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THE ROLE OF CONTRACTING IN IMPROVING HEALTH SYSTEMS PERFORMANCE

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THE ROLE OF CONTRACTING

IN IMPROVING HEALTH SYSTEMS

PERFORMANCE

by

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INTRODUCTION

People's health has improved considerably in the course of the twentieth century. Proof of this is the spectacular increase in life expectancy; barely half a century ago it was no more than 48 years whereas today the global average figure is 66 years. Numerous determinants have certainly contributed to this; broad sectors of the population have seen their income increase, better working conditions have made life less harsh and dangerous, food has become healthier and individual and collective hygiene have improved. Moreover, the higher level of education, especially that of women, has led to a better understanding of health issues. In addition, medical knowledge and practices as well as methods of treatment have made great strides in recent decades. Finally, the organization of health systems, which broadly developed during the nineteenth century, has made it possible to coordinate efforts, notably under the aegis of States favouring conventional universalism, in other words free access to all types of care for all.

Nonetheless, despite all these efforts, the performance of health systems is still too often unsatisfactory. As the World Health Report 2000 *"Health Systems: improving performance"*, points out "these failings result in very large numbers of preventable deaths and disabilities in each country; in unnecessary suffering; in injustice, inequality and denial of basic rights of individuals. The impact is most severe on the poor, who are driven deeper into poverty by lack of financial protection against ill-health". The supply of services, both public and private, does not always meet people's needs.

It is true that in recent years, health systems' organization has undergone a considerable evolution. One factor which has unquestionably contributed to these changes has been the mitigation of rivalry between the public and private areas in all spheres of economic, social and political life. In an effort to make up for the inadequate performance of their health systems, most countries have undertaken reforms. Political decision-makers had several choices: devolution allows more authority to be vested in local Ministry of Health officials; administrative decentralization is a means of transferring responsibility for health to a local authority; autonomy for public providers is designed to endow health facilities with autonomy, within the public sector, based on legal status; separation of funding bodies from service providers allows competition between providers, whether public or private to be introduced; the broadening of the range of possibilities for funding health, through risk-sharing arrangements, makes possible the emergence of an actor charged by its members with negotiating access to care; privatization, at least in the conventional sense, involves transfer of ownership from the public to the private sector; development of the private sector is a strategy option for political decision-makers wishing to withdraw from the provision or funding of health services.

However, these institutional reshufflings do not always yield the expected results. The different actors carry on in isolation and fail to seek the synergy that would be beneficial. Likewise, the way in which the supply of health services is organized is broadly based on hierarchical authority, on a vertical command structure, which is not conducive to participation by all.

Nevertheless a new approach endeavours to make good these shortcomings. Actors are striving to come out of their isolation and to set up coordinated actions in order better to respond to the demands and needs of people. The relationships they develop may be based on consultation; exchange of information and the development of joint principles for intervention (joint declaration, charter, etc.) are some of the forms this may take. However, there are limits to this moral commitment. Accordingly, it is increasingly common for such relations to be based on contractual arrangements, which formalize agreements between actors who accept mutual commitments.

The first part of this document describes recent trends in health services organization, more particularly in the developing countries, together with the gradual emergence of contracting as one of the tools available for improving the organization of health system. The second part of the document focuses on the diversity of the situations to which contracting may apply and on the opportunities offered to countries, bearing in mind that the possible choices must above all be based on an analysis of national situations. The third part stresses the risk of uncontrolled development of *ad hoc* contractual arrangements and examines the need to resort to contractual policies that provide a reference frame for each contractual arrangement, thus making possible a health systems approach. Part four examines the role of the State, and more particularly of the Ministry of Health as the guardian of peoples' welfare; contracting means that the State acts and intervenes in a wholly innovative manner. Lastly, part five highlights a number of lessons to be drawn from the experiments currently under way in both the developed and the developing countries.

1. THE EVOLUTION OF HEALTH SYSTEMS ORGANIZATION IN DEVELOPING COUNTRIES

Until the end of the 1970s, in many developing countries the organization of health systems involved two actors: on the one hand, a public system that was entirely organized by the central State which enacted laws, norms and regulations, laid down health policy and ran health facilities that were financed by public revenue and public assistance, and on the other a private system, either for-profit or run by the churches, and which operated independently and in complete autarky[1]. That is two tight worlds. In line with the then prevailing welfare state rationale, most of these countries opted for a free and State-run health service. It is true that during the period, the different private sectors developed, although in a compartmentalized fashion and almost without the State knowing.

