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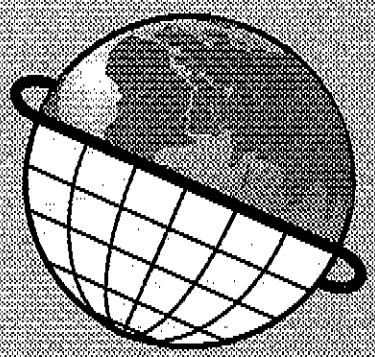

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The contractual approach: new partnerships for health in developing countries

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The contractual approach: new partnerships for health in developing countries

by

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World Health Organization

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Preface

Many countries, partly because of financial difficulties but also because the efficacy of the Welfare State has been called into question, are moving towards greater privatization of the health sector. In many cases this movement is not accompanied by any redefinition of the role of the State, which results in a *laissez-faire* attitude that is prejudicial to the most vulnerable population groups.

At the same time, however, we are now witnessing a rather unexpected trend towards a strengthening of the powers of the public authorities in health matters. The tremendous expansion of new technologies, the wide range of new ventures and the increasing number of decision-making centres have produced opportunities for progress but at the same time a number of threats, which have revealed the irreplaceable role of both central and local governments in protecting the public.

This public health protection covers a large number of functions, ranging from quality assurance of services to the health security of all sectors of the population, particularly the most vulnerable groups, not to mention the supply of public goods such as clean air, safe water or information.

Protection of the public by the authorities is being strengthened by a wide range of instruments, and one of the more important of these for strategic purposes is contracting. How can existing institutions be persuaded to provide services which they would not otherwise provide spontaneously, such as preventive services? How is it possible to ensure the coverage of populations when the supply of services to those populations would not yield even minimal profits for the providers? How can we improve the efficiency of public services through the delegation of responsibilities so as to make the taxpayer aware of the social use to which public resources are put?

There are countless examples. Nevertheless, the contractual arrangements between the public authorities in the least developed countries and the potential contractors do not yet seem to be properly organized. It is particularly important to ensure that contractual arrangements are used for strategic purposes: this approach can help ensure the reallocation of public resources and their utilization for public health objectives and the population groups in greatest need.

This document describes the tool that contracting represents, and the conditions for its proper use. The strategic potential of this tool is outlined. At a later stage the logical continuation of this initial attempt at analysis and education would be illustrate the application of this tool in the specific context of countries with limited capacity and enormous health needs.

Dr Michel Jancloes
Director, Division of Intensified Cooperation
with Countries in Greatest Need

1. INTRODUCTION

During the past 30 years the health systems of the countries in greatest need have undergone far-reaching changes. In the 1960s many of these countries adopted free health care as the principle for the operation of public health structures. This choice was based on a number of considerations:

- the ability of the population to pay was at that time extremely low. Very few people belonged to the élite or to the middle classes. In the rural areas large sections of the population practised in a barter economy;

- health should not be regarded as an ordinary commodity. The International Conference of Alma-Ata was to make people aware of the limits of curative medicine and of the need to pay more attention to prevention, education, nutrition, sanitation and housing;

- in more general terms this pattern was supported by the then prevalent philosophy of the Welfare State. There was no question that health was one of the prerogatives of the State. It was the task of the State to provide the means for attaining health for all by the end of the century.

It is true that the demand for health care in these countries was still relatively low, but it was hoped that the situation would improve. When the people became better educated and better informed, and had higher incomes, they would be able to express the demand for an optimum level of health. At the same time, economic growth would enable governments to release more and more resources for health.

Pending the arrival of these better times, of course, external aid was expected to provide these countries with the necessary resources. This external aid was at that time called upon for the improvement of infrastructure (building of hospitals and clinics, purchase of surgical equipment, ambulances, etc.), for the development of major vertical programmes for the elimination of major diseases such as leprosy and tuberculosis, and for the provision of technical assistance until such time as national staff were trained.

Alongside this system, the private sector was developing but in a departmentalized fashion: in most countries the health facilities of the religious missions have always been in operation At the same time, a commercial private sector came into being (private clinics). In 1985 the countries with a low level of human development were spending an average of US$ 4.2 per capita[1] on private health services. If India is excluded, the average per capita expenditure of these countries was US$ 7.5. Mean per capita expenditure in the countries with an average level of human development was of the order of US$ 11.8. This expenditure went on drugs sold in private pharmacies or on the market in general, and on consultation fees for physicians and other health personnel in both the "modern" and "traditional" sectors. This growth of the private sector may be classified under what Muschell (1995) calls "passive privatization", whereby the private sector develops of its own accord, and not as a result of a change in the government policy.

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[1] UNDP (1990); the monetary values are expressed on the basis of exchange rates that ensure parity of purchasing power.

The pattern described above was gradually called into question. The onset of the economic crisis, followed by the debt crisis, strengthened that process. The governments of the countries concerned had to face up to serious financial crises that led almost all of them to adopt restrictions and/or reforms as part of structural adjustment plans. The situation of the public structures deteriorated inexorably: recruitment of staff into the civil service was limited by economic constraints, salaries were paid after long delays, the operational resources of the health structures were drastically reduced, and drugs gradually disappeared from the health centres and hospitals.

When faced with this funding crisis, the first type of response by governments was to seek funding from sources other than the State budget. Providers of external aid were asked to make an additional effort and in particular to cover certain items of operating costs : it is estimated that in the late 1980s some 13% of external aid for health in Africa was spent on the financing of recurrent expenditure.[2] Governments set up cost recovery systems which were often designed as a replacement for State financing. Countries that had banned private medicine or had got rid of the health structures run by certain NGOs (particularly religious bodies) once again gave permission for these practices and facilities. These actions were seen more as pragmatic measures designed to reduce State expenditure than as ideological changes. It should be stressed, however, that this new approach did not usher in any change on the part of the State. The country had to get through a difficult period: once growth returned it was expected that the State would resume its initial role and its place in health provision.

At the same time, people began to question the concept of the Welfare State and the role of the State in the health system, not only in the financing of health services but also in the organization and production of services. Discussion focussed on two areas:

- the involvement of the State in implementing health services;
- the insufficient recognition of the existence of the private sector, and the importance of full integration of that sector into the national health system.

The basis for the discussion in this document is therefore as follows:

- The organization of health services should be considered within the framework of the **national health system**. This latter term refers to the nation State, not to the Government. All the health services present within the country's territory contribute to the population's health and thus form a part of the national health system.
- The national health system involves (i) several actors (the public sector and the private sector, but this document adopts a more detailed classification) and (ii) several functions or roles (financing and implementation of services, and also the ownership of health structures, definition of services, supervision, etc.).
- These actors and the functions they occupy are not independent of each other but are increasingly interdependent. The partitioning which has long prevailed, and which led people to speak of health systems in the plural, is gradually becoming blurred and giving

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[2] Source: Better health in Africa, World Bank.

way to a national health system in which all the actors will have their place, as long as their interrelationships are better defined.

The consideration of these interrelationships is the central theme of this document, which is structured as follows: after this introduction, the second section draws attention to the advantages and drawbacks of the market and the State in implementing health services and prepares the ground for establishing the interrelationships between the two systems. The third section outlines the contractual approach, on the basis of theoretical considerations. The fourth presents ways of drawing up contracts. The fifth presents ways of drawing up contracts. The sixth section is more specifically concerned with the role of communities within this system. The seventh raises the question of the capability of the public authorities to supervise processes that involve a contractual approach. The final section discusses some initial investigations in developing countries: Nepal and Madagascar.

2. THE NATURE OF THE PROBLEM: PUTTING AN END TO THE SEPARATION OF THE PUBLIC AND PRIVATE SECTORS IN THE ORGANIZATION OF HEALTH SERVICES

This section begins with a brief summary of the advantages and drawbacks of the market and the State in implementing health services. The literature on these questions is plentiful. The justification for this summary is that it defines the environment within which the discussion in this document takes place.

2.1 THE MARKET ECONOMY: ITS ADVANTAGES AND LIMITATIONS[3]

2.1.1 The advantages

The market pure and simple ensures the efficacy of the production and distribution of a large number of goods and services. Distribution follows the demand of consumers, a demand that is satisfied and thus maximizes the well-being of each consumer. In this kind of market economy the responsibilities of the State are minimal. First of all, the State must be involved in defining the rights to individual property in order to ensure the smooth running of a market. Minimal State protection also ensures absolute respect for the conditions laid down, for example, in work or trade contracts.

The advantages frequently mentioned involve greater attention to consumer preferences: flexibility in the provision of services (more convenient opening hours for clients than those of the State services, better reception of clients, more personal/human relationships between patients and health personnel, possibility of negotiating fees, payment in kind, reduction of red tape, etc.), greater readiness on the part of the prescriber to consider the patient's preferences for the type of treatment he considers most suitable.

Moreover, it is generally acknowledged that the private sector is better managed. In the area of personnel management (flexibility in recruitment, pay scales, career development, etc.),

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[3] See also Inman (1987).

the private sector is perceived as being more effective. Private sector procedures for the purchase of supplies and drugs are much more flexible than those of the public sector. The mobilization of resources is also faster and more flexible: an NGO will be able to call directly on funding agencies, some of which will be non-institutional.

Because the private sector is subject to competition, it is expected to provide goods and services of better quality.

2.1.2 Limitations of the market

Despite the advantages mentioned above, there are cases where the market economy is far from being perfect and where improvements are essential. The economic theory of well-being tells us that the State could be the agent that rectifies the faults. The problems that arise out of **market failure** as reviewed below.

First of all, the pure market economy does not lead to maximum efficacy in the case of a **public good**. A public good may be defined as a good for which rationing (or the exclusion of some consumers) is not possible and from which it is not desirable to exclude consumers.[4] The example *par excellence* of a public good of this kind is national defence. It is quite impossible to exclude citizens from the protection provided by such defence. In any case it would not be rational to exclude citizens because the marginal cost of protection for one additional citizen is zero.

The question now arises as to who will be responsible for producing the good. Production by a private company is a fairly risky matter, since the company will soon be faced with the problem of the "**free rider**". This is someone who benefits from the public good but does not contribute to paying for it. He is not punished for this behaviour because he cannot be excluded. If we acknowledge that such behaviour is fairly widespread, it will be difficult for the company to finance the production of the good. In the extreme case there is the situation where the population would like to consume the public good but it is not produced. The State is an economic agent *par excellence* to attend to the production of the public good, for reasons of economic well-being.

A second argument for calling upon the State is that of **externality**. An externality occurs when the consumption of a good or service by any consumer has an impact on the well-being of other consumers or on the production of other goods or services. An externality is said to be positive (negative) when consumption by this consumer increases (reduces) the well-being of other consumers or when it increases (reduces) the production of other goods or services. In the health field, vaccination is an example of a service which produces positive externalities. If vaccination remains a purely individual decision, in practice an underutilization of vaccination will be observed. This underutilization results from the fact that the individual disregards the beneficial effects of his or her vaccination on other people. An economic agent like the State may intervene, for example through vaccination campaigns, in order to improve social well-being.

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4 Stiglitz (1986, p. 101).

Thirdly, there are enterprises that achieve **economies of scale**. This means that the mean cost of production diminishes with an increase of the size of production.[5] It follows from this that a monopoly is the most effective means of production; this is a "natural" monopoly. The theory of social well-being prescribes that production must be sold at the marginal cost. This would mean the monopoly making a loss. A private monopoly could not apply the rule of price equal to marginal cost, since it has to make profits. Once again, the State may take over the exploitation of the monopoly.

Fourthly, there is the problem of **incomplete and asymmetrical information** held by consumers concerning the quality of certain goods and services. The problem of incomplete information arises when a consumer is not fully informed of the characteristics of a good or service. For example, an individual may underestimate the importance of a vaccine against tuberculosis. The State may intervene, for example through compulsory vaccination, in order to "correct" the behaviour of the ill-informed individual. Another example would be the case of a patient who requests a treatment which he considers appropriate, but which is not appropriate from the public health viewpoint (injection of antibiotic for the treatment of a simple cold).

The problem of asymmetrical information may arise, for example, when drugs are sold on the free market. It is very likely that the manufacturer and/or seller is better informed as to the efficacy and safety of the drug than the purchaser. Moreover, this asymmetry of information may lead health personnel to overprescribe when that boosts their earnings: it is very difficult for patients to argue with the health personnel since they do not have sufficient medical knowledge.

2.1.3 The market and equity

The initial distribution of the ownership will clearly determine the final allocation of the goods and services to individuals or population groups. The market economy does not in itself judge whether this initial distribution is fair or equitable; it simply accepts it.

Should the population consider that this structure is not acceptable, a reallocation of ownership would be necessary. In this case the State would be asked to introduce a policy of taxes and transfers. The State might also establish sectoral policies, for example to benefit the poorest population groups. In the case of a health policy, the State could take steps resulting in an equitable distribution of health services.

2.2 THE STATE AND ACTIVITIES IN THE HEALTH SECTOR

2.2.1 The response of the State to market failures

By applying the basic principles described above, we arrive at a number of clear recommendations concerning the role of the State in the health sector. In order to offset the inadequacies of the market as defined above, the State may take responsibility for:

(i) organizing the production of public goods, such as an insect eradication campaign;

(ii) organizing goods and services with externalities, such as vaccination campaigns;

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[5] This implies that the marginal cost is lower than the mean cost of production.

(iii) operating a "natural" monopoly; one example would be an enterprise for the distribution of generic drugs, provided that it does actually achieve economies of scale;

(iv) organizing health information and/or education campaigns, such as information campaigns on family planning, sexually transmitted diseases (STDs), prevention of diarrhoeas, etc.;

(v) taking steps to eliminate asymmetrical information; these steps might include the official registration of health professionals and official recognition of drug quality;

(vi) drafting a health policy aimed at achieving equity; this policy might include a scale of charges for health services that is favourable to the population groups in greatest need or total exemption from payment for certain services.

In practice, the activities actually carried out by the State frequently exceed the first five responsibilities on the above list. In many developing countries the State is the owner of substantial infrastructure (such as health centres and hospitals) and is the producer of health services. The rationale put forward for this is frequently the concern for equity and access to care for the entire population. In taking this line, societies reveal doubts as to whether the private market for health services, even if regulated by the State, is capable of achieving the objective of equity.

2.2.2 The State's performance in practice

2.2.2.1 Inefficiency in regard to allocations

A general improvement in health status has been seen during the past 50 years. Undoubtedly a large number of actors have contributed to this favourable trend, including the State. Nevertheless, the State is often criticized on the grounds that it could do better. The first criticism concerns **allocative inefficiency**, because the State's resources are allocated in a less than optimum manner. For example, it may be thought that the State spends too much on curative health services, whereas education or health services tend to be neglected. Yet the latter are often crucial for the improvement of the people's health. Another example concerns the distribution of resources within the State health budget: the funding of central hospitals may take precedence over the funding of preventive health care, whereas it has been shown beyond all doubt that the latter is particularly beneficial for health development.

Inefficiency in allocations is partly due to political decisions, where these tend to strengthen the interests of groups of health professionals or to favour certain population groups (urban inhabitants, for example) at the expense of others (for example, the poor rural population). Such decisions often involve a preference for specialized hospital services.

