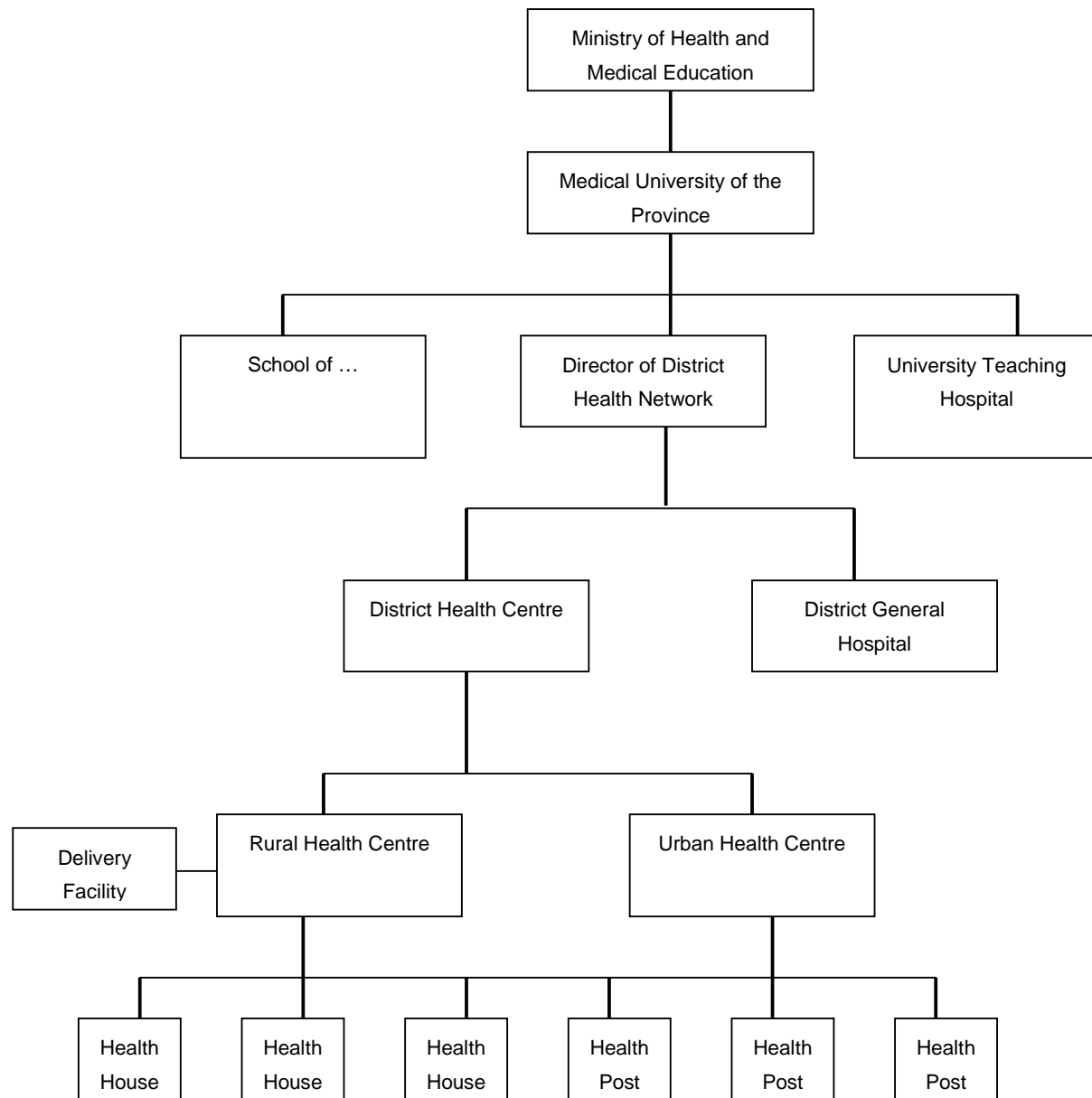
Type of Hospital	No
University	484
Private	123
Charity	238
Social Security Organization	50
Others	33
Total	928

Source: Ministry of Health and Medical Education, 2001

It is worth noting that most private hospitals are well-equipped with modern technology and are located in major cities, particularly in Teheran.

Whereas conflict of interests, inefficiency, inequity, poor management and public dissatisfaction characterize the costly, urban-oriented curative services (public and private sector), primary health care services run satisfactorily.