The sway of the welfare state philosophy came to an end at the beginning of the 1980s. The Governments of the developing countries found themselves forced to address profound financial crises as a result of which virtually all of them introduced restrictions and/or reforms. The situation of the public facilities deteriorated inexorably. States long endeavoured to resist the deterioration. They would not or could not admit their failure. Shortages gradually and insidiously became the norm.

A more manifest desire for "active privatisation" (to use J.Muschell's expression[2]) then emerged, in which Governments, following the general trend towards privatization of the public sectors, encouraged private actors to emerge in order to enhance the efficacy of health services. Transfer of ownership in the strict sense of privatization was the exception. It took the form rather of the expansion of NGO, in particular non-denominational health facilities, and the development of private clinics and private practice.

Nevertheless, both these periods were heavily marked by rigid compartmentalization of the efforts of health actors, with each of them setting up its activities in its own environment. But at the same time, as each of them wanted to extend its sphere of influence, we also witnessed rivalry or clashes: installation of a new public health centre in the vicinity of an existing private centre; failure of a private practitioner to refer patients to the public hospital, etc.

For some ten years now, it has been possible to observe a marked evolution in the organization of health systems. This is no doubt largely attributable to the disappearance of the public–private ideological confrontation. There have been far-reaching reshufflings which have taken two directions: on the one hand, the number of actors involved in health has increased and become more diversified under the dual pull of private sector development and of processes of democratization and decentralization, fostering the emergence of a civil society and of structured and responsible local authorities. On the other hand, this trend has gone hand in hand with sharper separation of roles; actors have increasingly specialized in a particular health system function: provision of services,

procurement of services, management of health facilities, health financing and health system regulation.

1.1. THE DIVERSIFICATION OF ACTORS

A situation in which the public sector, represented solely by the Ministry of Health, and a private sector, whether for profit or not, ignore or clash with one another to provide health services is increasingly remote from reality. Reshuffling has taken place first of all within the health system and then among the sector's actors. Thus, recent years have been marked by two far-reaching changes which have resulted from the diversification of the ways in which public services are managed:

- *Devolution*: the heavily centralized administration which has long prevailed is gradually being replaced by an administration to which authority is devolved. Devolution within the health sector has essentially developed through the organization of a three-tier health system: central, intermediate (regional) and local (health district)[3].

- *Autonomy*: while appreciating that a health services production unit operating along traditional lines of administrative management acts as a check on the efficacy of such facilities, but at the same time appreciating the undesirability of privatizing the facility or entrusting its management to a private institution, the Ministry of Health may opt to endow it with a status that allows it autonomy. While remaining part of the public sector, the health facility possesses legal personality to perform a public service mission and enjoys administrative and financial autonomy. This autonomous status currently extends to various types of health service: first and foremost hospitals, but also agencies responsible for procurement and distribution of drugs and medical supplies and training schools.

This diversification has also involved the arrival on the scene of operators from outside the health field:

- *Populations:* during the first half of the twentieth century, modern medicine has been marked by the growing role of hospitals as a tool for improving people's health. Moreover, health professionals determine peoples' needs using technical criteria based on the progress made by medicine. In such circumstances, the involvement of populations is virtually non-existent. From the early 1960s, this vision was called into question, first of all on economic grounds, but also because people do not always react as health professionals would like them to: they take time to consult, fail to comply with treatment and neglect prevention… The trend is gradually reversing: people's involvement has to cease being passive and become active. This approach was vindicated by the Alma Ata Declaration on Primary Health Care of 1978. The initiative taken by Colombia, where there is an ombudsman (*defensor del pueblo*) officially appointed by the Ministry of Health to act as a mediator for the population is also noteworthy.

- *Local authorities:* administrative decentralization marks a new and far-reaching change in the evolution of health systems. The establishment of local authorities signals the appearance of an actor from outside the health field. Responsibility for health and/or health facilities are devolved to them. Some countries emphasize health status; in this case, local authorities are responsibly for ensuring that health policy is implemented as well as possible. In other countries, it is public health facilities which are transferred to the authorities; they are required to ensure they are properly run;

- *Institutions specialized in risk-sharing*: necessary as it undoubtedly is, direct payment for health services has limitations which are now well recognized, in particular as regards access and equity. For a time, it was believed that these shortcomings could be overcome by risk sharing within and by health facilities. However, and this is particularly so in the developing countries, health facilities are poorly equipped to play this role. As a result, specialized institutions such as insurance and micro-insurance systems have come into being; on account

of their considerable financial resources, they are capable of influencing the very organization of the health sector.