2.2.2.2 Operational inefficiency

Another criticism is levelled mainly at the production of services by the State itself. It is claimed that the forms of production are often less than optimum, which results in **operational inefficiency**. With regard to the use of drugs, for example, managers confine themselves to very expensive brand names. This practice further increases the costs and/or charges of the health services. These costs and/or charges could be substantially reduced by using generic drugs. This

operational inefficiency generally produces a negative effect on access to care and hence on equity.

Furthermore, the cumbersome administrative procedures of public structures lead to additional costs that reduce efficacy accordingly. Another example concerns staffing: services are often overstaffed and it is not possible to adjust the number of staff to what is really necessary. This overstaffing often goes hand in hand with very low salaries, resulting in loss of motivation by the staff. This loss of motivation in turn impairs efficacy and may even result in the absence of any real services for patients. Similarly, staff salaries tend to be determined not so much by performance and efficacy as by considerations such as length of service.

Operational inefficiency often results from the behaviour of health professionals in carrying out their tasks. To return to the example concerning branded drugs, a number of primary health care systems provide a substantial incentive for prescribing a large amount of drugs at high prices: this occurs when part of the health professional's income depends on revenue from the sale of drugs to patients. In this case it is clear that the quest for operational efficacy runs is directly opposed to the personal interests of the prescriber.

With regard to both inefficiency in allocations and operational inefficiency, people also speak of government failure[6] when the inefficiency of the State is considered. It is not difficult to find the causes of this failure if we study the behaviour of the individuals (civil servants, for example) and/or agents (such as medical associations, pharmaceutical industry federations) involved in the drafting of health policy.

In general terms it may also be pointed out that some inefficacies are partly due to the limited capacity for the design and implementation of health policy. It is still rare for a research department within the Ministry of Health to have the capacity to study alternative mechanisms for promoting greater efficacy, while bearing in mind the financial interests of the health personnel.

2.2.2.3 Equity problems

Inefficiency in allocations and operations often goes hand in hand with an equity problem. As pointed out above, the government allocation may favour hospitals to the detriment of the basic services for rural and/or poor populations. Operational inefficiency may also lead to costs and scales of charges that these populations cannot afford.

It is also frequently observed that the allocation from the State health budget does not take the size or the needs of these populations sufficiently into account. Often, the poorest districts do not even receive a share in proportion to the size of their populations.

The reasons for this situation are similar to those stated above, namely, the preferences of medical associations or pharmaceutical manufacturers' federations, or of civil servants and politicians, who may give precedence to the interests of a middle or urban class over those of the people in greatest need.

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[6] See, for example, Wolf (1988).

2.3 THE SOLUTIONS CUSTOMARILY PUT FORWARD

Although there have been failures on both sides, the tendency in recent years has been to lay more stress on the failures of the public sector; this attitude has been strengthened by the increasingly severe budgetary constraints that have to be faced by many developing countries. The consequence of this has been to look upon privatization as a way out of the difficulties encountered by the public sector. In a number of countries the State has shown a willingness to pull out and private structures of all kinds have sprung up: NGO structures, private hospitals, private medical practices and so on. This privatization movement affects many countries: for example, the Czech Republic has announced plans to transfer 70% of hospital beds from the State sector to the private sector (whether for-profit or not-for-profit). Similarly, in China, it is estimated that since 1993 expenditure on health by households and businesses has been three times as high as that of the State budget.

According to this approach, privatization has been presented as an appropriate solution to all problems; accordingly, State intervention in the health field should be extremely low and should concern only a few very specific areas such as medical ethics, certification of qualifications and some public health programmes (AIDS, for example).

However, many individuals and institutions were not slow to qualify this approach. While privatization can certainly provide solutions, it should not be regarded as the universal panacea. In the early 1990s debates were organized on the concept of the public/private mix. All the studies[7] on this topic are based on the following table:

		PROVISION	
		PUBLIC	**PRIVATE**
FINANCING	**PUBLIC**	Government funding and provision, free at point of use, of national health services	Services contracted to private providers
	PRIVATE	Cost recovery system Private beds in public hospitals	Private health care funded by private insurance

The principal value of this table is that it identifies a number of actors (in this case, two, but later on a distinction will be drawn within the private sector between the for-profit and not-for-profit sectors) and a number of functions (in this case, two, financing and provision).

[7] See, in particular, the document *Interregional meeting on the public/private mix in national health systems and the role of ministries of health*, Mexico, 22-26 July 1991 (document WHO/SHS/NHP/91.2).

Even if the classification of the actors and functions is still simple, the framework for analysis has been laid down: a health system may be described in terms of the various combinations of actors who finance and produce health services. Nevertheless, the interrelationships identified have not been operationalized. For example, if it is decided that the private sector may finance private beds in public hospitals, what are the procedures for implementing this? Will this decision take the form of a ministerial order specifying the number of beds that must be privatized, or will each hospital be free to decide for itself? In the latter case, what are the negotiating procedures, who will take the decision, and how will this decision be recorded? These are all questions that require answering in order to put this approach into operation.

Here, the whole concept of privatization is at stake. Should privatization be seen from a narrow viewpoint, consisting simply of the sale of public health structures to private investors, or from a broader viewpoint in which private actors are invited to participate with the State in the production of health services? This latter concept has been developed by Rondinelli & Iacono (1996); it also tallies with the concept of "active privatization" put forward by Muschell (1995).

2.4 TOWARDS A NEW DEFINITION OF STATE RESPONSIBILITIES?

At the start of this document the authors laid down a challenge: the quest for ways and means of preserving the advantages of the public sectors **and** of the private sector, while reducing their drawbacks and inefficiency. In other words:

- is it possible to maintain the major responsibilities of the State (as outlined in section 1.2.1 and as will be defined later), while improving its performance?

- is it possible for the private sector to preserve its efficacy while doing more to attain public health objectives?

There is a large amount of literature concerning the developed countries on the new forms of resource management. One of the most influential proposals is that of Enthoven (1990, 1993) on **managed competition**. This proposal contains the concept of "sponsor", that is, an organization that is genuinely able to set up a structure for the organization of health services without itself being responsible for the production of those services. At the same time the sponsor may stimulate competition between different producers of services, but only under certain conditions. This idea has been applied to some extent in the United Kingdom, where the district health authorities are allocated a budget by the central government; these districts can then negotiate contracts with hospitals. One of the purposes of managed competition is to curb the rise in health costs. Again in the United Kingdom, a general practitioner is able to become a fund manager (general practitioner fund holder) for financing health services for the patients who decide to register with him. He can use this budget to purchase health services on a competitive basis. Once again, this competition is intended in principle to curb rising costs.[8]

How do matters stand for the developing countries? Would managed competition be an appropriate idea? Discussion on the possibility of applying it has already begun (see Broomberg, 1994). Doubts about its application are raised, for example, because of the existence of local

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[8] See Glennerster (1995).

monopolies (e.g. a single hospital or a single doctor in a district with 200 000 inhabitants). So there would often be an absence of competition. On the other hand, a **negotiated** contract between two parties, such as a health district on the one hand and a hospital managed by an NGO on the other hand, is always possible: such a contract might, for example, stipulate the range of services to be offered to the population and set the prices for health services at an affordable level.

This document will pursue further the study of contracts. Contracts may be established between different levels of the State. For example, responsibility for the health development of districts could be assigned by the State to the health districts themselves, which would be allocated budgets (in the form of fixed sums) which they could then use in accordance with their priorities. Such budgets might also be allocated to NGOs or missions. It would also be possible to draw up contracts between the State or the districts on the one hand, and other agents (pharmacists, physicians, NGOs and missions, cooperatives, etc.) on the other hand, for the production of services: such contracts might cover all the services under the health system or only specific services.

Depending on the conditions of the country concerned, the contracts could be open to competition or else a contract could be negotiated directly between two or more partners. The most important aspect to be considered is the public health aspect: this new method of management should improve the efficacy of services and the degree of equity of the health system. This brings us to the idea that the underlying problem for the health sector is not the choice between public sector and private sector as a means for attaining the objectives of the health policy. The problem is rather how to integrate both within an overall vision of an effective health system.

All those involved in the health field would therefore be invited, depending on their roles and functions, to produce health services within the framework defined in the national health policy. Contracting, which will be expanded on below, should then be regarded as a tool facilitating the implementation of this approach. It is thus no longer a matter of setting public sector against private sector, but rather of inventing ways and means of getting both sectors to collaborate in order to provide the best possible response to the population's needs. Public and private sectors are each capable of both good and bad. What needs to be done is to reduce the bad and keep the good. But talking is not enough: this meeting between the two needs to be organized and structured, and the contractual approach participates in this process. It is not a matter of defending the public or private sector but of organizing their collaboration and ushering in a new era in the implementation of health services.

3. THE CONTRACTUAL APPROACH

The foregoing paragraphs showed up the weaknesses in the implementation of health services both by the public sector and by the private sector. At the same time, however, both sectors revealed their strengths. It would seem that nowadays, as regards the production of health services in the developing countries, neither of the two sectors gives full satisfaction and that there is a need to explore new avenues in order to retain the strengths of both sectors and eliminate their weaknesses.

3.1 GENERAL PRESENTATION OF THE CONTRACTUAL APPROACH

In order to define the contractual approach we need to go back to the concept of health system and its development over time. The health system is characterized by:

- **Diversity of the actors**

It can be observed at the present time that in most countries the implementation of health services is becoming more complex. Just a few years ago the structure of many health systems was relatively simple. It involved two players: on the one hand, a public system wholly organized by the State at central level (which passed laws and issued standards and regulations, laid down health policy, and had its own health structures which it financed from tax revenue) and, on the other hand, a private for-profit system (made up of structures such as clinics or of independent health personnel such as private physicians or pharmacists) which operated in accordance with rules similar to those governing the rest of the private sector (code of ethics excepted). These two systems lived in totally separate worlds: it is thus significant to note the use of the term "public health system" as opposed to "private health system".

The increase in complexity arose no doubt out of the inadequacy of the public sector to provide the population with good-quality services that everyone could afford. This trend to diversification came about first of all from the increasingly strong involvement of NGOs in implementing health services: these not-for-profit structures slotted in between the public sector and the for-profit private sector, borrowing characteristics from both. Subsequently, following the general trend towards decentralization, the communities emerged as actors with something to say in the implementation of health services. The recognition of their role has become widespread, with the introduction of participation of the public in health financing.

More recently, independent health financing bodies have grown up in the least developed countries (social security agencies, mutual associations, private insurances). Besides their primary role of financing health services for their members, and by virtue of the power conferred upon them by the large sums of money at their disposal, they participate in deciding how to implement health services or even directly in implementing them.

Finally, it is important not to disregard the active role played by businesses in the modern sector. In most countries they are obliged by law to become involved in looking after the health of their employees including sometimes their families. They have several options for this: to set up their own health structures, to transfer their contributions to mutual associations, social security bodies or private insurances, to negotiate health services for their employees directly with healthcare providers, etc.

- **<u>The diversity of functions</u>**

The agents involved can have a number of functions:

- they may be providers of services: the State, NGOs, businesses, private producers of health (independent personnel or clinics); businesses and financing agencies may also set up as "health service providers", offering health services to the population from their own health facilities or surgeries;

- they may finance health, and here two approaches should be distinguished. i) The traditional approach, of budgetary allocations: the State, and decentralized territorial units or businesses divide their health budget among the health facilities they decide to support. In such cases there is no strict correspondence between a budget and a product. ii) The second approach regards the financier as a buyer of services, and that buyer finances products or services but not facilities;

- they may be owners of health facilities: all the agents defined above may be owners of health facilities; this does not make them their managers. Conversely, not all managers of health facilities are their owners;

- they may be agents who help define the services to be set up and who help manage those services: this function is distinct from the implementation of services. It consists in the first place of defining the activities which are then to be implemented. It also concerns management: a given agent can be involved in the management of a health facility without directly participating in the provision of health services;

- finally, but this concerns only the public authorities, there is the function of authority: a provider of health services may operate only if authorized to do so. In some cases, such authorization may be accorded to anyone satisfying a number of predetermined conditions: for example, regulations will determine the conditions under which a physician may open a surgery. But such authorization may be subject to negotiation rather than being automatic: such is the case when the authorization is not a right but something granted by an authority which assesses the matter first.

The progress of health systems implies both a diversification of agents involved and further separation of roles. The health system of a country can therefore be defined on the basis of the interactions between its constituents and the roles and functions they discharge. Such interactions are on the increase throughout the world. In order to take shape, such interactions call for negotiations leading to agreements, some of which are set out in formal contracts. The contract is therefore an instrument for formalizing such interactions. Such agreements can cover an extreme variety of subjects, as the following table seeks to illustrate.

The contractual approach in developing countries

Agency	Provider of services	Public health facilities	NGO health facilities	Private health facilities	Enterprise health facilities	Health facilities of financial agencies	Independent (physicians, pharmacists, etc.)
Government authorities	Authority	Authorization to negotiate private practices	Licence	Authorization to operate	Authorization to operate	Licence	Authorization to operate
	Property		Public service management			Provision of premises	Temporary lease of premises
	Definition of services and management	Definition of autonomy Advice, know-how, network (franchise)	Definition of activities to be carried out, tariffs, etc. Advice, know-how, network (franchise)	Contracts for hospital or outpatient services	Openness to the public	Definition of activities to be carried out, agreement on tariffs, etc.	Contracts for provision of primary health services, distribution of essential drugs
	Finance	Allocation of human resources and operating budget	Allocation of human resources and subsidies	Task exemption for services rendered	Negotiation of compensation for services rendered	Subsidies for public health activities	Ways of remuneration
Community association	Property		Provision of premises			Provision of land to build on	Use of premises
	Definition of services and management	Roles and tasks within the management committee	Roles and tasks within the management committee	Participation in the Board of Governors	Roles and tasks within the management committee (staff association)	Participation in the Board of Governors	Obligation to distribute essential drugs
	Finance	Participation in building and maintenance	Participation in building and maintenance	Tariffs for the people	Conditions of access for the people		Negotiation of acceptable rates

Agency	Provider of services	Public health facilities	NGO health facilities	Private health facilities	Enterprise health facilities	Health facilities of financial agencies	Independent (physicians, pharmacists, etc.)
Businesses	Property		Rent/provision	Rent		Rent/provision	Provision of premises for external consultations
	Definition of services and management	Definition of responsibility for wages	Definition of responsibility for wages	Definition of responsibility for wages		Definition of responsibility for wages	Definition of responsibility for wages
	Finance	Modes of payment for services rendered	Modes of payment for services rendered	Modes of payment for services rendered		Modes of payment for services rendered	Modes of payment for services rendered
Independent financing agencies (health systems, private insurance funds)	Property		Expensive equipment made available				Hiring of expensive equipment
	Definition of services and management	Definition of care for contributors	Definition of care for contributors	Definition of care for contributors	Definition of care for contributors		Definition of care for contributors
	Finance	Modes of payment for services rendered	Modes of payment for services rendered	Modes of payment for services rendered	Modes of payment for services rendered		Modes of payment for services rendered

Two examples show how the tables should be read:

- Community associations are now active partners in the definition of health services: take the case of such an association and consider its interactions with the health facility belonging to an NGO in a given geographical area. The community association at the NGO must then come to an agreement on the role and tasks of the association in the management committee;

- Mutual funds become financing agencies of increasing importance: this mutual fund can seek an agreement with the public health facility in the area where its members live, to negotiate how the services provided for its members by the health facility are to be paid for.