The main reasons for the notable success of the primary health care system of Islamic Republic of Iran are believed to be the firm commitment of the government to health and the relatively proactive public health approach adopted since the development of the primary health care network. Allocating a relatively modest share of government budget (around 7%) and GDP (around 1.7%) to public health, and using low cost, culturally appropriate and acceptable public health strategies, the Islamic Republic of Iran has succeeded in reaching almost universal levels of immunization, breastfeeding and use of iodized salt, in providing safe drinking-water to almost all communities and extending relatively inexpensive (if not entirely free) but efficient public health services to the remotest corners of the country. In addition to training low-cost community-based primary health workers, the country has also managed to expand opportunities for classical medical education opportunities at both general practice and specialized levels and has developed its pharmaceutical industry to a level that can meet the basic needs of the country (Mehriar et al, 2004). Figure 1 shows the structure of Islamic Republic Iran's health care system (public sector) in which the lowest levels of the system (health houses, and rural/urban health centres) mainly deliver primary health care preventive services under supervision of the public sector. The private sector has not been involved or participated in delivery of services in these areas. Only during recent years, after the waves of privatization which were legalized through the third major socio-economic development plan, have universities of medical sciences begun to contract primary health care services or part of them to the private sector (see Annex 2). At district level, however, the private sector does participate actively, even dominantly, in hospital-based service delivery.



Source: Abolhasani, 2001

**Figure 1. Organogram of the public health care system of the Islamic Republic of Iran**

## **CURRENT STATUS OF CONTRACTING OUT HEALTH CARE SERVICES**

### **Legal status of contracting out**

Contracting out in the Iranian health care system commenced with the introduction of the Third Socio-economic Development Plan in 1999. The Plan authorized the Ministry of Health and Medical Education to adopt policies by which public-private partnership was to be achieved. Article 192, included in the law of the Plan focused on privatization in general, and outsourcing in particular, in health care delivery. Another similar regulation (Circular 88) was later promulgated by the Planning and Budget Organization (PBO now MPO) to facilitate purchasing services from private sector. While Article 192 emphasized mainly privatization and contracting out clinical services, no clear distinction was made between clinical and non-clinical services, in terms of contracting out, in Circular 88. Consequently, medical sciences universities, as contracting agents, were faced with at least two guidelines with remarkable differences. The universities utilize the guideline they prefer, creating a complex environment in terms of performance evaluation, homogeneous information generation and policy continuity.

An attempt has been made to pilot Article 192, in the catchment areas of 7 selected universities of medical sciences in different provinces of the country (UHSR, 2003). In practice, unified performance has not been observed in this respect. Some of universities rushed to contract out almost all clinical and non-clinical services, while others did so within a very limited framework, and the rest remained indifferent.

According to a report in 2004, 46 units of health care delivery were transferred to the private sector through contracting. Contracting for purchasing 45 items of clinical services, together with 10 items of non-clinical services, was also reported. Tabriz Medical Sciences University is the pioneer among the universities in terms of contracting out clinical services and privatization. Shiraz and Gilan universities in contracting out health services.

Apart from well-known medical sciences universities in major cities, the remaining universities have mainly chosen to purchase non-clinical services from the private market; this approach seems to be similar with other countries' experiences in privatization (Witter's et al. 2000).

### **Experience of the Ministry of Health and Medical Education**

#### *Performance-based service contracting*

The Ministry of Health and Medical Education has decided to provide health care services for a large segment of the population (mainly rural and deprived) through contracting out, establishing a referral system, and employing family physicians. This is a new approach in Islamic Republic of Iran's health care delivery policy which the Ministry has adopted in response to a parliamentary requirement for health insurance coverage of the rural population.

Among different types of contracting, the Ministry of Health and Medical Education relies on performance-based service contracting (PBSC), defined as follows.

PBSC involves strategies, methods and techniques that describe and communicate measurable outcomes rather than direct performance processes. It is structured around defining a service requirement in terms of performance objectives and providing contractors the latitude to determine how to meet these objectives. In other words, it is simply a method of acquiring what is required and placing the responsibility for how to accomplish it on the contracts. In this respect the government has developed measurable standards of performance together with negative incentives for non-performance, and fee for performance, as major characteristics, or key concepts of PBSC. It seems that within the PBSC poorly managed contracts could be big money losers.

#### *Stages of implementation*

An administrative and technical committee has been organized in the Ministry of Health and Medical Education for the purpose of designing the service packages, performance monitoring system, and contracting and process standards. A database was designed for devolved units and for financial processes and a training package was provided and training workshops conducted in this respect. A situation analysis was also conducted in order to operationalize Article 192.