1.2. Separation of functions

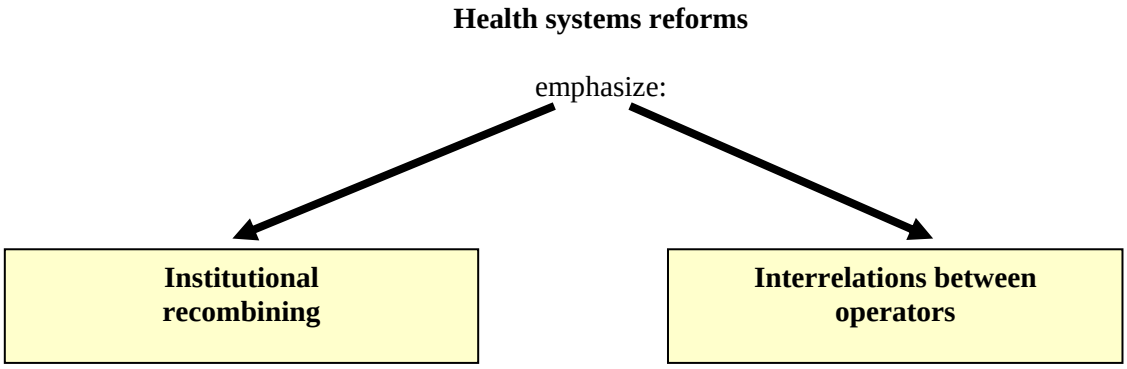
Whereas in the past, a health actor simultaneously played all roles, the trend within contemporary health systems is towards greater specialization:

- *Separation of the financing of health services from their provision*: for many years, these two essential roles were played simultaneously by health actors: naturally, the first to come to mind is the State which, through its health facilities, offers free health services to the population. However, the same is true of health facilities run by charitable organizations. In the developing countries, the practice of cost recovery, -in Africa, the Bamako initiative-, was to set in motion the separation of these two functions. However, this separation is still at an incipient stage, since it is organized within the health facility. With the emergence of prepayment systems, the separation is more marked. Besides, within the public sector, separation of provision from financing was introduced through the emergence of specific agencies responsible for managing public funds. In England, this separation between Provider/ Purchaser is one of the cornerstones of the health system reform [4] initiated by Mrs Thatcher when she was Prime Minister; its purpose was to create virtual markets between these actors. The ensuing competitive spirit has been called into question since Mr T. Blair became Prime Minister;

- *Separation of ownership of capital from the managerial function*: in the most usual organization structures, the owner also performs the management function; he directs the establishment because he is its owner. As a result of the emergence of legislation conferring legal personality on public-sector establishments, the notion of Board of Management emerged, with a dual implication. First of all, an entity responsible for defining the establishment's policy orientations, approving its management and deciding what actions to undertake comes into being within the health facility. [5] Besides, this body, whose members may come from all horizons (users' associations, the population, municipal authorities, and the establishment's staff) [6] is not responsible for the day-to-day running of the health establishment, which is entrusted to an executive management.[7]

- *Highlighting the capacity of the State to regulate relations between the other actors of the health system*; For many years, the State focused on producing and financing health services. Its gradual withdrawal from these two functions compelled it to re-examine its role.[8] As Musgrove observes [9], it is not a question of State withdrawal but of selective commitment: parsimonious use must be made of the provision and financing functions targeting specific objectives while developing regulatory instruments. It is possible to exercise this regulatory role in different ways: for example, by means of accreditation systems making it possible to identify health actors whose actions are circumscribed by national health policy or by laying down a legal framework within which health actors may draw up perfectly legal contracts and negotiate with perfect peace of mind.

This gradual transformation of the roles and status of traditional actors and the emergence of new ones has occasionally taken place without interference; for example, the growing importance of NGOs was not, at least initially, the result of a deliberate intent. However, it was also amplified by the health system reform programmes introduced by countries, frequently with the support of their development partners. The emphasis was then placed on institutional reform as a prerequisite for any improvement in health systems performance. Institutions with better defined objectives, enjoying greater autonomy and acting in greater proximity to populations should be the guarantee of greater efficiency. These health system reforms are part of a broader trend towards New Public Management[10].



