

Sample agreement framework

Regardless of its textual content, an agreement is essentially a contract that can be formulated according to the following framework:

Section 1: Parties to the agreement

Section 2: Purpose of the agreement and objective of the health facility network, if such a network is contemplated

Section 3: Entry into effect, duration and renewal

Section 4: Amendments

Section 5: Termination

Section 6: Disputes and methods of arbitration

Section 7: Obligations of the two parties

Sample agreement

The following sample provides a very precise description of the obligations of the two parties, in the particular context of the formation of a network of health care providers. Agreements, such as the one presented here, are concluded with each health facility belonging to the network. Provisions concerning the provider network (Article 1) and progress groups may be omitted if the health micro-insurance scheme does not contemplate forming such a network.

The idea of forming a network of the health care providers with which agreements have been concluded is, however, an interesting one: it motivates providers to become informed and to seek training, and it provides their establishment with a guarantee of quality. It serves to increase the effectiveness of health care and to contain costs as a result of better coordination and better circulation of information among the providers in the network, particularly as concerns patient medical records.

The relatively explicit nature of the wording may appear to be cumbersome, but it is necessary if one wishes to produce an agreement that may be considered a proper legal instrument.

SAMPLE AGREEMENT

between **"The Provident Society" insurance company**
and the health facility _____ (name of health facility)

Agreement No. _____

Preamble

The text of this agreement was approved on 2 October 2004 by the General Assembly of **"The Provident Society" insurance company**.

This agreement is concluded between the **"The Provident Society" insurance company**, hereinafter referred to as the "insurance company", or the party of the first part, whose registered office is located at _____, and _____, hereinafter referred to as the "health facility", or the party of the second part, whose registered office is located at _____.

Article 1 – The purpose of the agreement

This agreement defines the mutual obligations of the **insurance company** and the **health facility** with respect to the network of approved health facilities established by the **insurance company**.

The objective of this network is to:

- facilitate access to health care for members of the **insurance company** and their families by setting up a third-party payment mechanism for certain services in network health facilities, and by improving the circulation of information within the network concerning the type of treatment suited to each pathology;
- improve the quality of health care through the application of quality standards stipulated under the agreements and through the good practices defined by the progress groups (see definition below);
- improve the level of health education of the members of the **insurance company** and their families through prevention and health information programmes;
- improve the cost recovery of the network health facilities through the provision of coverage by the **insurance company** for medical expenses associated with the consumption of certain health services;
- facilitate the further training of health professionals in the network, and increase their knowledge base as a result of the establishment and development of progress groups;
- increase the effectiveness of health care, and limit costs as a result of better coordination and better circulation of information among the network health facilities, particularly concerning patient medical records.

Article 2 – Entry into effect, duration and renewal

This agreement shall remain in effect from 1 January 2005 to 31 December 2005. It shall then be revised and renewed on an annual basis. Such revisions may, in particular, concern quality standards, the degree of compliance with each standard, the degree of compliance with treatment protocols, and the level of participation in progress groups and in health information and prevention sessions (see definitions below). They may also concern the dates and frequency of evaluations.

Article 3 – Amendments

Each year, by 31 November at the latest, either party may propose to the other, in writing, that amendments be made to the agreement.

To the extent that such amendments concern the objectives of the **health facility** (quality standards, treatment protocols, participation in progress groups, facilitation of health information and prevention sessions) or the methods of payment, the consent of the two parties shall suffice. The new agreement shall enter into effect for the **health facility** as of the following 1st of January.

To the extent that the amendments concern provisions of the agreement affecting other health facilities in the network (such as fees that are identical in all approved health facilities), they must be approved by all network health facility managers and the **insurance company's** board of directors. If approved, these amendments shall be incorporated into the text of a new agreement, which must be ratified by the general assembly of the **insurance company**. The new agreement shall enter into effect for all health facilities in the network as of the following 1st of January.