One advantage of this table is that it shows clearly the variety of areas in which contractual arrangements can be made. The current literature on contracts is too prone to reducing the object of contracts to the matter of an exchange between buyer and provider of services of a product for a given price. Most literature on what is known as contracting out conforms with that outlook: studying the effects of privatization of certain non-medical services within health facilities (catering, maintenance and laundry). The table shows clearly that the notion of contract is much wider: a contract can therefore be defined as a relationship of mutual obligation where two or more partners come to an agreement.

The above table makes for simplified description of links between agents and their functions, but the drawback is that it does not cover the interrelations in all their complexity. Actual agreements can be more complete and can cover several objects at once. For example, a contract can cover at one and the same time the State, an NGO health facility and an independent mutual fund, and can deal with a range of issues such as State subsidies to the health facility, definition of care for members, how services provided for members are to be paid for, and charges for the treatment of non-members. The possibilities are infinite. Contracts can therefore be classified according to whether they deal with a group of activities in one health facility or one specific activity (such as tuberculosis screening or vaccination of young children).

Contracts are therefore instruments that allow multiple relations among agents in the health sector to be formalized. They must therefore be analysed if the structure of the health system is to be understood. There are thus systems with trickle-down contractual arrangements, such as where the central authorities negotiate a plan contract with regions and/or districts which, in turn, subcontract the use of a number of public health facilities to NGOs, which enter into agreements with local mutual funds for health, in the treatment of certain strata of the population. This set of contractual arrangements must be analysed if a complete view of the health system is to be obtained.

This presentation, still simplified at this level, might be taken to imply that once the negotiations are complete and the agreement is reached, the provider of services is necessarily the only party responsible for implementation of the health services (to the limit of the terms of the agreement). In this case the role of the co-contractor is restricted to setting the terms of the contract: once the contract is signed the co-contractor's role becomes passive, and is restricted to checking that the terms of the agreement are complied with.

The current literature almost exclusively regards contracting under this form of independence. There are many advantages to this type of contractual arrangement. Once the contract has been signed, the operator of the health service is independent of the co-contractor. He may implement the health service in accordance with his own way of operating, as long as this does not infringe the terms of the agreement. But this type of contractual arrangement makes the co-contractor a passive partner once the preparatory phase of the contractual agreement has been completed.

Contractual agreements do not automatically make the co-contractor a passive partner when health services are provided. Even when the day-to-day provision of a health service is restricted to the operator, the contractual agreement can allow the co-contractor to play an active role after the contract has been signed. It can have many aspects, of which we shall consider two:

- a role supporting the operator: in which case the terms of the agreement will specify that the co-contractor, especially when that co-contractor is the authorities[9], will provide support to the operator without however interfering in the daily running of the service. This support can take different forms: financing of certain activities (specially those with externalities), social financing (caring for the indigent), and above all provision of know how that the operator does not necessarily have;

- the role of network animator: in accordance with principles inspired by "franchise" or "concession", the co-contractor, even if contractual agreements are established with each of the operators, shall strive to put the operators in touch with one another in a network.

These roles make the co-contractor an active partner over time, in which case we can really speak of "cooperation".

Whereas the document sets out to cover all forms of contract as adumbrated in the table above, the emphasis will be on contracts involving the authorities, in their many functions. In this context, implementation of health services can therefore be presented in accordance with a simple classification based on the partners concerned:

- only the authorities are involved in the setting up of a given health service: they are both owners and operators of the service;

- at the other extreme, there are health services operated by private legal entities. These include non-profit-making legal entities such as associations and NGOs, and also profit-making legal entities such as companies and individuals;

- between the two there is the situation where the authorities reach an agreement with another legal entity which is to operate health services. Within this group, the contractual arrangements can vary, especially in accordance with the role of the authorities, whether "cooperation" or "independence". That is the main point of the following section.

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[9] We use the term "authorities" henceforth to designate everything to do with "public affairs", i.e. the central authorities of the State, and also of the regions, provinces, districts and communities.

Before continuing explanation of this classification, it is worth reviewing the notion of contract, which is after all central to the approach. Whereas contracts have always been studied by jurists, they have for some time been the subject of interesting analyses in the fields of economics, sociology and political science, which have revolutionized analysis in that area. Since they are not well-known, we shall consider them here in the light of our subject.

3.2 CONTRACT THEORY

As we have seen, a modern health system brings in a large number of parties, each of which can play a different role. The resulting interactions must be codified. Those involved have divergent objectives and interests. This leads the protagonists to negotiate, so as to find agreement that will allow action to be taken: the contract is the element that seals the agreement and confers legal force on it.

The first thing to notice about a contract, - whose importance will become apparent, - is that it brings together two or more legal entities. By legal entity we mean a physical or moral person. A contractual arrangement can therefore be defined as follows:

A contractual arrangement (or contract) is therefore an agreement between two or more economic agents through which they undertake to assume or relinquish, do or not do certain things. A contract is therefore a voluntary alliance of independent partners.

We must therefore ask why two partners seek an alliance and try to formalize it in a contract. The alliance must give the partners (or at least one of them, according to economists of the Pareto School) an advantage or surplus that would not have existed had the two partners not been allied. In game theory, we speak of a game resulting in a "cooperative solution" producing a cooperative surplus.[10]

A contract is therefore collaboration between partners. Yet this collaboration is not automatic, since where there is no communication between the two parties no cooperative solution can be achieved: this is generally described in the economic literature by means of "prisoner's dilemma" (see box below). For it must be understood that when the contract is signed the surplus is still to be produced: the partners exchange promises of behaviour, not finished products. The contract is therefore an instrument which institutes roles or clauses that establish the possibility of cooperative behaviour in the interests of both parties.

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[10] Cooter R.D., Ulen T.S.: "Law and Economics" (London: Scott, Foresman & Company, 1988, pp 92-94).

The prisoner's dilemma

Two people are arrested for theft. Each is then faced with the following situation: if both remain silent, both will be freed; if one accuses the other, who remains silent, then one receives a reward and the second a long prison sentence; if each accuses the other, each gets a year in prison.

From the point of view of each player taken individually, the best strategy is to accuse the other, in the hope of gaining the reward; this, of course, means that each goes to prison for a year. Where there is no communication between them, there is no cooperation, although both would benefit from remaining silent, since then both would be freed.

To achieve the optimal solution for the two individuals together, they should communicate and, at the same time, stick by their agreement: to this end, the agreement should be formalized, with sanctions in the case of non-compliance.

There are several reasons why there is no automatic cooperation, and why explicit contracts or arrangements must therefore be made.

- The moral hazard: this arises from the fact that one of the signatories of a contract might find it advantageous not to comply with the terms of the contract. This type of "opportunistic" behaviour[11] is common in the area of the provision of services that interests us. For example, if the clauses of the contract are not explicit enough, the person in charge of the health centre may promise to perform a given number of pre-natal examinations per month or to do everything necessary to detect cases of leprosy. The contracting parties are thus rational enough to seek systematically to exploit to their advantage flaws in the contractual arrangements they establish. From the point of view of the person who does not keep his promises, there may be less of a surplus to share since he will not have contributed to its production, but that lack of surplus for him will be compensated by a reduction in costs (or efforts) he will not have provided.

Opportunistic behaviour therefore derives from the rationality of the economic agents.

- The free rider's behaviour: in the health sector there are examples of public goods in respect of which individuals or families can behave like free riders. For example, villagers may say they are happy that an insect eradication campaign is being organized using aircraft, in their district. But if they are asked to finance the campaign, they are no longer interested, assuming that other villages nearby will finance it and that they will thus benefit from its effects without bearing its costs. If everyone thinks like that, the campaign simply is not organized. An explicit arrangement between the authorities and the population can resolve this problem, so that each is sure that the other will not avoid its commitments.

[11] This expression is coined by O.E. Williamson "Markets and Hierarchies: Analysis and Antitrust Implications", New York, The Free Press, 1975.

The metaphor of the free rider

This metaphor explains why an individual, though affected by the production of a good or public service, does not collaborate in its production and seeks to benefit from this work done by others. A ship is chartered and passengers pay for transportation; the free rider is the one who benefits from the chartering of the ship and boards without paying.

- Assymetry of information - anti-selection or adverse selection. One party has information, the other does not, and he will use it to his advantage. For example, it is not in the interest of the manager of a non-State health centre to tell the authorities how much the identification of tuberculosis cases costs; this will enable him to request a higher subsidy from the authorities than the service actually costs. What pushes someone to opportunistic behaviour is that his partner would find it difficult or impossible to check. This lack of observability arises either from the observer's inability to tell whether the other person is indeed using the best procedure, or from the high cost of checking. In the example cited above, it is expensive for the partner to go and check that the manager of the health centre has indeed done everything possible to detect cases of leprosy in a given region.

The assymetry of information[12] can also lead to the phenomenon of "adverse selection". The classic case is the setting up of voluntary health insurance. If the insurer sets no conditions for entry, it is likely that most of those who take out insurance will be those at high risk of illness. In order to maintain the financial viability of the insurance, therefore, the insurer must increase the premium. This then discourages those at low risk from taking out insurance. This procedure can continue until such times as the premium becomes so high that there are no more clients. Of course, the insurer can guard against this adverse selection by obstructing entry to individuals at high risk (for example by refusing individuals suffering from a certain disease or the population over 65). Thus, only the low risk population remains insured ("cream-skimming"). Alternatively, society can take steps to ensure that the entire population is guaranteed access to insurance: by declaring insurance compulsory, for example, or by forbidding private insurers from refusing applications, or both.

In this context, contracts are seen as coordination mechanisms that lead the signatories to exchange the information needed for the general interest.

In short, whenever parties identify an interest in collaboration, a contract is needed in order to:

- coordinate the activities of the partners, ensuring production of a surplus;
- distribute the fruits of cooperation;
- ensure that promises are kept.

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[12] Analysis of information imbalance was introduced to the literature by G.A. Akerlof, "The market for "lemons": quality, uncertainty and the market mechanism" Quarterly Journal of Economics, vol 84, 1970.

To this end, the parties are obliged to adopt rules of behaviour accepted by both. According to Schimanoff[13],*"a rule is a prescription to which people may conform, which indicates what behaviour is required or preferred or forbidden in given situations"*. By establishing rules, the contract establishes the possibility of cooperative behaviour to the advantage of all. Cooter and Ulen (op.cit.) also assert that the contractual approach, by reducing the costs of communication and follow-up, stimulates cooperation.

3.3 THE CLAUSES

A contract can be regarded as a set of clauses designed to ensure that the above-mentioned objectives are attained. The situations to which it applies obviously differ greatly. However, each contract contains clauses that are intended to solve identical categories of problems. Every type of contractual arrangement can be described by a limited number of clauses. According to Brousseau[14], a contract can be formed by a set of seven essential clauses:

3.3.1 Definition of products

In the contract, the parties must define the objective of their alliance, the product that must emerge. In the case that interests us, for example, the parties must define the health services that will be offered to individuals. The definition can be made jointly - this is "joint contracting", or by one of the parties (probably the authorities) - and this is known as "sub-contracting".

The definition must be as accurate as possible, to make it match the actual situation as closely as possible. It can also be fitted into a framework agreement that has been established earlier, usually with a larger number of parties, which sets out the outline of the agreement.

Such is the case in Cambódia, where a charter has been prepared for all those working in the health sector. The Charter establishes the outline of all activities in the sector. But this does not obviate the need for specific agreements which, taking the Charter as a point of reference, allowed different specific matters to be taken into consideration (such as geography and morbidity).

3.3.2 Choice and organization of the resources deployed

A contract must specify the resources to be deployed by each party in order to attain the objectives defined in advance. Furthermore, the contract must state how those resources are to be managed.

For example, the contract for production of health services must not stop at the number of people who will work in the department concerned; it will also be used to indicate the precise terms of reference of each of these persons and their performance criteria.

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[13] Schimanoff J.B. "Communications Rules: Theory and Research", London, Sage Library of Social Research, 1980.

[14] Brousseau E. "L'économie des contrats. Technologies de l'information et coordination interentreprises", Paris, PUF, 1993.

3.3.3 Coordination in time and space

Although this would seem to go without saying, this clause must be specified in a contract. It is not simply a matter of identifying the product and the means of production. It must also indicate when and where they should be available.

For example, a contract that simply stipulated the number of vaccinations to be conducted in a year can lead to an attitude on the part of the provider of services whereby, if he reached his quota in the month of October, he would stop vaccinating (or slow down). A number of vaccinations per month would limit this type of behaviour. Similarly, a contract that does not specify where the vaccinations are to be administered might lead those responsible to vaccinate first and foremost those who are easily reached, because they live near the health facility.

These first three categories of clauses therefore concern the technical steering of the alliance: it is a matter of knowing who is doing what, when. The contract must define these matters as precisely as possible. However, in the area of concern to us, the complexity of products and of means of production is such that the contract cannot cover all the routines used in implementation. The contract is therefore "incomplete", leaving scope for interpretation in situations that cannot be foreseen to the last detail. It therefore becomes important for the contract to state who is authorized to decide in such cases.

<u>The notions of "routine" and "incomplete" contracts</u>

- "routine": this does not mean routine repetition of a given action but reactions that come with experience and lead to standardized response to a given situation. In the field of medicine, diagnosis and treatment algorithms constitute routines that remove the need for health workers to assemble all the necessary information for each situation;
- the "incompleteness" of a contract: the parties agree without being able to envisage all the events that could occur. The clauses of the contract do not determine precisely the rights and duties of each partner. However, this incompleteness must be offset by an indication of who is authorized to take these decisions when such situations arise. This awareness of the need to designate the decision-making authority is what gives this notion value.

3.3.4 The system of guarantees

The guarantee clause defends each party against opportunistic behaviour. The guarantee is a means of putting pressure on the other if the contract is not respected. It must be first and foremost a means of dissuasion. The penalty incurred must therefore exceed the expected benefit from opportunistic behaviour, to ensure that it is not in the signatory's interest to break the terms of the agreement.

The importance of this guarantee clause arises from the specificity and complementarity of the partners. If the partners are particularly well suited, the extra value produced by their

alliance is great and they will be less tempted to separate, unless other partners with the same features are found.

The system of guarantees therefore seeks to establish a situation of mutual dependence, where each is the "hostage" of the other, making it expensive to leave the alliance.

3.3.5 Monitoring mechanisms

A contract is a set of promises on behaviour that partners make to one another. There is no point in making promises that cannot be checked. Here again the mechanism should be dissuasive first and foremost. The signatory who knows that he will be monitored in accordance with the terms of the contract he has signed will not be tempted to break his promises. Who will exercise this monitoring? The contract should say. There are two types of monitor:

- the legal system: the law can guarantee the proper execution of a contract. The contract must therefore be precise and should clearly indicate the competent jurisdiction, the type of law, and the referral procedures. In this case, if a contractor thinks that the other is not respecting the terms of the contract, he can take the case to court. It should therefore be noted that the plaintiff must prove the faults of his partner;

- a designated supervisor: here the contract indicates a supervisor accepted by both parties. This third party - an auditing firm - is paid to monitor the fulfilment of the contract. Unlike the law, he is empowered to investigate. If well chosen, this monitor is a professional specialized in the relevant area. He is conversant with information that is often very specialized.