- *The rationale for institutional recombining*

In our view, institutional recombining is a prerequisite for improving health systems performance. When faced with a poorly functioning health system, several options are open to political decision-makers:

> - devolution vests greater responsibility in local Ministry of Health officials; thus, in this setting, the district chief medical officer will no longer require prior authorization from the Ministry to implement certain activities;
> - administrative decentralization allows some responsibility for health to be transferred to a local authority; for example, the State may decide that municipalities rather than the Ministry of Health will be responsible for running public health centres;
> - autonomy for public providers is intended to assign, within the public sector, to some health facilities autonomy based on the definition of a legal status;
> - separation of funding bodies from providers makes it possible to introduce competition between health providers, whether in the public or private sector;
> - broadening the range of health funding options, through risk-sharing arrangements, makes possible the emergence of an actor, whose members (the population) have charged it with negotiating access to care;
> - privatization, at least in the conventional sense, entails a transfer of ownership from the public to the private sector;
> - development of the private sector may represent a strategy for political decision-makers wanting, by this means, to withdraw from providing or funding health care.

As a rule, these institutional recombining policies go hand in hand with regulatory measures; in order to mitigate the undesirable effects of these measures which, in one way or another, entail greater "privatization" of the health system, political decision-makers are generally inclined to accompany them with control and support measures based either on tighter control or incentives[11].

The concept of privatization

At first sight, privatization seems a simple concept. According to the conventional dictionary definition, privatization refers to the transfer of ownership of a public-sector entity to the private sector. Its antonym is nationalization.

In ordinary usage, privatization has only this meaning. In this context, it is impossible to interpret contracting as a form of privatization. This is because privatization supposes a change in ownership whereas contracting starts with the existing situation in terms of the actors present and seeks to establish relations between them.

However, in the specialized literature on the reform of the State, the concept of privatization has taken on a wider meaning: privatization also encompasses the adoption of a management model that draws on the rules of the market. If we apply the rationale developed by D. Rondinelli and M. Iacono[12], privatization of this sort may be achieved in several ways:

- By transferring ownership[13]: as in the case of a public enterprise whose ownership is transferred to the private sector, what is involved here is transfer of the ownership of certain public entities (hospitals, health centres, a laboratory, a drug distribution service, etc) to the private sector. This is described by some authors as State "disinvestment":[14] the structure's assets are partly or completely sold;
- While preserving public ownership, ensure that public entities adopt the managerial practices of the private sector: suppression of arbitrary subsidies and public monopoly status, institution of a status under which the entity is autonomous, possibility of outsourcing certain tasks, use of non public-sector work contracts. The public entity adopts private-sector managerial techniques: it becomes an independent enterprise and is less and less part of a larger whole as in the case of an administration ;
- While preserving public-sector ownership, entrusting the management of public entities to the private sector: delegated management;
- While preserving control over public funding, purchasing services from private providers, regardless of whether they operate from health facilities;
- Persuading the private sector to take the place of the public sector: in this case, ownership is and remains private, but the private entity takes the place of the public actor which previously performed the activity.

We can thus say that in each of the above five situations, the health system will be increasingly privatized because it will operate more in line with the rules of the market.

However, some strategies may limit privatization: for example, persuading the private sector to collaborate with the public sector: in this case, ownership is and remains private, but the entity agrees to align its activity on national health policy. This could be described as greater State intervention.

There are thus three factors that allow us to assess privatization in terms of:

- ownership of the structure: as generally understood, this involves transfer of the ownership of the structure from the public to the private sector;
- management of the structure: the structure is managed in accordance with the rules of the market and the private sector. In other words i) users are considered to be clients, ii) services are defined on the basis of demand from clients, iii) the production process is determined by this demand and production costs must be controlled. One corollary of this is the need for the actor to give up the hierarchical administrative rationale and acquire a degree of autonomy;
- the structure's mission or objectives: this involves determining whether there are no constraints affecting the providers' mission (laissez-faire) or whether the State intervenes to define their mission (through contractual arrangements or regulation), and consequently influences the definition of the products.

The table below sets out all these elements:

Evaluation criteria / Reform	As regards ownership	As regards management	As regards mission
Transfer of ownership	**Handover from public to private**	Transfer of ownership privatizes management	**- Laissez-faire or - State intervention through contractual arrangements or regulation**
Grant autonomy to public structures	Status quo (public)	**Operating more in line with market rules**	Quasi status quo (public)
Handing over management of a public facility	Status quo (public)	**Handover from public to private**	Quasi status quo (public)
Persuading the private sector to take the place of the public sector	Status quo (private)	**Replacement of a public by a private actor**	Quasi status quo (public)
Nb: bold characters show the elements mainly affected by privatization			

- *The rationale of interrelations between actors*

The rationale of the relationship between actors, -which for the sake of convenience, we shall call contracting -, accepts institutional arrangements as a element of the system, regardless of whether they are the fruit of the status quo or of a reform. The strategy is thus based on coordinated action by health actors to improve health system performance. Better coordination and combination of the efforts of each actor in implementing a national health policy is intended to improve the efficacy of each of them. However, for individual efficacy to become overall system efficacy, mechanisms for regulating these relations need to be introduced.