#### *Types of services contracted out/devolved*

The following categories of services have been devolved:

Outpatient services (general practitioner, specialist and dentist)  
Pharmacy  
Rehabilitation services  
Laboratory services  
Diagnostic radiology services  
Hospitals' wards  
Primary health care services

Table 2 shows the trend of devolved units of health care services in 3 successive years.

**Table 2. Number of devolved units, 2002–2004**

	2002	2003	2004
Urban health centre	83	120	11
Health post	19	86	172
Rural health centre	8	14	24
Radiology	10	23	15
Laboratory	6	14	101
Pharmacy and paramedical clinic	4	11	14
Hospital wards	5	57	271
Emergency wards	6	36	51
Total number	140	360	568

Three steps were taken by the Ministry of Health and Higher Education with regard to designation of performance-based contracting for family physicians' activities as follows:

Job analysis, which determines needs, services and outputs expected.

Performance work statement (PWS), which meets defined and precise contractual agreements with family physicians in relation to measurable performance standards for their activities (output).

Performance assessment plan (PAP), which enables the Ministry of Health and Higher Education to evaluate and assess the performance of the contracts.

The size of population covered by a family physician, patients' satisfaction, quality of data records are used as part of quantitative and qualitative measures for performance evaluation. Input criteria, such as human resources, equipment and building, also have been employed in this respect. These three categories of criteria, together with a coefficient which meets differences and diversities of service delivery settings, provides a total score for performance of a FP in a specific period of time and helps to the Ministry of Health and Higher Education to manage payment for contracted family physicians. The relationship between performance total score and percentage of payment is as follows:

<b>Performance score</b>	<b>% of payment</b>
90–100	100
	90
	80
	70

The contract is nullified if the total performance scores of a family physician remain below 60% after three evaluations.

### **General environment and public–private sectors**

As is expected from a centralized, mixed and undeveloped socioeconomic structure, the private sector in the Islamic Republic of Iran, particularly in health care markets, is not yet fully developed. As a for-profit sector, it is mainly involved in the hospital industry, located in major cities, and has been reluctant to invest in preventive care and in remote or deprived areas. The performance of the private sector is not effectively regulated. This sector rarely uses the Ministry of Health and Higher Education's tariff schedule, or evaluates services delivered, and accreditation of institutions/hospitals in this sector, seem to be less effective in improving public–private relationship. At the tertiary level of health care delivery in the Iranian system, the private sector is highly active and seems to exploit the public sector's resources, particularly human resources.

In contrast, the public sector suffers from inadequate managerial skills and capacity, inappropriate executive and legal context and insufficient knowledge and experience with respect to the health care industry. These deficiencies are possible reasons for the significant change in approach reflected in Article 192. For example, while in the early days of

implementation it was officially documented that the health houses and package of services delivered there must be privatized (in any way), this policy was proposed to be nullified beginning in March 2004. Lack of stability in policy leaves room for individual preferences of authorities of medical sciences universities, which in turn may increase complexity of the system and reduce its efficiency.

A very comprehensive guideline, including the philosophy of privatization and decentralization, decentralization in health care systems, standards for contracting and methods of payment, examples of bidding and contracting forms, packages of services and monitoring and evaluation of services, has been developed by the Unit for Health Sector Reform in the Ministry of Health and Higher Education. However, there is still room for more clarification and elaboration of Article 192, possibly for the unification of approaches used by medical sciences universities to privatization and contractual arrangements. An executive guideline is being developed in the Ministry in order to move ahead in efforts to achieve the goals of the Third Socioeconomic Development Plan. However, contracting for health care in the Islamic Republic of Iran is in its nascency and may require time and other resources to be successfully implemented and managed.

In terms of types of contracts, and methods of payment, it can be said that block contracts and cost-volume contracts are dominant. Per capita, global and even capped fee-for-service methods of payment are practised for services purchased from the private sector (Appendix 2).

Contracting out or purchasing services from the private sector is a new approach to dealing with health care market problems in developing countries in general, and in the Islamic Republic of Iran in particular. Attempts to adopt policies regarding reform in health care services in the Islamic Republic of Iran date back only three years, and contracting out in health care markets suffers from lack of organizational and managerial capacities in both the public and private sectors. Because of this environment, there is no uniformity among the medical sciences universities (as agents of the Ministry of Health and Higher Education) with regard to purchasing services from the private sector.