3.3.6 Remuneration of the parties

The division of the benefits of the alliance between two partners is a key element in many contracts. This division is often difficult to make since there are no objective criteria to guide it.

<u>An illustration</u>

Take a removal firm: to shift a piano, four people are needed. If there are only three, the team's productivity is nil; if there are four, productivity is maximum. The productivity of the marginal worker thus equals that of the entire team. Each member of the team can then call himself fourth, claiming the entire output of the team.

The output of the team cannot be attributed to any of the co-contractors individually, and there is no objective criterion for division. Only negotiation enshrined in a contract can rule on the sharing out.

In the area of concern to us, the problem is no doubt less difficult. Take the example of a health centre belonging to the authorities but managed by an association. The benefits of the contract - payments made by patients - are left to the manager. But if the authorities want to claim a proportion of income, the contract must stipulate how, and the basis of calculation.

Remuneration of the provider of services must be clearly defined in the contract. Such remuneration can come from two sources: payment by the co-contractor and/or sale of services to clients:

- the contract can stipulate that the co-contractor pay the provider of services a sum that can be either a pre-established budgetary allocation or remuneration for each service performed (e.g. the number of vaccinations administered);

- the contract can arrange for the sale of services. The tariff in the full sense of the term - the catalogue of prices and the conditions of payment - must be included in the contract.

The entire difficulty here lies in the fact that the remuneration of the provider of health services must be high enough to make him effective in the production of services, but without excluding certain populations. If, for example, the authorities consider that the provider should reach all children requiring vaccination and that physical distance should be no obstacle, remuneration must encourage the provider to make a greater effort for children who are far away than for those near the health facility.

There are several techniques that aim to include incentive for the provider of services in the contract itself; the main ones are:

- The block contract. This arrangement was established in the United Kingdom at the beginning of the 1990s (Raftery et al., 1996), to give all the inhabitants of a given area a set range of services in exchange for a certain sum of money, with no specification of the quantity to be produced. This type of contract therefore guarantees an income to the provider of services.

- Capitalization. Under this arrangement the provider is regularly paid a set sum per subscriber to cover predetermined service costs. This type of contract is used in the HMO ("Health Maintenance Organizations") in the United States, where the payments are made by insurance.

- The sophisticated block contract is an extension of the simple block contract with a threshold and ceiling level of activity, and procedures for payment when those limits are exceeded.

- The cost-and-volume contract is similar to the sophisticated block contract, the difference being that the purchaser does not define in advance the volume of service to be supplied. The contract can, however, set different types of remuneration depending on the level of activity: for example, a certain price is set for each case treated up to a certain limit, beyond which the payment is made on a case-by-case basis.

- The contract per case. Payment depends on the number of cases actually treated ("case-based reimbursement"), and may depend also on the way the cases are treated ("cost per case contract" based on the number of hospital days and the list of services used). Such payment is retrospective.

The advantages and disadvantages of these systems are mostly connected with three factors: the quantity of services offered, their cost and their quality.

Advantages

Quantity. The quantity of services - expressed in the number of cases treated - is very important since it reflects the health coverage of a health facility (such as a district hospital). If health coverage is to be maximized, there should be a strong link between the income of the provider and the number of cases treated. The decision-maker will therefore prefer cost-and-volume contracts and case-based reimbursement contracts, where appropriate, in conjunction with a block budget system.

Cost. Controlling the cost of treatment is essential to health system reform, whose objective is greater efficiency in the use of resources. From the point of view of treatment cost, all the mechanisms described are satisfactory, except for case-based reimbursement if it is based on detailed charges for services. However, this can go with a reduction in the quality of care.

Quality. In practice, the quality of a health service is difficult to measure objectively, other than by approximation using the indicators of kind and quantity of services prescribed in the course of an episode of disease. In theory and from this point of view, only systems based on detailed billing for care provided encourage quality of care, but with the risk of escalating costs.

Disadvantages

Quantity. It is obvious that the block contract and capitalization are not in themselves incentives to maximize health coverage. Furthermore, it may be in the interest of providers to treat patients whose treatment is likely to be cheap, so as to maximize profits: this is the risk of adverse selection found especially in capitalization systems.

It should, however, be noted that whereas a block contract does not give incentive to maximize the number of cases treated, for the period it covers, the threat of a cut in this overall budget when the contract is renewed - or not renewed - does constitute an incentive, especially when the State remains owner of the health facility (Mills, 1995). This brings us back to the basic idea that a contract intrinsically produces an obligation of effectiveness.

Cost. As we have noted, case-based reimbursement provides a strong incentive to increase the cost of treatment if it is based on a detailed tariff, since it is in the provider's interest to over-use the resources at his disposal to treat the patient: excessive recourse to diagnostic methods (laboratory tests and X-rays), extension of stay, unnecessary recourse to surgery, etc. (the phenomenon of *moral risk* on the part of the provider).

Quality. Envelope systems such as block contracts and capitalization can lead to a reduction in services used for a given course of treatment: Barnum et al., for example, have noted a reduction in the length of stay and the attribution of intensive care in Brazilian hospitals.

The efficacy of arrangements for the remuneration of contracting parties compared

	Coverage	Cost control	Quality of service
Block contract	no*	yes	no
Capitalization	no	yes	no
Sophisticated block contract	average	yes	no
Cost-and-volume contract	yes	yes	average
Case-based reimbursement			
All inclusive price	yes	yes	no
Detailed tariff	yes	no	yes

* With the exception of implicit pressure for renewal of contract.

An antinomy appears between coverage (incentive to maximize the number of cases treated) and cost of treatment (unitary). Furthermore - and obviously - the financing mechanisms likely to provide control of the cost of treatment have an adverse effect on the quality of care, as measured by the treatment resources deployed.

However, this can be attenuated by the existence of active competition among providers, as Barnum et al. (1995) observed for some systems in the United States.

3.3.7 Duration

The length of the contract is a very important element since it determines the behaviour of the partners. For example, the behaviour of the director of a health centre who has signed a management contract with the authorities will depend on its duration. If he knows that the period is of, say, five years, he will be able to start a public awareness campaign, whose results of course will not be immediate: he would not do this if the contract were only for two years. The advantages and disadvantages of the lengths of term must therefore be analysed carefully.

3.4 TAKING THE COST LINKED TO CONTRACT INTO ACCOUNT

The cost of one contractual arrangement rather than another depends on the transaction costs[15] associated with it. The drafting and implementation of a contract entail different types of cost:

- Costs *ex ante*: the preparatory phase of a contract entails costs: choice of potential partners and negotiation with them takes time; people have to get to know each other and identify skills. This phase of negotiation calls for people who are able to do it (see below);

  These costs can be so high for the potential provider that he may decide not to bid to supply the service. From one point of view this reduces competition, but on the other

[15] The theory of transaction costs was developed mainly by Williamson in "The Economic Institutions of Capitalism", The Free Press.

hand it could be suggested that the providers eliminated in this way are among the weakest and therefore the least effective.

- *Ex post* costs: these are related to monitoring of the completion of the contract. Once the contract has been signed, steps have to be taken to ensure that each partner respects his commitments. Information must therefore be gathered and processed, the monitoring mechanisms (audit, etc.) have to be financed, and in some cases the arbitration provided for in the contract invoked. All these activities cost money. Furthermore, this calls for highly skilled and competent human resources.

  On the basis of the literature, Mills (1995) finds transaction costs of the order of 7% of the value of the transaction for preparation of bids alone in the United Kingdom, rising to as much as 20% in the United States. According to the same source, in the United Kingdom the cost of monitoring contracts would be 30% higher than that of monitoring the direct supply of services. The risk is therefore that transaction costs absorb all or part of the gains in efficiency achieved through the contract, and may even outweigh such gains.

To these costs we may add the losses caused by a contract that is ill-suited to a given situation. A bad contract produces a bad situation for as long as it lasts, or at least until it can be terminated: this situation can cause damage that is difficult to repair, especially among the population.

The more precise the contract, in other words the better it covers all the possible situations, the greater these costs will be. A balance must therefore be struck in the negotiation and implementation of a contract between perfect operation that is planned and regulated in advance, and another contract whose terms are more vague but whose drafting and monitoring cost less.

For example, must a contract concluded between the authorities and a health service operator stipulate the number of visits per month to each village, the time spent on each visit and the quality of personnel involved, or simply the number of trips per month? The answer affects the quantity and cost of monitoring.

3.5 AGENCY RELATIONS

Contractual arrangements established between persons[16] fall into two categories.

- Joint management relations: in such cases, two partners decide to join forces on an activity. This happens when, for example, two companies decide to produce a new type of car between them and establish an economic interest group between them, a joint subsidiary in which each invests resources for this objective;

- Delegation relations: in the literature, this comes under *agency theory*. The agency relationship can be defined as a contract in which one person (the principal) employs

[16] By persons we mean both natural and artificial persons. Sometimes the term "legal entity" is preferred.

another (the agent) to carry out on his behalf a given task, whereby a degree of decision-making power is delegated to the agent.

This agency relationship is important for our purposes. The principal (the authorities) entrusts to an agent (a separate legal entity) the task of conducting a specific mission. This mission may be very simple, and/or it may be outside the field of production of health services (such as the catering service in a hospital, maintenance of premises or equipment), specific (vaccination of all school children in a given area) or very broad (production of all the basic health services in a given geographical area using the health centres there).

The principal chooses this contractual arrangement because he believes the agent with whom he is negotiating a priori has the ability to discharge these tasks more efficiently than could the principal himself. The agent accepts this contractual arrangement because it entitles him to conduct an activity in the field of health totally legally.

In addition to this, delegation by the principal to the agent may be:

- complete: a matter of subcontracting. The principal, once the contract is signed, has only the passive role of monitoring;

- partial: in which case, after the signing of the contract and depending on its terms, the principal continues to have an active role alongside the agent.

The problem in this relationship is that of knowing which contractual arrangement will best enable the agent to act in the interest of the principal. In our case, how can the authorities be sure that their agent will take all steps to provide and supply the best service to the population of the area? It is hard to know whether the agent is doing his best unless one devotes enormous (and therefore expensive) resources to monitoring. Furthermore, the authorities do not always know what actions are the most effective: for example, is an outreach vaccination strategy preferable to increased numbers of vaccination sessions at health centres?

In the contractual arrangement he negotiates, the principal must therefore find the right way of inducing the agent to adopt the optimal behaviour. There are various ways of doing this:

- there is the entire field of financial *bonuses/penalties*: the contract establishes either rewards (in the form of bonuses or various financial advantages) if the agent achieves a given result, or penalties if he does not reach a given level (removal of credits, support staff, etc.);

- there are also methods which are not directly financial: for example, the authorities may grant or deny the label of excellence or simply membership which it gives to health facilities with which it has concluded agreements.

Agency theory therefore shows the contract as a means of inducing the agent to maximize his own efforts. The contractual approach can thus be seen by the authorities as an effective way of inducing the private sector to collaborate more. Rather than using the "stick" the authorities can try to reach an understanding with private agents. This is what Senegal intends to do in order to develop a true partnership; this is also being explored by Cambodia with the Association of

Physicians. This shows that the contractual approach can also be regarded as a way of regulating or even "cleaning up" the private sector.

4. THE MODES OF PRODUCTION OF THE HEALTH SERVICES

The following analysis focuses on the provider of health services and his relations with the authorities. The following table is meant as a grammar, a tool describing the ways in which health services are put into practice. To this end, several criteria have been established: they are summarized in the first column of the table below. This table should be used as follows: the criteria of the first column should be considered and examined in order going down, in the following stages:

- "Partners involved": which partners are involved in the provision of health services? Is the provider of services to work alone (as in the case of public facilities of the state, or at the other extreme, completely independent providers) or will the provider have formal links with the authorities?

⇓

- "Type of organization": especially where there are two partners involved, it should be known whether or not there are statutory links between them.

⇓

- "Type of relations with the authorities": describe the contractual arrangements to be established .

⇓

- "Involvement of the authorities": this criterion defines the type of involvement of the authorities in the provision of health services.

⇓

- "Standardized forms of contract": for each of the situations defined in the previous stage, standardized forms of contract are named here that can be used, although of course specific contracts can always be drawn up.

MATRIX DESCRIBING IMPLEMENTATION OF HEALTH SERVICES

Partners involved	Government authorities alone		The authorities + public law legal person	The authorities + private law legal person			Private law legal person
Type of organization	Administration		Predetermined contractual agreements	Full contractual agreements			Independent private sector
Features of links with the authorities	Within the administration		Freedom in a defined area	Cooperation		Independence	No link (tolerance or ignorance)
	Delegation	Devolution					
Involvement of the authorities	Direct or delegated management	Hierarchical power	Control Licensing	Joint management	Network	Subcontracting	Laws and regulations
Standard contracts		Direct or indirect state control	Concession to 1 public establishment Public service concession Plan contract	Joint subsidiaries: (private interest groups, joint ventures)	Franchise Concession of a commercial nature	Public service concession Accreditation	

The following presentation uses the first criterion of the table - number and identity of partners involved when health services are provided. This first criterion distinguishes the case where only one partner is involved, from that where the authorities reach agreement with another, separate partner.

4.1 IMPLEMENTATION OF SERVICES INVOLVING ONE AGENT ALONE

In the first case, this partner is either the authorities or a private legal entity.

4.1.1 The authorities as provider of health services

The authorities here are both owner and operator of the health facilities. There is only one legal entity in play. This health service operator is thus the only one who decides which resources he will mobilize to produce health services, and it decides which type of health service it will obtain. This does not mean that it is the only financier of these resources. It uses public financial resources (the budget of the authorities) though it can also have them financed by development partners and by patients either with direct payment or through a third party (employer or insurance company). In general, the service can be operated in various ways:

- Direct management: here the health service is managed entirely by the authorities. Health workers are administration officials who come entirely under the rules of the civil service. Provision of service then works like any administrative service. Expenditure comes under the rules of public accounting, with a complete monitoring prior to the operation. If there is income, it goes to the treasury.

- Delegation: an authority may delegate part (but never all) of its remit. For example, the district chief physician may delegate part of his responsibilities to the manager of a health centre in his area. This may involve either delegation of power (the delegate acting in place of the authority) or delegation of signature, (where the delegate simply acts on behalf of the authority but does not substitute him). In this case also, the authorities are entirely responsible; delegation cannot be said to come under a contractual agreement, since there is only one legal entity;

- Decentralization: in this process, certain powers are allocated to subordinates by legislation or regulation. The subordinate is still under the hierarchical authority and, of course, is not a separate legal entity. However, the hierarchical power confers certain possibilities, such as the power of approval, on such subordinates.

This decentralization can go as far as "*indirect control*": the service thus benefits from a certain administrative and especially financial independence (an autonomous budget) within the group to which it belongs. This is connected with the notion of *multiple distribution* in commercial law. Especially in the case of the manager - representative, the branch office is simply an establishment run by an employee with responsibility for managing the sales point.

The three cases described above have very little autonomy from the administrative authority.

- Devolution: it involves subnational levels of administration with some independence from the national level. Strictly speaking, these are independent agents with special legal status. An example is municipalities mandated by the central government to organize primary health care services, which receive a grant from the State and staff that are administratively dependent on it. But from our point of view, this is the same type of agent: the authorities. The simple, though important, difference is that this authority is organized in several distinct entities which are not totally independent since the subnational levels in the last resort come under the central authorities.