This document adopts the second of these rationales. While not disregarding the rationale underlying institutional recombining, it considers it as a fact. As regards decision-making, it places itself at the point where the decision-maker plans to choose contracting from among the range of solutions available to solve a given problem. The document thus endeavours to illustrate the opportunities offered by contracting and the means of making effective use of it; it also examines the prerequisites for its success and the potential pitfalls. In particular, the document will attempt to stress the danger of contracting turning out to be merely a tool at the service of private interests without regard for the community, and of its consequently bringing about no real improvement in health system performance. The document will then explore the contractual policy as a tool for regulating contractual arrangements between health actors.

2. THE RATIONALE OF CONTRACTUAL RELATIONS

The combined effect of the diversification of actors and the separation of roles has made health systems more complex, making it no longer desirable, for a number of reasons, for them to operate in isolation (efficiency, equity, etc.); actors have gradually realized the need to build relations. We need to consider their actual form. The forms taken by these relations are not insignificant. One path followed to avoid isolation is coordination. Here are some of its forms:

- *Recognition of the other* means acknowledging that one's counterpart is a worthy partner. Simple as it may be, in practice this is not always easy: it is hard to overcome a sense of superiority (in the case, for example, of the administration) or of uniqueness (as in the case of a religious NGO). Recognition may even be formalized; a system of accreditation thus becomes a means of coding mechanisms offering recognition. Accreditation constitutes recognition of a counterpart's legitimacy, its skills and activities.

- *Coordination*: through coordination, actors exchange information and opinions both on the fundamental values and the conduct of their activities. The exchange may be very informal (coordination meetings) or lead to the drafting of joint principles of intervention (joint statement, understanding, charter…). There is certainly a moral commitment, but such relations create no obligation in the legal sense.

There are limits to these relations; some actors realize that their relations with others call for more formal commitment. The contractual arrangement is a tool that meets their expectations because it will strengthen their relationship. There are numerous definitions of a contractual arrangement. We offer the following: *a voluntary alliance between independent partners who accept reciprocal duties and obligations and who each expect to benefit from their relationship*. There are three important elements in this definition:

- The notion of voluntary alliance between independent or autonomous partners means that an actor may not be compelled to enter into a relationship although, at the same time, an actor must be capable of doing so, in the legal sense, in other words he must possess a legal status as a juridical person. The independence of the contracting parties confers on them equality in the eyes of the law; although in reality it often reveals an imbalance of power between the parties to a contractual relationship;[15]

- Commitment entails reciprocal duties and obligations: this is the very substance of a contractual relationship; however, the level of commitment may vary. Although a contract represents a binding commitment, meaning that it must be complied with, the manner in which this will be done will vary depending on whether it is a classical or "transactional" contract or a "relational" one.[16]

Classical and relational contracts

A conventional contract is determined by the following characteristics: the purpose of the contract is clear, the contract is of limited duration, from the moment of its establishment the parties know exactly what they expect, and the future is foreseeable (exhaustiveness of the contractual clauses).
However, reality is another matter; in many cases, it is not always possible to be certain about the future, the unexpected may occur (such as an epidemic): these hypotheses are the fruit of what economists refer to as bounded rationality, according to which agents are incapable of correctly perceiving all the choices open to them or all the consequences of their choice. It is impossible to determine in advance all the actions that will need to be taken; it becomes impossible and/or too costly to provide for all possible scenarios (known as the inexhaustiveness of contracts). This is particularly true of complex relations.
Nevertheless the desire to enter a contractual relationship is no less real: we may then talk of a relational contract. A relational contract is based on the parties' confidence that each will act in their mutual interest. Consequently, there is no need for the contract to be exhaustive and detailed; agreement on the main objectives of the relationship, the methods of work and the means to be used to carry out the actions will suffice. The flexibility and cooperation characteristic of this type of contract are intended to secure not only its permanence, but also contractual efficiency and peace of mind.