At the present, preventive care, paramedical services and dentistry are the most common services, contracted respectively. The universities contract out for packages of (mainly) preventive services, and are generally satisfied with this strategy. Improvements in access to services, increased efficiency, promotion of quality of services and responsiveness are given as outcomes of this strategy (Appendix 2).

## **DISCUSSION**

In management of contracts for purchasing any/clinical services from the private sector, transaction costs, methods of payment, competition and risk-sharing, opportunistic behaviour on purchaser and provider sides, and contract goals and nature are discussed in relevant literature. The efficiency and types of contract, conditions for setting successful contracts, links with total quality management, renewal positions (if any), penalties for

nonperformance, process for resolving disagreements, and advantages and disadvantages of contracts are also important concepts in this respect (Witter S. et al. 2000; Flood M.C, 2000).

In health sector reform policies, the impact of contracting is thought to be dependent on how it is implemented. Done well, it can improve technical efficiency (by promoting cost control), allocative efficiency (by redirecting resources), and clinical and service quality (if the contract includes measurable performance goals). As well, contracting to improve access by requiring a volume of free care on thereby improve the equity of system performance (Robert JM et al, 2004).

Contract implementation and management, however, particularly in a complex health care environment in a developing country such as Islamic Republic of Iran, require managerial capacity and skills, adequate human and financial resources, intersectoral and intrasectoral coordination and collaboration, and broad cultural, legal and political agreements.

The Iranian health care system faces a number of institutional, financial and administrative gaps: gaps between the public and private sectors, levels of health care delivery (disrupted referral system), payments and remuneration, physician and staff earnings in hospitals (between different groups of physicians and between physicians and non-physician staff), and rules and laws as practice guidelines in provision and delivery of health care services.

Neither health care managers nor their counterparts in the private sector have been trained and acquired necessary skills for quality contracting Meshed Medical Services University. The private sector is not yet very well organized and on occasion demonstrates opportunistic behaviour. For example, according to some of interviewees, the private sector still interested in having a middle man's role instead of actively participating in production and productive processes Teheran Medical Services University.

Lower payment, together with oversecurity of employees' positions in public sector (and lack of economic thinking among managers in different organizational level (Momensaraie and Pourreza, 2002), are indicated as the main reasons for inefficiency in public sector performance.

It is a fact that the nations least equipped to make their public sector function effectively are often those least able to discipline private markets to achieve public ends (Robert, M. et. al). However, even in an environment with these better characteristics, on some occasions contracting out produces more results. For example, out sourcing of a laboratory in one of Teheran's hospitals led to more tests and greater income (TUMS).

## **CONCLUSION AND RECOMMENDATIONS**

### **Conclusions**

Contracting out of health care services in the Islamic Republic of Iran was initiated under the Third Socioeconomic Development Plan introduced in 1999. In fact it can be considered a privatization policy emphasized in the plan and its legislation (Article 192).

From an administrative point of view, contracting parties, both medical sciences universities and the private sector, suffer from relevant background, experienced staff, and organized uniform approach in terms of services to be contracted, methods of payment, and rules and laws practised.

Providers' playing both sides of the street contaminate public-private partnership, and lack of reliable information, or regular evaluation of private sector/providers hinder decision-making regarding contract renewal and continuity of the policy.

A volatile bureaucratic decision-making environment has led to an individualistic approach in purchasing services from private sector by the universities (lack of uniformity and homogeneity). Some universities rely on the Article 192 and others on Circular 88. While Article 192 emphasizes marketization of clinical services Circular 88 permits all clinical and non-clinical services to be contracted out. This may be a reason for the different approaches to purchasing services from the private sector.

Services contracted by the universities mainly cover primary health care, outpatient and non-clinical services. Limited and mostly inexpensive types of service are contracted out. Information resulting from evaluations of the performance of private providers, has not yet been organized. Such information remains unavailable, though it has been emphasized in Circular 88 that every medical sciences university should submit a copy of contracting parties' performance to the Management and Planning Organization.

Privatization and contracting out in Islamic Republic of Iran has mainly focused on primary health care services and expensive specialty urban-oriented curative services have remained almost untouched. Since primary health care services in Iran are delivered almost free in rural and poor urban areas, this approach, if accompanied by user fees, may in the long term widen gaps in equity between rural and urban areas, and limit access to health care services.