Article 4 – Termination

Each party has the right to terminate the agreement in writing. The letter of termination must be received by the other party prior to 31 October of the current year. The termination enters into effect as of the following 1st of January.

Article 5 – Disputes

In the event of a dispute, the parties shall submit to the arbitration of a third party, or in the event of the failure of such arbitration, to the judgment of the Court _____
(name of court).

Article 6 – Obligations of the two parties

1. Obligations of the health facility

The **health facility** agrees to:

- observe verification procedures (see Article 7);
- observe procedures concerning requests for prior agreement (idem);
- depending on the case, issue a treatment certificate or individual invoice (idem);
- observe quality standards (idem);
- observe treatment protocols (idem);
- participate in progress groups and apply good practices defined by these groups (idem);
- organize and carry out prevention and health information efforts aimed at scheme members and their families (idem);
- authorize the **insurance company** to undertake periodic evaluations of the extent to which these obligations have been observed (idem).

2. Obligations of the insurance company

The **insurance company** agrees to:

- observe the procedures for paying the **health facility** (see Article 7);
- utilize the contractual fees for calculating the amounts of payments (idem);
- transmit documents enabling the **health facility** to follow verification procedures in the case of third-party payment (printout of members and dependents who are up-to-date with their premium payments and who have completed their waiting period);
- transmit blank forms for prior agreement requests, treatment certificates, and individual and consolidated invoices;
- promote the **health facility** among members and their families (idem);
- organize progress groups in which **health facility** staff members will participate (idem);
- organize prevention and health information efforts aimed at scheme members, and compensate **health facility** staff members who prepare and facilitate such sessions (idem).

Article 7 – Details of obligations

1. Verification procedures

If the health services utilized by a patient are provided through a third-party payment mechanism, the **health facility** staff must previously have verified that the patient is entitled to coverage: patient's name appears on the membership card, entitlement to third-party payment services, entitlement to coverage (patient's name appears on the printout of covered persons that is updated each month and transmitted by the **insurance company**). When in doubt, the health facility staff must contact the **insurance company**. In non-urgent cases, it may request that the patient submit a letter of guarantee signed by the **insurance company**.

In the case of a third-party payment mechanism, the health facility staff must, after having dispensed services, require that the patient sign a treatment certificate (form provided by the **insurance company**) and give the patient a duplicate of the certificate, which the patient must, in turn, submit to the **insurance company**. This certificate is proof that the health services were effectively dispensed.

In the absence of a third-party payment mechanism, the staff of the health facility must produce a detailed invoice of the services dispensed (invoice forms supplied by the **insurance company**) and give it to the patient, so that the patient can, in turn, obtain reimbursement from the **insurance company**.

2. Procedures for request of prior agreement

In certain cases, the services included under planned surgical operations may be covered by the **insurance company**. The staff of the **health facility** must – before such services are dispensed – fill out a form requesting prior agreement (form supplied by the **insurance company**) and give it to the patient, who then brings it back signed by the **insurance company**, provided the latter has approved the request.

3. Quality standards

As of 1 January 2006, the average waiting time before delivery of the first medical treatment or service to members or dependents of the **insurance company** shall be reduced from 3.5 hours (current level) to 2 hours.

As of 1 January 2006, the percentage of days without stock shortages of 5 essential drugs (list drugs: _____) shall be increased from 65 per cent (current percentage) to 90 per cent.

As of 1 January 2006, the following procedures shall be applied systematically in order to ensure the confidentiality of medical records:

- non-medical staff is not authorized to ask questions of a medical nature;
- all questions of a medical nature shall be asked in private, i.e. behind closed doors, out of the sight and hearing of others, in the absence of persons who are not part of the medical staff (other patients, visitors, administrative staff of the **health facility** and others);
- Female patients may – if they so desire – be examined/treated by female medical staff;
- if the patient is accompanied by a relative or a friend, the medical staff shall request the patient's consent prior to authorizing the accompanying person or persons to enter the consultation or examination room;
- the medical staff shall keep a medical record for each patient and file these records in a locked location. The patient's file shall be taken out at the time of consultation or treatment and returned when these are finished.