4.1.2 Independent private entities

This covers any body not directly linked to the authorities and which produces health services. Their legal status can vary greatly from associations and cooperatives to companies and individual entities. They are not linked to the authorities by any contractual relationship. This independence of operation is simply governed by the laws of the country in areas such as ethical codes of the medical profession, the public health code and more generally the laws and regulations of the country. From the legal point of view, there is no distinction between profit-making and non-profit-making bodies.

The authorities have no formal link with these legal entities. From the legal point of view they are ignored. From the organizational point of view the authorities often tolerate them, recognizing their right to practice. In a number of cases it can even take account of them. For example, the authorities tend increasingly to take account of existing private health facilities when making their health maps. The authorities would therefore not make a priority of setting up a public health centre in an area where there already is one, run by an NGO which provides all the services usually found in a health centre. However, even in such cases, the authorities have no formal links with those facilities. At most, the understanding remains tacit.

However, this autonomy from the authorities does not mean that those private bodies cannot establish contractual arrangements with the authorities. Nothing prevents two associations managing health services from coming to an agreement on joint running of specific activities. In such cases more or less formal contractual arrangements are made. If they are formal, they conform to the usual rules of commercial law. The authorities, in so far as they have not forbidden this type of service, cannot interfere with such contractual arrangements unless it changes the law or regulations. For example, it can prevent a foreign private firm from directly investing in a national private system of health services, or it may rule that agreements may not be made between more than X private facilities...

4.2 PROVISION OF SERVICES BRINGING SEVERAL AGENTS INTO PLAY

Implementation of health services is no longer a matter for a single body as above: the authorities are a private legal entity. It is the result of an understanding among several agents. But it is better to speak of functions or roles than of agents. The distinction is important.

- For the provision of health services there is usually close correspondence between the function and a provider of services: the function of the health facility is to ensure the production of health services. But as we shall see, it can also play other roles such as that of contingency fund when prepayment systems are set up.

- The roles of the authorities can be more diversified. Whereas they are of course responsible for administration in the main sense of the term - supervision, monitoring, legislation and regulation - they tend also to have the role of technical support to providers of care.

The system can be more complex, bringing other functions and/or agents into play:

- The role of technical support can be separated from that of administrator, and can thus be done by a different entity. If, for example, health facilities need technical training (in-service training, use of information, etc.) the role can be played directly by the authorities (the Department of Training of the Ministry of Health, the Department of Statistics, etc.), or entrusted to an external agency, depending on the links with other agents, which should be defined. This technical support role can come from the central administration, which gives an impulse to have an autonomous body set up to provide the service or, on the contrary, the role may come into being because different bodies need technical support and join to establish the body that will provide for them. In the latter case, we have an "agency" or a "consortium", where resources or expertise or both are pooled;

- Community participation. Increasingly it is asked that communities be associated with the health system. Their involvement in the operation of the system, especially through management committees, makes them important agents whose functions must be clearly defined by law first of all, and then through contractual arrangements with the other agents;

- Financing. When the users of health services contribute to health expenditure (other than through taxation) they can do so either directly or through special entities such as insurance companies and mutual funds.

The situation is often so complex that there is not always a bi-one-to-one correspondence between the functions defined above and the various legal entities. For example, one NGO may at the same time manage various health facilities and act as technical support for them; it can at the same time form a health mutual fund for the population of the areas in which its health facilities operate. Then again, the State may provide finance through a health insurance fund.

One must therefore give thought to the links between these functions and/or agents. Systems change from one country to the next, but the approach is the same: analysis of existing arrangements in the awareness that these can be more or less tacit. This analysis of each of the contractual arrangements must be done with precision. In a second stage, those analyses must be consolidated to give an overview, an analysis of the health system of the country concerned. This systematic analysis is essential for planning of reforms that could be made to the health system.

For simplicity's sake, we will begin with a detailed analysis of the simplest case of a health system involving only the authorities and the provider of health services. The formal agreement between the authorities and a distinct legal entity is enshrined in a contractual agreement, which means that the authorities and some legal entity providing health services have negotiated ways in which the production of health services is provided.

These contractual arrangements can be spelt out to different extents. There may be a single contract which makes no reference to any model, or on the other hand the law may recognize a certain number of types of contract. This can be seen with franchises: the law in certain countries

and European law define a franchise with different degrees of precision and the type of contract that goes with it. This classification of contract into a certain number of types does not mean there is no leeway for change, even within a given group of codified contracts. For each of the situations discussed below we shall specify the types of codified contract that best correspond to the situation. This does not at all mean that only such model contracts can be established by partners. The trend is towards what some call "categorized contracts", which do not fit into any pre-established category.

We must now define the legal entity that is to reach agreement with the authorities. It may come under:

- private law: as in the previous case, these will be associations, cooperatives, companies and individuals (individual entities);

- or public law: a separate legal entity, with legal personality and financial autonomy, but established by and linked to the authorities. In French law, this is called an *"Etablissement public"* (public establishment). In more general terms some speak of delegation, where there is transfer of managerial responsibilities for clearly defined functions, to organizations outside the central administration but indirectly monitored by it.[17]

This distinction has an important consequence. In the first case, contractual arrangements that can be established between two legal entities can be described as "full" which means that they are not affected by any pre-contractual limitations. In the second case, however, the legal links between the two entities restrict the domain of the contractual arrangement: such contracts are termed "pre-restricted contractual arrangements".

Before analysing the consequences of these distinctions, it is worth recalling the four main phases of a contract:

- Identification: this relates to the moment when the partners identify each other. The process can take one of two forms: the first is where the authorities themselves seek out potential partners (by active search or calling for tenders); here the authorities have the initiative. Otherwise, the authorities do not have the initiative, when they act as an authorization committee, in cases where the initiative comes from the legal entity providing services that seeks authorization to do so;

- Negotiation: once a partner has been chosen the negotiations begin. The contract may be either drafted entirely in this phase or simply adapted from a standard contract (adhesion);

- Exploitation: this corresponds to implementation of the terms of the contract by the user of the health service, once the contract has been signed. The length of this phase is stipulated by the contract;

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[17] "Decentralization of health systems" A. Mills, J.P. Vaughan, D.L. Smith, I. Tabibzadeh, WHO/SHS, 1991.

- Evaluation: at the end of the contract, the results achieved are evaluated. This phase is particularly important when continued collaboration through renewal of the contractual arrangement depends on it.

Involvement of the authorities in each of these phases varies with the type of contractual arrangement.

Public establishment

A public establishment may be defined as a public law legal entity which takes on a specific mission and has the administrative and financial autonomy to do so. A public establishment must be established by - and is therefore attached to - a public entity (state, region, province, community...).

Under French law there are two main categories:

- Public Administrative Establishment (EPA): governed by administrative law; it is staffed by civil servants and its accounts come under the rules of public accounting. This category generally covers schools, public hospitals, etc..

- Public Industrial and Commercial Establishments (EPIC): these tend to come under private law; their staff are covered by labour law and the accounting is commercial. The director is nominated by the authorities (even if he has been elected). There is a board of administration where the authorities are well represented.

The public establishment is a typical form of technical or operational decentralization that affords a degree of autonomy. Nevertheless, it remains under higher supervision. This can take a variety of forms, but always based on the following points:

- power of approval: the most important financial decisions (budget and investments) are taken only after they have been approved by the higher authority;

- power of annulment: the authority can annul a decision by the public establishment. This is the domain of a priori control that allows the appropriateness of the decision to be called into question;

- accountancy: whereas the commissioner is the director of the establishment, the accountant is from the treasury. This separation of commissioner from accountant is a key principle of the administration.

4.2.1 Pre-constrained contractual arrangements

Here there are two distinct legal entities, and the prerequisites for contractual arrangements are therefore present. But the two entities are related in ways that restrict their freedom: this might be called "*restricted freedom*". The arrangement linking them can be regarded as a contract, but a compulsory contract, one from which there is no escape.

If, as we have seen, a number of areas must come into these pre-constrained elements, such elements must be clearly stipulated during negotiation for the establishment of the distinct legal entity. Individuality can then be given to this status, and it can thus be said that this individual status is a sort of contract. But it is not an agreement in the full sense of the term as it cannot be rescinded by the legal entity.

Over and above establishment of these official relations, the two entities can make specific contractual arrangements to define the substance of their agreement. Such things are real contracts which include all the elements defined above.

Contracts between the authorities and a legal entity which is linked to it can take several forms:

- Public service concession: in which management of a service is entrusted by the public agency to a manager, who is not paid by the users, but the public agency remunerates him on the basis of results. The agency sets the indicators of expected results, such as price and quality of service.

- Variant on the public service concession: the community (the licensor) entrusts to a public body (the concessionary) the running of a public service, on the understanding that the concessionary will draw remuneration from income received from the users of the service. This type of concession is usually long-term, since it is the concessionary who makes the investments. The community chooses the concessionary at its own discretion.

- Leasing is distinguished from concession only by the fact that the lessee pays the community a set sum and gets his earnings from the users.

- Plan contract: the authorities and the separate legal entity negotiate a plan contract; this is one which sets out how the service concerned is to develop in the ensuing years. The advantage of this technique is that it gives greater freedom of operation to the separate legal entity, which thus does not need to renegotiate each of its activities on a case-by-case basis. It can thus see quite far ahead and adapt to fit. These plan contracts can have different names such as programme contracts and establishment plans;

- Uncategorized contracts: those which do not come under any of the categories mentioned above, and therefore do not obey any particular pre-established rule.

4.2.2 Full contractual arrangements

On one side there are the authorities and on the other a legal entity governed completely and exclusively by private law. The contractual arrangement between such entities is "full" in the sense that there are no prior constraints from statutory links between the two.

The contractual arrangement means therefore that the authorities and an independent legal entity under private law have freely negotiated the ways of implementation of the health services. The latter can therefore be classified in accordance with two models: "Independence" and "Cooperation".

4.2.2.1 The "Independence" model

During the identification and negotiation phases, the two entities - the authorities and provider of health services - maintain active relations. Each must have the skill required to achieve the best possible arrangement. Such skills cover many areas - juridical, financial and technical. Each must be a seasoned negotiator. But once the contract is signed, the provider recovers his freedom in the space defined by the terms of the contract. The role of the authorities then becomes passive. The authorities have no right to intervene in the regular operation of provision of care. They must restrict their role to monitoring in application of the contract. It is up to the authorities to prove cases where the provisions of the contract are not respected.

The contracts can take the form examined above of "public service concession", but it could be that they do not fit into any of the pre-established categories. Such contracts can be described as approval or authorization. The authorities agree with partners to provide a health service in accordance with a clearly established agreement.

Since these two entities are independent, it is no longer a matter of supervision. However, depending on the balance of forces when the contract is established, there is nothing to prevent the authorities from inserting clauses instigating some form of monitoring. This will usually be done *ex post*.

Finally, it should be noted that these contractual arrangements imply a bilateral relationship between the authorities and the partner. Each contractual arrangement is an individual case and there is no link between contracts or between co-contractors.

4.2.2.2 The "Cooperation" model

Cooperation means that the active role of the authorities does not stop at the signing of the contract. The authorities continue to play an active role according to what the contract stipulates in the exploitation phase. Such cooperation can take one of two forms: co-management or a network.

A. Co-management

The authorities can be particularly active in the case of co-management. The authorities and a private partner can agree to set up a joint subsidiary, which means pooling resources to provide a given service. Each side brings financial and human resources and know-how, and a legal entity is created which is independent of the two initial contractors, although this new entity depends entirely on them through control mechanisms (Board of Administration). Most of such entities take the form of a Mixed Economy Company, a Public Interest Group (G.I.P.).[18] Examples are no doubt rare in our field of interest, which is the production of basic health services. They could, however, be developed in national hospitals.

[18] The Public Interest Group is the equivalent in the public sector of the Economic Interest Group (G.I.E.) in private business.

B. Network contracting

This is a new departure which is being tried by a number of countries. It begins with the simple premise that the authorities are there first and foremost to regulate:

- check that care is of good quality at the best possible cost;
- ensure equity in access to care for the entire population of the country;
- ensure that public health is put into practice (taking account of externalities, production of public goods, etc.).

To this end, and for the reasons set out at the beginning of this text, the authorities need not themselves be producers of health services (even if they wish to remain the owner).

"Independent" type contracts such as those described above do deprive it of some of its opportunities for regulating, since its role becomes passive the moment the health services are put into effect.

The problem is then that of reconciling independent operation of health services, which guarantees effectiveness, and the opportunity for the authorities to play their regulatory role to the full, knowing that this word should not be taken in the sense of constraining but rather of energising. The solution is possible with two tools from the traditional commercial sphere: "franchise" and "concession".

- **Franchise**

A franchise is a contractual arrangement which is increasingly being codified. In the European Code of Ethics, a franchise is defined as "a system for the commercialization of products and/or services and/or technologies which is based on close and continual collaboration among legally and financially distinct and independent enterprises, the franchiser and the franchisee, in which the former accords the latter the right and imposes the duty to operate an enterprise in accordance with the concept of the franchiser".

The difference between a franchise and the traditional agreement between two partners is as follows:

- The franchiser must be able to provide something to the franchisee. This contribution can take various forms:

  * Financial and material contributions. Provision of premises and equipment at the beginning of the franchise, followed by provision of staff and subsidies for the operation of certain activities, and various forms of care, during the implementation of the contract.

  * Provision of know-how. Without interfering in the management delegated, the franchiser has a dual responsibility:

  .A duty to assist and advise: the franchiser must help the franchisees by giving them information, providing them with advisors, giving them various forms of training, providing them with managerial tools (such as accounting software). This contribution

is important to the franchisees, who are thus relieved of certain tasks in which they are not necessarily skilled, and which might be expensive to develop (devising of a new product, publicity campaigns, management software, etc.), a concept such as a way of devising a health centre, pyramid structure, (referral and counter-referral), selection of a minimum package of activities (MPA) etc;

. A duty to monitor the performance of the franchisees. The franchiser must be able to check that the franchisees are doing their work properly and carrying out their mission.

This dual responsibility is important, and is certainly one of the original features of the franchise. Without the involvement of the franchiser there is no franchise. This involvement always leads to a loss of autonomy for the franchisee, who accepts it because the benefits outweigh the disadvantages. In the business world, the franchiser has the franchisees pay for these services with a percentage of turnover or commission. In our case, the authorities generally take no commission, but the arrangement ensures that the public services is provided cheaper and in an agreed way, and that it can be checked without recourse to the legal system or even auditing.

* Setting up of specific commissions: for training, management, development of new products, etc. Franchiser and franchisees therefore work together, each side using its know-how and experience to improve the products of the network.

- The notion of network: at the base of the system there is the idea that the higher authority wishes to coordinate a network of legal entities that share an objective. The franchiser is thus an organizer of the network, whose coherence he strives to safeguard. The franchisees know that they all belong to the same network, and this identification as part of a network is important. It can take the form of simple visual recognition (use of a logo) or it can go beyond that, to pride of belonging to a particular group (team spirit or even identification with a caste).

The role of the franchiser is crucial: only he can maintain this spirit of the network. If he does, it is because he profits from it himself, gaining effective health services.