It seems that unemployment of numbers of young physicians and paramedical graduates has played a significant role in developing contractual arrangements in health care services delivery in the Islamic Republic of Iran. It means that adoption of privatization, and in some extent contracting out policy, is determined by force rather than choice. Other reasons should also be taken into account in this respect. However, implementing a policy which designed and developed in industrialized countries decades ago in a developing country with poor organizational structures and management will hardly work effectively, at least in a short period of time. In relevant literature, individualism, rationalism, utilitarianism

and legalism have been indicated as the bedrocks of socioeconomic development of industrialized countries. “Organizational cultural lag” as a dominant characteristic of developing countries, including Iran, may hinder these essential components of development.

### **Actions to be undertaken**

As a first step, the long-term process of reform, particularly in the health sector, should be appreciated and acknowledged by policy-makers. However, the reform itself seems to be the product of the experience of industrialized countries’, and its applicability in the context of a developing country such as Islamic Republic of Iran with traditional, religious, fragmented and complex structures, is yet to be determined.

#### *At strategic level*

Justification among top decision-makers about the necessity, importance and usefulness of contracting out;

Achieving commitment high-ranked managers and politicians;

Providing appropriate, updated and evidence-based legal environment, as well as financial resources, for its successful implementation.

#### *At operational level*

Identification of capable individuals/institutions in private sector as counterpart for contracting;

Identification of services purchasable from the private sector;

Standardization of delivery of purchasable services;

Publicizing necessity for reform in health care/social marketing;

Designing and implementing a management information system for recording and evaluating private sector performance;

Capacity-building in/empowerment of both the public and private sector, requiring training the right personnel for the purpose of managing contractual arrangements in health services;

Capacity-building for teamwork and utilizing other specialties, capacities and capabilities instead of monopolizing reform plans and activities by only one group of professionals (physicians or the others).

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## **Annex 1**

### **QUESTIONNAIRE**

1. Do you have any contract(s) for health care purchasing from private sector? If yes, would you please specify the services in this respect?
2. How do you choose your private sector partner for contracting out? Based on previous familiarity, colleagues' advice, bidding, good reputation or else?
3. How do you pay for services purchased from private sector? Fee for service, global, per unit, or else?
4. Have you ever experienced problems/difficulties (legally or administratively) in conducting contracts with private sector (such as delay on payments and so on)? If yes how did you solve the problem(s)? Through referring them to the court, arbitrary, or other ways?
5. Do you use any evaluation process for services purchased from and delivered by private sector? How? What is your instrument and who does (do) conduct the process?
6. How renewing of contracts takes place? On what conditions/circumstances?
7. How and when a contract is nullified?
8. Which part of the contract (university or private sector) gains more profit/benefit from contracting processes?
9. What was/were the consequences of out-sourcing and purchasing services from private sector? Decrease in unit cost, increase in accessibility, increase in quality of services, increase equity, or else?
10. Is there any specific team/group or unit in your university responsible for contracting out and purchasing services from private sector? If yes, please explain more about its structure in terms of its personnel work and educational experience.
11. On the whole what is your prediction about the future of this process (out sourcing and contracting out of health care services)?

Islamic Republic of Iran

**Annex 2**

**UNIVERSITIES CONTRACTING PRIMARY HEALTH CARE SERVICES TO THE PRIVATE SECTOR**

<b>Medical Sciences University</b>	<b>Contracts with private sector</b>	<b>Name of services</b>	<b>Way of choosing private contractor(s)</b>	<b>Methods of payment</b>	<b>Difficulties during contract period</b>	<b>Method of problem solving</b>	<b>Evaluation of services purchased</b>	<b>Tools and responsibility for evaluation</b>
Teheran	Yes	ICU, pharmacy, dentistry, laboratory, radiology, and health posts services	Bidding	Fee-for-service + global	Yes	Negotiation, dialog and persuasion	Yes	Through a questionnaire/ checklist + field visit and process evaluation
Orumieh	Yes	PHC services	Bidding	Global	Yes	Negotiation, dialog and persuasion	Yes	Checklist/team
Meshed	Yes	Laboratory and pharmacy services. PHC services Open heart services	Bidding	Per-capita	Yes	Negotiation, dialog and persuasion	Yes	Checklist/team
Tabriz	Yes	Screening/preventive care	Bidding	Capitation	No	–	Yes	Checklist/team
Lorestan	Yes	-Nursing, theatre, laboratory and radiology services	Familiarity Colleagues' advice	Global	yes	Negotiation, dialog and persuasion	Yes	Checklist/weekly reports

Because of limited number of private contractors in the province (semi-monopolistic situation), bidding is not applicable .