4. *Treatment protocols*

As of 1 January 2006, the percentage of prescriptions for generic drugs issued to the members of the **insurance company** or their dependents shall increase from 35 per cent of the total number of prescriptions (current level) to 70 per cent. This increase will be facilitated by the organization of information sessions on generic drugs for the members of the **insurance company** and their families.

5. *Progress groups*

These groups shall be composed of health care workers from several health facilities and, in some cases, external partners (directors of foreign clinics, public health physicians, administrators of health care networks). They shall meet each month to: reflect upon topics concerning specific issues related to medical practice, envisage common measures to combat certain illnesses or better treat sick persons, lead prevention and health information sessions and prepare information materials directed to members of the **insurance company** and their dependents.

As of 1 March 2005, the **insurance company** shall have set up four progress groups in various locations throughout the province. As of 1 January 2006, 50 per cent of the doctors and nurses of the **health facility** shall be members of a progress group and shall have participated in at least six of the nine meetings held by the group during the first year.

6. *Prevention and health information actions*

These are prevention and health information sessions on specific topics: prevention of sexually transmitted diseases and HIV/AIDS, prevention of occupational accidents, prevention of the damaging effects of tobacco, basic measures to be taken in the event of a malaria crisis, generic drugs, etc.

As of 1 January 2006, the **insurance company** shall have organized three prevention or health information sessions at the **health facility** on the topics that were given the highest scores by the health facility's users. Such sessions shall be organized in collaboration with a partner prevention programme. The staff members of the health facility are invited to participate actively in promoting these sessions among their patients (whether the latter are members of the **insurance company** or not) and, if the staff members so desire, in preparing the content of these sessions and leading them.

7. *Periodic evaluations*

An initial evaluation shall be undertaken in May 2005. It shall enable evaluators to determine whether the verification procedures and requests for prior agreement have been properly applied and whether the levels of the quality indicators are increasing.

A second evaluation shall be undertaken in early January 2006. It shall enable evaluators to determine whether quality objectives have been reached: average length of waiting time, availability of medicines, confidentiality of medical records, treatment protocols, participation in progress groups, and participation in the promotion, organization and facilitation of prevention and health information sessions.

8. *Procedures for payment of health facility*

On the first day of each month, the **health facility** shall send the **insurance company** a consolidated invoice (model invoice supplied by the **insurance company**). The **insurance company** shall perform the necessary checks and pay the **health facility** on the basis of this invoice prior to the first day of the following month. Payment is made by bank

transfer to the **health facility's** account. The price of the health services is determined on the basis of the contractual fees (see below). The contractual fees are higher than the official fees because they take into account the increase in the level of quality of the health services and the increased availability of the **health facility** staff.

9. Contractual fees

		Contractual fee	Official fee (indicative)
Health centre	Consultations	600	500
	Pharmacy	$1.2 \times \text{Official fee}$	Official fee
	Uncomplicated deliveries	1200	1000
	X-rays	840	700
	Laboratory tests	$1.2 \times \text{Official fee}$	Official fee
Hospital	Consultations	840	700
	Pharmacy	$1.2 \times \text{Official fee}$	Official fee
	Medical hospitalization	$1.2 \times \text{Official fee}$	Official fee
	Uncomplicated deliveries	1800	1500
	Dystocic deliveries	3600	3000
	X-rays	1080	900
	Laboratory tests	$1.2 \times \text{Official fee}$	Official fee
	Planned surgical operations *	Official fee	Official fee
	Unplanned surgical operations	$1.2 \times \text{Official fee}$	Official fee
* Subject to the prior agreement of the insurance company			

10. Promotion of the health facility

The **insurance company** agrees to provide a list of the network health facilities to the members and their dependents. This list is part of the welcome package for new members, which is given to each new enrollee. The list is also posted at the premises of the **insurance company** and at each local branch.