The franchise is thus a contract in which the franchisee is accorded the right to use the know-how, the brand name and the technical assistance of the franchiser.

- **Concession**

A concession, on the other hand, is a contract under which a licensor grants a licensee the right to market his products on an exclusive basis in a given territory. There are many points in common with the franchise, but there are also differences:

- The contribution of the licensor is much smaller than in the case of the franchise, especially in terms of know-how. The licensor will for example see to publicizing the group, establishing a commercial policy and setting recommended prices, but there is no real assistance in areas such as management and technique. The licensee is regarded as a thorough professional who does not need to be told how to operate:

- Since there is less supervision and training, licensees are more free in their actions, but they also run greater risks.

Nevertheless, the concession can be marked with the spirit of the network in that, even if each agreement between licensor and licensee (or concessionary) is specific, the concessionary identifies himself with a given group.

In both franchise and concession, therefore, as in agency theory, there is a principal and there are agents. This organization is particular, meaning that the principal is the one who started the network which he wishes to develop. If each contract he concludes with an agent is specific in a way that adapts it to circumstances, the network will be based on a model contract that he himself has prepared. The power of negotiation of the potential agent is therefore to be found within this framework. In some cases, this power is almost nil: the interlocutor can either join up or stay out of the network.

This standardization of the contract is a sign of efficiency: once the model contract has been established, it is not necessary to spend time and resources on ad hoc negotiations for every new contract. But standardization can also be seen as a sign of equity. In a network worthy of the name, differences between agents cannot be too great or they will put the consumers in unequal situations. By proposing a standard contract, the principal puts all users on the same footing. By turning to the network, the user knows he will have an identical service whichever point in the network he chooses to use.

A few examples

- Franchise: many distribution makes operate with the franchise system: Budget, Century 21, Europcar, Holiday Inn, McDonalds, Midas and Pizza Hut.

- Concession: most of the major car makers distribute their products using the concession or dealership principle. The dealer distributes the vehicles of the make in accordance with the terms of the contract, but this does not prevent him from being a totally independent car repairer.

- **The roles of the authorities**

In this cooperation model, the potential roles of the authorities can be listed. This means identifying the contributions of the authorities to providers of services during the operational phase; here the authorities play an active role as partner in provision of services.

- Managerial support: of course, the providers of services who have concluded a contract with the authorities will often be better managers than the authorities are. Nevertheless, the authorities can help them with new methods by telling them of other experiences and helping them obtain software developed elsewhere, or even by helping them with training;

- In-service training: the authorities can give the members of the network in-service training on the specific problems of the network;

- Distribution of information: the authorities can facilitate an exchange of information for the benefit of the members of the network: information circulars, letters, etc.

- Exchange of experience: the authorities can facilitate exchange of experiences of the members of the network;

- Ad hoc support at particular times, for example during epidemics.

5. THE DRAFTING OF THE CONTRACTS

Whether cooperative or independent, contractual arrangements are prepared in a great variety of ways. Take the case where the authorities decide no longer to run some of the health centres they own, and to transfer the operation to a particular private body. There are two main categories for preparation of contractual arrangements, depending on which role the authorities play.

5.1 CONTRACTS PUT OUT TO TENDER

All potential providers of service in this approach are able to compete for the market in question. The technique used is that of the invitation to tender: the authorities put a contract out to tender and wait for potential candidates to turn up. This can entail a contractual framework that is already finalized or it can invite various proposals. Using this method, the authorities trust on competition to produce the best proposal.

Whereas this approach obviously presents all the advantages of competition, especially that of leaving it up to potential operatives to choose themselves by making the best offer they can, it does have several major drawbacks:

- The first has to do with the possibilities of agreement among potentially interested parties. In a given region, the number of such parties is always limited and they tend to know each other quite well: there is therefore a great temptation to agree on a division of the market;

- The second arises from the possible lack of competition in many parts of the country. In rural areas, health services that do or could operate are few or may even hold a monopoly. This is often not because they have ousted rivals but because population density is so low that there is no niche for several partners: the partner who is already set up therefore holds a monopoly that is difficult to get round;

- The third is the problem of assessing the quality of services in an offer from a potential partner; but the experience of the provider may come into play, to exclude providers devoid of experience who make attractive offers;

- The fourth has to do with "insider-dealing", especially when public facilities take part in the tender. In such cases, the managers of public facilities, because of their status, can have access to information that partners in private facilities would not easily obtain;

- The fifth is that, given the results of the invitation to tender, some partners (such as NGOs) which are well-established in the area, might find themselves excluded from the market. This will pose a political problem which is all the more difficult to resolve when the NGOs have been in the health district for a long time, doing work that is appreciated by the people;

- The sixth, and perhaps most important, is the narrow margin for negotiation among future partners: the provider proposes and the authorities dispose, which means that the authorities are compelled to choose among the proposals made in accordance with predetermined selection criteria. But it does not really enter into negotiations with its future partner.

5.2 NEGOTIATED CONTRACTS

Here the authorities do not trust to competition, but rather to their knowledge of the area to select the best-placed partner or partners to provide the expected services. Once the choice has been made, authorities embark on full negotiations with the partner concerned.

This approach has the disadvantage of leaving the choice of potential partner to the authorities, with all the risks of wrong or questionable decisions that it entails. Furthermore, the authorities also have to devote skill and financial resources to the process. Finally, the negotiation must persuade the partner to reveal his position, whereas the call to tender means that it is in the interests of the partner to state his proposal as completely as possible, at the outset. Here, a good negotiator can see the weakness of his opposite number and not reveal this optimal position. In such cases negotiation leads to less than optimal results.

What matters in the end is that negotiation and its results be transparent. Negotiation committees and publication of contracts are among the procedures that enable the formal or informal opposition forces to express themselves and even to dispute the contract; this means that the market of negotiated contracts can regulate itself.

This strategy has two advantages: (i) choice of the partner who seems best placed to produce the services desired, and (ii) true negotiation with the future partner - in-depth discussions on the objectives to be achieved, the strategies to be employed, etc. This approach is certainly much more exacting than the call to tender, so it requires greater resources from the authorities to produce a final arrangement.

A mixed technique can consist of identifying a few potential providers and asking them to make an offer: this is the principle of restricted consultation or restricted call to tender.

6. THE ROLE OF THE COMMUNITIES

From the aftermath of the Second World War until the end of the 1960s, especially at the time when countries were becoming independent, many adopted free care as the principle of operation for public health facilities. The authorities had to provide a population which was ill-educated, ill-informed and very poorly paid with basic health care through public health facilities, without having them pay for the services. Of course, demand for health care in those countries remained low and the services were still inadequate. But it was then hoped that the situation would improve: the people would gradually become aware of the need for better health, and economic growth would provide increasing resources. Until better days came, foreign aid would work as a temporary stopgap.

The economic crisis of the mid-1970s changed all that. The governments of those countries had to face up to severe financial crises that made almost all of them adopt restrictions. The state of public facilities deteriorated: staff recruitment was limited by structural adjustment plans, wages were paid very late, the budgets for running health services were severely cut, and drugs gradually disappeared from health centres and hospitals. Financial crisis caused the whole idea of the welfare state to be called into question.

The idea gained ground that the people should contribute more to health.

- The contribution is first and foremost financial. Since the authorities no longer have the means to ensure the operation of health services, the people are asked to pay something. In various ways they have to contribute to cost recovery. Rather than true cost recovery, many prefer the notion of sharing costs between the authorities, the development partners and the people;

- The role of the people is not restricted to this financial contribution. Of course, one of the first justifications of greater public involvement is based precisely on the fact that, since they finance the health services, the people should be associated more closely with their implementation. Such is the logic of the Bamako Initiative. But the argument goes further. Involvement of the population is based on the logic of raising awareness. In other words, the people involved in provision of health services are people who have realized the importance of health and who take steps to ensure they are able to participate in decision-making on their own health.

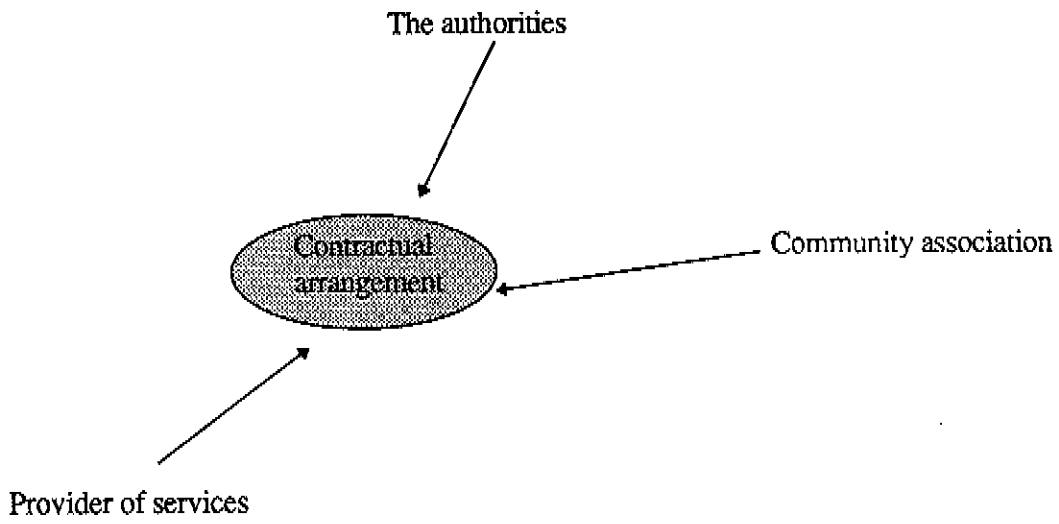
We must therefore consider how this involvement of the people can be combined with the situations described above. To this end, it is worth considering how the community is organized, since there are different degrees of organization.

- **Community represented by a legal entity**

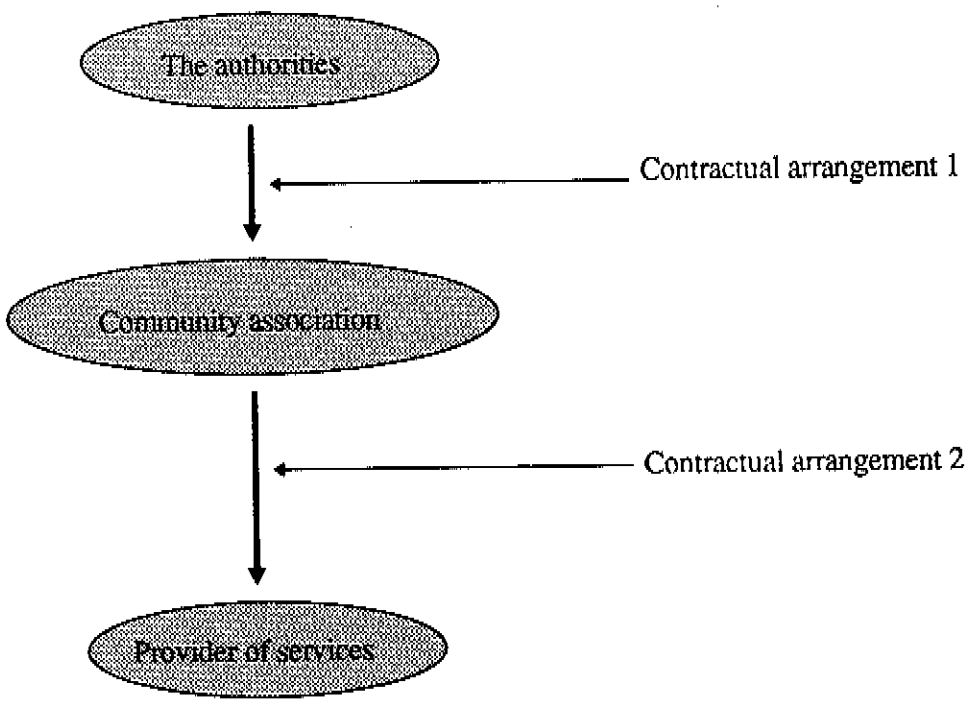
Such a community is organized. It forms an entity which has legal personality recognized in the laws of the country. For example, a village community creates an association, an urban area forms a district committee. Such entities are recognized by law: they have statutes that are lodged with the appropriate administrative authorities, rules, etc. They therefore have legal personality, with all that derives from that status.

In the framework defined above, this legal entity has all that is required to participate fully in a contractual arrangement. Such a community can be involved in one of two ways:

- Tripartite arrangement: the legal entity representing the community participates fully as an agent in the development of a contractual arrangement, along with the authorities and the health service provider. For example, it may be decided that the village association representing the people will jointly manage the funds accruing from participation of the population with those responsible for the operation of the health facility, though it will not intervene in the day-to-day provision of health care.



- Subcontracting: true subcontracting is where the authorities sign a contract with the association representing the community, which subcontracts the provision of health services to a specialized legal entity.



- **The community represented by individuals**

These are persons designated by the community to represent it. They do not have legal personality entitling them to act as a public official. From a strictly legal point of view, such people represent no one but themselves.

In terms of the problem that concerns us, the community does not participate in drafting of the contractual arrangement because it is not a legal entity. In this case a contractual arrangement between the authorities and a health service provider can accommodate the role of representatives designated by the community, going on to associate them as individuals with various tasks in the day-to-day operation of the health facility.

To make this explicit, let us take the example of someone designated by the community to serve on the management committee of a health centre, holding the key to the safe containing income from cost recovery. Suppose this representative is dishonest and empties the safe. To whom can the operators of the health centre turn? Only the individual is responsible; since the community has no legal existence, it cannot be charged.

Once again, a contractual arrangement can function only between legal entities recognized by law.

This representation of the community by individuals works well as long as their role is consultative. It is an effective means of obtaining the community's opinion without the need to bring the community together each time it is sought. The community designates these people to give their various opinions to those who are providing the health services.

However, this representation can have no official mandate to represent the community in actions entailing responsibility.

7. THE ABILITY OF THE AUTHORITIES TO MANAGE THE PROCESS

This contractual process of negotiation, monitoring and evaluation requires skills that the authorities do not necessarily have. The authorities must be strong and able to face up to the contractors. They must have staff trained in contract law, in the running of a network, in evaluation, and in conventional non-administrative supervision. It is rare for the health ministries of the least developed countries to have such capacities. Furthermore, the process assumes that the people involved in the contractual phase will be above the temptation to corruption. The winning, renewal and routine evaluation of a contract are very important to providers of services: they may be tempted to influence State officials, who often have very low salaries.

As J. Kutzin (1994) shows from a strictly economic point of view, the contractual approach is only of interest in so far as its benefits outweigh its costs (in terms of training, supervision, evaluation, etc.).

Every programme aimed at strengthening contractual arrangements must begin by ensuring that the capacities of the authorities, as described above, are sufficient to ensure full success to the operation.

An institutional analysis must also be made in order to see where this capacity should be situated within the Ministry of Health. In general, this function of supervision of the contractual approach is not part of the Ministry of Health's structure.

7.1 WHERE SHOULD THIS FUNCTION BE SITUATED?

- At central level

  - Department in charge of planning: this certainly has information that can be used for the preparation, monitoring and evaluation. But it is not skilled in implementation of services;

  - Department in charge of decentralized administration: it must participate, since the role of district and/or regional medical officer is important. It is the decentralized administration that must deal with the everyday management of such contracts (preparation, supervision and evaluation). But it cannot do so without central support, especially if there is a network. It will not have the technical resources needed to master the arrangement.

  - Departments in charge of health structures: these are useful when the authorities themselves provide the health services. But they no longer have a place when services are contracted out. However, it is there that the skills are to be found that will check whether the services offered and provided by the contractor are up to standard.

  - Legal department: the legal department of the Ministry of Health can contribute, but it is not accustomed to this kind of contract.

- At decentralized levels

  Decentralized levels of administration generally do not have the necessary skills for such an approach. But it is the decentralized administration that is in contact with the providers. It therefore has an important role to play, at every stage in this approach (from preparation of contracts through negotiation and monitoring to evaluation). Central administration must therefore train decentralized teams to discharge these tasks: standard district teams must therefore be trained in this new approach.

What has to be done?

The work to be done falls under three headings:

- Negotiation of the contract: this all depends, of course, on the approach chosen (call to tender, case-by-case arrangement). At this stage, however, the authorities must already have done the following:

  - identification of potential providers;

- drafting of a guide for the selection procedure;
- appointment of selectors or negotiators;
- drafting of model contracts;
- specification of procedures for official registrations.

- Follow-up of the contract: these are provisions for the entire duration of the contract, and their form depends entirely on whether the authorities play a passive role in accordance with the independent model, or an active role as in the cooperation model.

  - For "Independence", the following is required:

    . the decentralized authorities must sit on various committees and supervise preparation of reports on activities and financial reports;
    . annual evaluation of these reports must be prepared;
    . evidence of non-compliance with the contract must be gathered;
    . the procedures for conciliation and legal redress must be followed.

  - In "Cooperation", in addition to the above, the following is required:

    . establishment of the committees on the network;
    . ensuring that the committees operate;
    . work as a facilitator and communicator of know-how.

- The terminal phase of the contract: when the contract comes to an end, it must be possible to make a final evaluation of the operation of the contract, results achieved and problems encountered, so as to either renew or terminate the contract. This calls for close examination and specific investigations.

  This phase is important, especially when the provider does not manage to comply with contractual obligations (whether or not there be goodwill). Non-renewal of a contract poses problems. A replacement must be found. Above all, unless the provider has committed serious errors or misdemeanours it is always difficult, especially in dealing with an NGO that owns the health facility, to withdraw the right of management and give it to another institution.

7.2 HOW CAN THESE DIFFERENT ASPECTS BE RECONCILED?

There are therefore two problems:

- one concerns lack of capacity in the ministry (at every level): the Ministry of Health needs staff with very specific skills who are not to be found in the Ministry, or probably even in the country or among the development partners;

- the other concerns provision of these skills within the Ministry of Health. At present, some of the skills that must be used in this approach (information, statistics, supervision, etc.) are scattered around the Ministry of Health; others do not exist. It seems necessary to unify training for the approach if responsibilities are not to be dispersed, with a consequent failure of the contractual approach.

This unity of the training arrangement is of strategic importance. It must be the backbone of the Ministry of Health, since that is what guarantees the quality and equity in access to health care.

Some, however, advocate separation of technical support from conventional administration:

- Technical support: as we have seen throughout this document, this contractual approach, especially because of its novelty, calls for high-level technical supervision. Most of the providers of services today find it difficult to prepare reliable contracts. If they need assistance to do so, many are likely to think that the conventional administration is not able to give them the technical support and advice they need: they have no confidence in an administration which would be judge in its own case, since it is the administration also that signs the contract with them. Some therefore think that, to be effective, this technical support should come more from the providers of services themselves than from the administration. Without being totally independent of the administration, the technical support should have enough autonomy to be of help to the providers. The resulting structure might take the form of a technical union or an agency, a flexible structure that could give its members the advice they need;

- The institutional function: the authorities, i.e. the administration, must keep its roles of inspection, monitoring and monitoring. It also signs agreements with those chosen to provide health services. In order to discharge those roles it must also have the requisite skills. In this set up, the administration no longer does the technical work associated with the contractual approach, but it retains the power to sign contracts and the technical supervision of the agency. It thus guarantees the proper running of the health system.

7.3 STRATEGIES

This institutional analysis shows clearly that few Ministries of Health today have the capacities to run such a process properly, and many use this argument to invalidate the contractual approach. But the complexity of the approach should not be used as an argument against it. The strategy to be employed will be brought in gradually. At first, the Ministry of Health and its partners must use simple contracts: these will of course be incomplete and would not satisfy a bench of finicky jurists. But this strategy will enable the Ministry of Health to retain control of the process. Furthermore, the Ministry can choose to conclude agreements first of all with partners of known reputation.

In this way the incompleteness of the contract and the shortcomings in thorough evaluation of the results can be compensated by the "confidence capital" placed in the contractor. The painstaking preparation of an extremely detailed contract is needed above all when the partner is not actually trusted, or when it is suspected that the partner will take advantage of vagueness of the contract to spurn its spirit.

In the first stage, therefore, by developing understanding with partners deemed worthy of trust, the Ministry of Health can develop its skills and thus demonstrate the use of the contractual approach. It is only gradually, gaining experience and credit among partners, that it will be able to extend the range of its partners and adopt an approach that is more geared to competition and the rules of the market. With its experience, it will then be able to draw up sophisticated contracts protecting it from any abuses and enabling it to ensure that agreements are respected.

Such a strategy is a matter of time: it will take several years for the overall situation to be mastered by both the State and its partners. Even if the State were very quickly able to gather the skills to master such a process (which is not usually the case), it would need time to win the trust of its partners. It should be assumed that the partners do not automatically trust it, since in many cases they have experienced the State's inability to support implementation of effective health services. Private providers' suspicions of the State and fear of State interference, cumbersome legislation that makes negotiations uncertain, and various political pressures, all obstruct this contractual approach. In this scenario the support of a technical body that comes between the administration and the providers of services can be useful.

In strictly financial terms, the attractiveness of contracts proposed by the government can also be compromised in countries where the political or macroeconomic climate (Barnum et al. 1995) are unstable, since those conditions make the investment more risky.

7.4 THE ROLE OF DEVELOPMENT PARTNERS

Of course, certain partners have already gone through types of contract with the Ministry of Health or the Ministry of Planning for instance: an NGO cannot usually operate in a country until it has signed an agreement with the authorities. However, the contractual approach as described here is a true innovation, since it goes far beyond a simple agreement. It is also promising. But as we have stressed several times, the difficulty in least-developed countries will be in the lack of skill in this type of approach among those involved. Ministries of Health and health service providers rarely have the capacities to embark on this approach.

If development partners are convinced that this is the right approach, they must help the countries that choose it to build their managerial capacity for the appropriate work. The emphasis must be placed on training that gives more skills in management, marketing, commercial law and negotiation techniques. It must also develop research: so far we know very little about these reform processes and their effects, especially in terms of equity and effectiveness.

However, one must also consider that development partners do not necessarily know a great deal more about this subject. Few have been trained in these new approaches. We are dealing with an area where least-developed countries and their partners in development must work together to build a new environment. This challenge is interesting in more than one respect; if well managed, this movement could renew collaboration, in the true sense of the term, between developing countries and their partners in development.

8. PRELIMINARY INVESTIGATIONS IN COUNTRIES

8.1 NEPAL

8.1.1 The increasing role of the private health sector in Nepal

A number of studies on health expenditure in Nepal have concluded that private expenditure is predominant. It is estimated that in 1993-1994 household health expenditure accounted for

73.9% of national expenditure on health.[19] Private expenditure is mostly on drugs and consultations with physicians and other health workers (in both the conventional and the traditional sectors). Some of this private expenditure is spontaneous: patients out of habit or convenience, go to a private doctor or private pharmacy. But part is caused by the inadequate performance of the public health sector. Some patients would like to go to health centres or hospital but they do not because they assume that quality of care will be poor (for example drugs will be lacking) or because they know that a physician will not be available outside working hours. Such patients therefore go to private pharmacies or doctors' surgeries that stay open longer.

Everybody expects the Nepalese private sector to retain or even increase its influence. Many physicians are tempted to set up private practices while maintaining their working hours in the public sector. Furthermore, a number of physicians, especially in town, and surgeons, want to set up their own clinic and work there full-time. In view of this potential drain of human resources towards the private sector, it might perhaps be possible to conclude agreements with professionals in the private sector or even establish private practices within public facilities, so as to retain as many health workers as possible within the public facilities.

At the same time, Nepal is developing village committees or associations that are capable of managing health services more or less directly. Are such bodies capable of creating attractive conditions to persuade medical personnel to work in the non-profit-making area of health services?

It is the role of the State in organization of health services that is at stake. In a health system with various producers of health services, the State is more of a regulator of the health system as a whole. The issue at stake is respect for the objectives of public health in the health system as a whole.

8.1.2. Towards a system of contracts in the interests of public health

The production of health services, when it comes from a variety of providers with very different statuses, cannot be left uncoordinated. Health is not a good like others and there is a public health interest that must be respected, as the first chapter explains.

The State can influence that production, but it is not the only agent with the opportunity to do so: others can act, especially through financing mechanisms: individuals act in various groups and businesses may also exert an influence.

The influence of the State can be exerted in three ways:

1. *as financier and producer*: by setting up health services itself; these can enjoy varying degrees of autonomy;

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[19] S.P. Shrestha and B.R. Shrestha, "Analysis of Health Economics in Nepal, Ministry of Health", October 1995, chapter 2 (p. 13). See also, for a prior empirical analysis, P. Mathema, "Analysis of Available Resources for Publicly Provided Health Services", in Ministry of Health and WHO, Second Seminar on Health Economics and Health Care Financing, Katmandu, Nepal, November 1993.

2. *as financier*: the Ministry of Health has financial resources which it can deploy to influence the behaviour or practice of certain health service providers, through contracts;

3. *as regulator*: (i) as administrator, the Ministry of Health may authorize providers of health services to operate: it can thus negotiate licences, thus influencing the behaviour of the providers; (ii) by passing laws and issuing regulations which all providers of services must respect (health codes, legal framework for health facilities, ethical code, etc.).

The first alternative does not depend on it alone; the other two bring into play separate partners with which it may negotiate; those partners can be the health facilities of NGOs, private physicians, private clinics, private pharmacies, cooperative clinics or surgeries, health departments of firms and finally the health personnel of public facilities. The central authorities can also entrust these processes to decentralized entities such as autonomous regions and communities.

Long-term planning of the health sector in Nepal is now underway. What follows is not a set of solutions currently in force in Nepal, but the main lines of discussion. For each situation described below, we will consider both the aspects of contractual arrangements concerning the authorities and those concerning financing or production of health services.

8.1.3 An outline of contracts

Provider of services / Financier and/or regulator	State	Village development committee	Various associations (NGOs, cooperatives)	Businesses
* State health facilities	Plan contracts[20] • Authorization to negotiate private practices within those facilities[21]	Contractual arrangements[22,23] with providers of service:	Contractual arrangements[22,23] with providers of service:	Contractual arrangements[22,23] with providers of service for the benefit of the employees
* NGO health facilities	Public service concession			
* Private physicians	Contracts for primary health services			
* Private clinics	• Contracts for hospital and outpatient services • Tax exemptions for services rendered			
* Private pharmacies	Contracts for distribution of MEG			
* Cooperative clinic or surgery	• Arrangements for authorization to operate • Contracts for hospital or outpatient services			
* Health services in business	• Contracts for hospital and outpatient services			

[20] Where public facilities providing health care enjoy a certain autonomy, the State must set out agreement with them through a contract such as a plan contract.

[21] Where public facilities providing health care enjoy some autonomy, once authorization has been obtained from the State, it is the facilities that negotiate contracts with health personnel to organize private practice within the facilities;

[22] Directly or through specific mutual funds.

[23] Contractual arrangements may have the following features: rates, modes of reimbursement for funds, type and quantity of services, arrangements for openness to the general public.

8.1.3.1 Contracts between the State and providers of health services

First case: contracts with the health facilities of NGOs

The contractual arrangements that the State can conclude with the health facility of an NGO fall into two categories: (i) "complete" arrangements covering the entire range of health services, and (ii) "specific" arrangements, on problems such as family planning, oral health or nutrition.

(i) "Complete" arrangements

The question for the State is whether this NGO health facility should be included on the national health map. If so, the State will contractually authorize and also oblige the NGO to act as a facility that is part of national coverage. The contract will then be along the lines of a **public service concession**. The health facility will be fully recognized since it is part of the health map; but this recognition comes with duties, the main one being that of catering for the population of the area. The contractual arrangement will stipulate norms that must be respected by the health facilities, especially in terms of staff (number and qualifications).

The contractual arrangement may involve certain financial commitments for the State: cofinancing of the building, a share in recurrent charges, the financing of certain activities such as tuberculosis screening and school health, and also attribution of State employees.

Of course, the contractual arrangement also covers procedures for monitoring and evaluation of performances. Depending on the degree of collaboration and involvement stipulated in the contract, the State may be regarded as either a "passive" partner whose role is restricted to checking that the agreement is respected, or an "active" partner which gives real support to the health facility, in terms of management, training, etc. In the latter case, the agreement is in the spirit of a **franchise contract**.

(ii) "Specific" arrangements

In this case, the State does not wish to regard the health facility as one that is able to respond to all the health problems of the local population, but simply as a facility that can respond to a health problem for which is has recognized competence. It may be a general health facility, one which addresses all health problems, though the State is only interested in some of its activities, or it may be a specialist facility which deals only with certain problems, such as nutrition or family planning. The type of contractual arrangement that the State can have with such facilities accords with the logic of the case described above.

Second case: contracts with private physicians

In addition to the legal authorization to practise private medicine, the State may conclude agreements with some of those private physicians. Such agreements can be of many types. We shall consider two:

(i) For a given area the Ministry of Health might negotiate a contract with a private physician for services to be supplied to the population. It might, for example, be decided that, since the local health centre has no physician under a public contract, the private

physician will take referred cases for certain health problems. The contractual arrangement would then state where the services were to be provided: whether in the physician's surgery or in the district health facility.

(ii) The Ministry may propose an agreement for a specific service. One example is the recent "DOTS" treatment for tuberculosis;[24] in order to be effective, this treatment requires special supervision: each TB patient is associated with an "observer" who regularly checks whether the patient has taken the necessary drugs. The observer then passes the information on to a "coordinator", who receives from the Ministry information on standards, teaching of observers and supply of drugs.[25]

It is obvious that private physicians could be involved in the DOTS treatment of their patients through a **franchise**. It would even be possible for a group of private physicians to be associated as a group running a "DOTS centre". This centre could be open to patients outside normal working hours. It could also provide microscopy and gather the necessary information on patients and their progress.[26]

Third case: contracts with private clinics

We refer to private clinics that can admit patients; at present, maximum capacity is around 60 beds. In Nepal, there is increasing demand for private hospitalization, especially in the urban middle class. These services can compete with those offered by public hospitals. The patients say that they get better treatment (better personal care for the patient, better hygiene, and advanced diagnostic techniques).

Such clinics have great potential in Nepal, and the State might consider bringing them in closer to the national health system. Through agreements concluded with these clinics, the State could grant tax advantages that varied with the degree of integration in the health system. For example, clinics offering affordable services, or which offer health education, or which are part of the EPI, could benefit from tax deductions or exemptions on specific goods or services (such as medical equipment or drugs).

Similarly, financial incentives could be provided for the private physicians of those clinics who are prepared to work a number of hours in a public facility.

Fourth case: contracts with private pharmacies and outlets

Essential and generic drugs are not yet sufficiently prominent in Nepal, since private pharmacies prefer to sell brand names. In order to improve this proportion and gain better access to care for the people, the State should seek agreement with private pharmacists whereby they would sell more generic and essential drugs. The State can conclude agreements with each private

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[24] DOTS means "Directly Observed Treatment through Short-course".

[25] Joel Almeida, Vikram Pathania & Charles Holmes, An ordinary innovator's introduction to TB cure/DOTS, WHO, Global Tuberculosis Programme, 11 July 1996, p. 2.

[26] Global Tuberculosis Programme, The role of private health care providers in TB control/DOTS with a focus on India, WHO, July 1996.

pharmacy; it would no doubt be more effective if such agreements were part of an umbrella agreement signed with the Guild of Pharmacists.

There are parts of Nepal where shopkeepers[27] sell essential drugs. It is rightly pointed out that that practice is not ideal, but it suits mountain people who live far away and often in isolation from villages and towns. For them the shop is the only source of drugs. The Ministry of Health cannot ignore this situation. Rather than leaving it unregulated, with all the attendant risks, it can seek to govern it by offering deals to the shopkeepers. In exchange for a licence to sell drugs, the shopkeepers would receive basic training from the Health Ministry: training in treatment of a certain number of diseases, better knowledge of drugs, and information on their storage and expiry dates. This type of agreement would be along the lines of franchise contracts with both parties collaborating, rather than being some kind of repressive control.

Fifth case: contracts with autonomous State facilities

Facilities providing health services can both belong to the State and be autonomous in their operation: such are public establishments which, while in the end answerable to the State, are to an extent autonomous since they are legally separate from the State. Although the law manages their relations with the State, it is often preferable to spell out those relations in specific agreements that stipulate the commitments of each side. Such contracts can vary in nature. They often derive from the "plan contract": the parties agree on the objectives to be achieved over a given period, and on the resources each side should invest.

Sixth case: private practice in State health facilities

Private practice in State health facilities can take two forms: either the provision of outpatient care on the premises of the State facility by staff of that facility, or the establishment of a private department within the State hospital. In both cases, the State (or the responsible body if the State facility is autonomous) must reach agreement with the party concerned: the officials of the health facility.

The advantages of these practices are well known and can benefit the State health facility, the staff involved and the population. But the agreement must be carefully drafted to avoid differences prejudicial either to the public part of the health facility or to the poorest part of the population which will not have access to the private services of this public facility. It should not be forgotten that public facilities can increase their resources by sharing revenue with the professionals who are involved in the private services of the public facility. This increase in resources can be used also to reduce public charges, or even to offer some services free of charge to the poor.

Similarly, the agreement between the State and the health personnel of the State health facility may give the latter the option of private work outside the State facility, for example in a private practice or in a private clinic.

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[27] In Nepal, they speak of "drug hill" shopkeepers.

8.1.3.2 Contracts between population groups and providers of services

Population groups are becoming increasingly important in Nepal. These are not decentralized administrative entities but groups formed and recognized by the authorities. Such groups, especially village development committees (VDC), are increasingly being involved in the organization of social and health services. For example, they are concerned with the most decentralized health facilities such as local health posts.[28]

These various population groups are therefore increasingly the partners of health facilities, especially State facilities and those of NGOs, in the organization and management of health services. With them, they reach agreements on the type of services to be established, the prescription of essential drugs, exemptions for the poorest, and allocation of resources accruing from cost-recovery. This involvement should be clearly established. To this end, those groups, with the health facilities, must establish contractual arrangements that define the role of each participant.

But the role of such groups is not necessarily limited to involvement in management of the health facility. Increasingly, there is a new role in operation of financial solidarity procedures.

Whereas charging for services in health facilities is becoming a matter of course, direct payment by the users causes serious problems. Health facilities are ill-placed to set up prepayment mechanisms on the spot that guarantee horizontal solidarity (between the sick and the healthy) and transverse solidarity (between the rich and poor). There is thus a tendency to bring in outside agencies, which can act as insurers, taking in the premiums from families who pay insurance. This body would then negotiate the provision of health care for the population covered with the local health post or with other facilities. It could finance the health care provided by these facilities, paying set prices for services rendered. Another arrangement is possible whereby the group pays the health facilities a set sum per person or family insured.[29]

These bodies can then form a consortium that could contract with the district hospital to provide hospital care for the individuals and families. Here too, there are several possible ways of financing, such as fee for service and payment of a lump sum per person or family.

8.1.3.3 Contracts between companies and providers of services

Companies can set up their own clinic or offer basic care for their workers. For several reasons (including under-utilization of their own facilities), they may be interested in offering their services to the entire population of the area. The Ministry of Health and the various population groups described above, may wish to come to an agreement with these facilities and companies, thus avoiding expensive duplication in the area. A contract is then needed to define the part each has to play. In effect, the health facility of a company will not be opened up to the entire population unless the others involved make some contribution.

Companies can also offer welfare protection to their workers, either (a) by agreement with a local health insurance company, or (b) by setting up its own mutual fund (alone or in

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[28] Called "sub-health posts" in Nepal.

[29] "Capitation payment".

conjunction with other companies). These insurance systems in their turn will establish service contracts with the local health facilities, trying to obtain from them the best service for the contribution they make.

8.1.4 Final remarks

The development of a health system is the result of the activities of many agencies responsible for regulation, production of services and financing. Each has a role to play. Nevertheless, it is up to the State to discuss and establish health policies in collaboration with the various agents.

For the sake of simplicity we have concentrated on contractual relations involving only two partners. In real life, the situation is often more complex and involves several partners simultaneously or successively. This is true, for example, of a public hospital that has autonomy: the contractual arrangement could cover the management committee of the hospital, the State and an insurance company. In another case, a company will conclude an agreement with the management of the mutual fund, which in its turn will sign agreements with various providers of health services.

In the case of Nepal, the main brake on development of these mechanisms is not in the desire to establish new contractual practices among the agents in the health system, but rather the skill to do so. At present, neither the Ministry of Health nor various agents of the health system has the skill or the experience. Gradually and together, they must find the way to master this process.

8.2 MADAGASCAR

The national health policy of Madagascar has made its first strategic priority the "decentralization of the national health system, which must have at its base the health district; this decentralization implies an effective transfer of powers and resources". Furthermore, Decree No. 96-169 empowers the communities to manage the basic health centres (and the primary schools), which entails transfer of responsibility from the Ministry of Health to the municipalities. The Ministry of Health, in section 1 of the Plan that it has just finalized, aims to conclude agreements between the district management teams and the municipalities.

Furthermore, the municipalities should then have the right to choose how to manage its health facility: either managing it itself (perhaps through an agency), or authorizing a provider of care to run it (a non-profit-making association, a users' association, or a private commercial agency).

The country is therefore moving towards a contractual approach, but there is a long way yet to go. Before the legal changes implied by this approach are contemplated, the procedures must be defined and the problems identified. Here, by way of example, are a few of the questions that were raised during a recent mission to the country by one of the authors of this document, on the transfer of the basic health centres to the municipalities:

- The problem of management of the staff of the basic health centres: Who manages them? Who pays them? Who appoints them? Who supervises them?

- Do the communities, which are newly established, have the capacity to conclude agreements with the district management teams and with management associations?

- Are district management teams also entitled to sign contracts? Are they able to monitor and evaluate the performances of the basic health centres in this new set-up?

- If each basic health centre has a specific contract, is this a district approach, i.e. an overall vision of the health district? How can we envisage an approach in terms of the district health development plan if each health service has an agreement of its own?

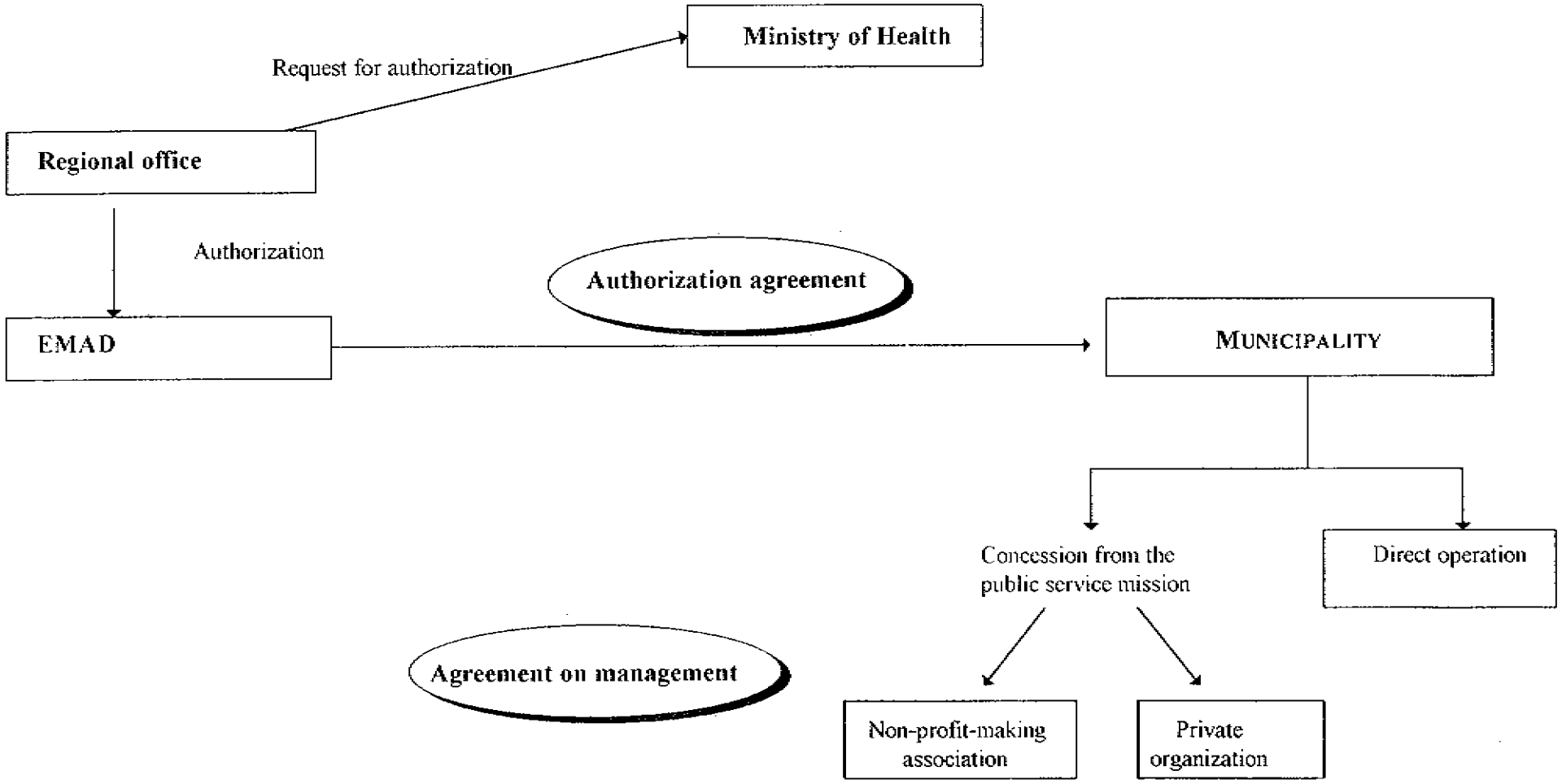
- What is the role of central level in such an approach? What support can it give to district management teams? Should it, as the master plan states, define criteria for accreditation, giving the district management teams standards by which to select the nonpublic health care providers with whom a contractual arrangement could be made at district level?

Although it has declared its intention to go along the road of contractualization, the Ministry of Health has not yet given specific form to its intentions. Since the appearance of Decree 96-169 there has not been a significant operational advance. However, it seems that a number of development partners are prepared to help the Ministry of Health to launch a number of experiments.

8.2.1 The project to build up health services in Mahajanga Province

The regional health development office of Mahajanga Province, in collaboration with GTZ and CIDR (the International Centre for Development and Research, France), is now moving decisively towards the contractual approach. In 1992, community participation was introduced into the health system. To this end, users' associations were set up which (1) autonomously manage the village community pharmacies, and (2) jointly manage the basic health centre with the health personnel. There are also joint financing and joint management programmes between the district management teams, the users' association and the head of the health post.

Since the decentralization process began, subsequently, the project has found it necessary to give a specific interpretation and operational effect to Application Decree 96-169. This is why the "model for decentralized joint management of a basic health centre" has now been put forward. The proposed experimental arrangement can be summarized in the following chart (adapted from the chart put forward by GTZ in Madagascar):



Adapted from the GTZ Madagascar plan

The proposed move, which is the object of operational research on these projects supported by the regional office and other funders, will take place in two phases:

- Agreement on authorization: this governs relations between the district management team and the commune. It is a mutual commitment that defines the missions of the health establishment (predetermined by the Health Ministry or negotiated case by case?), determines the mode of management of the basic health centre that will be chosen by the commune, determines the resources (especially human resources) that will be attributed both by the district management team and by the commune. This agreement also stipulates the relevant cost-recovery system.

- Management contract: if it does not itself run the basic health centre, the community will entrust its running to a legal entity which could be either something along the lines of a "users' association" or a private entity. This operator must then sign a contract undertaking to respect the public service mission of the health facility, and set up a management committee with the health workers of the basic health centre. At this level, the Project will still prefer management by a users' association.

If the process recognizes two types of agreement, it is recommended both be signed at once.

The project supported by GTZ still needs some fine tuning, but the framework is there and it will certainly serve as a reference for all those who go in that direction. The experiment will have valuable things to teach us about other regions of the country, and also for other countries where those actively involved in the health system are asking similar questions.

8.2.2 Investigations of the European Union

The European Union has begun preparation of the eighth FED in Madagascar. Among the preselected components are support for development of the private sector. It should be noted that 40% of the 4500 physicians in the country are out of work. It is a matter of urgency to put the potential of these physicians whose situation if often very precarious, at the disposal of the most vulnerable populations. It should also be considered that some rural areas have no health facilities at all. The European Union, following the same line as the ILO's initiative in 1990, would thus offer to set up these out-of-work physicians in areas where there is no care; in return for the assistance they would receive, the physicians would sign a contract committing them to public service work. This is not therefore support for the establishment of conventional professional medicine, but establishment of a true public service mission in a given geographical area.

It will therefore be a matter of making contracts that set out in detail the duties and obligations of both the decentralized administration of the health district (the district management team) and of the physician signing the agreement. Though this initiative is very promising, it has its problems: does it mean that areas where such physicians are established will never have a basic health centre? Will the communities concerned not be tempted to set up basic health centres, at the risk of making the establishment of the out-of-work physician nonviable?

Finally, we should note the choice made by Madagascar to consider provision of health services at district level that are based more on a contractual relationship among those involved than on the traditional approach involving delegation or decentralization. Whereas the principles seem to be accepted today, the practice calls for a great deal of thought. The Ministry of Health

should therefore acquire the skills to run this movement, which is undoubtedly going to develop further in the country.

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