Classical contracts are wholly enforceable; for this reason, contracts will contain penalties for failure to comply with their clauses; their application is ensured by third parties outside the contract, such as the legal system (the courts). Relational contracts, however, are not enforceable. When a bilateral cooperation agency signs an agreement with a friendly country's Ministry of Health to build a hospital, a commitment is certainly made by both parties; however, it will obviously be difficult for the beneficiary country to compel the bilateral cooperation agency to fulfil its commitments. The same is true of global partnerships such as the Global Alliance for Vaccines and Immunization. Fulfilment of commitments relies on mechanisms other than penalties: the credibility of the agents, their notoriety or reputation, trust, good faith.[17] Such contracts are "self-enforcing": it is in each party's interest to comply with the contract if it wishes to preserve its reputation and credibility[18,19].

- The benefits of the relationship: actors are not inspired by altruism. They will enter a contractual relationship only if they expect to reap benefits for themselves. It needs to be borne in mind that a benefit is not necessarily solely financial. For example, a humanitarian image may represent a considerable benefit for a pharmaceutical company. Moreover, it should strongly be emphasized that we are talking about net benefit; any contractual relationship entails costs,[20] and the examples provided below show that the costs may outweigh the benefits yielded by contractual relations;

Interactions between actors are diverse both in terms of their nature and their scale. There are numerous typologies for contractual relations: some are based on the nature of the contract (public - private), others on the actors involved, and others on the scope of the contract (hospital contracts, drug supply contract…). We propose to group them into three categories depending on the purpose of the contract, i.e. depending on the primary purpose of the contractual relationship: a) a delegation of responsibility, b) a purchase of services, or, c) cooperation. Besides, the strategies followed by the actors may respond to two rationales:

- The rationale of *"somebody else doing it"*: realising that it is not efficient enough, a health actor, will come to an agreement with another actor to perform the activity in its place. This is the rationale of what economists refer to as the agency theory, in other words, the actors are not on the same footing: one of them -the principal- seeks a solution to its problems from an agent who will act on its behalf. In order to secure the best possible service, the principal will take the best bid, and to this end set the providers in competition with one another;

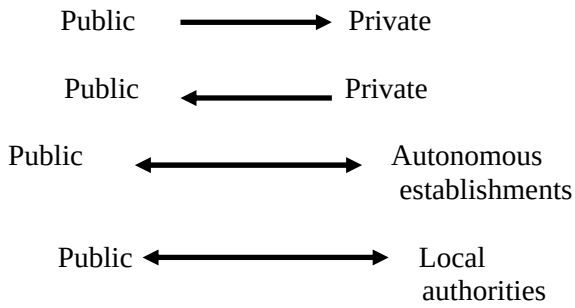
- The rationale of *"working together"*: after having determined where their synergies lie, partners cooperate for a common purpose. The actors in such a relationship consider themselves to be partners who, each in their own way, contribute to solving the problem. Relations between these actors are based on cooperation.

Depending on the nature of the situation, an actor will adopt what it considers to be the most appropriate solution. Whenever (at least) two actors come up with the same analysis, a contractual relationship may come into being. The following examples illustrate the diversity of solutions to which actors resort.

2.1. CONTRACTUAL RELATIONS BASED ON DELEGATION OF RESPONSIBILITY

The rationale is as follows: rather than itself managing the health services it owns or pursuing on its own the development of health services, the State will seek out an actor to do it in its stead. In contrast with privatization, the State retains control over the development of health services by establishing contractual relations with actors who agree to the delegation of responsibility.

This general principle of delegation of responsibility takes various forms which are summarized below:



1. Contracts delegating responsibility to a private actor: Rather than setting up and operating a service itself, the State negotiates with a private actor. However, we need to distinguish between an existing service and one that is to be created:

. Contracts delegating public service: a private organization (such as a private company, association, foundation, trade union or mutual fund) manages a public or State service on behalf of the State. In such cases, the State delegates or devolves work to a private organization. An operating agreement designates the organization as the operator of the public service which is entrusted to it together with specifications determining how it is to be operated. Examples of this are the contract with a midwives' association to operate the Bardot maternity hospital in Côte d'Ivoire,[21] and contracts for a private company to operate hospitals in South Africa. Mali has committed itself to a more systematic approach, because its national health policy stipulates that the State will no longer operate basic health centres whose management is to be entrusted to community health associations (ASACO).

Community Health Associations (ASACO) in Mali

In 1990, the MoH, having realized the limits of a centralized health system, based on hospitals and free care, was to adopt a new sectoral policy, the main thrust of which was greater responsibility for the populations who would henceforth be responsible for managing the Community Health Centres (CSCOM) through the intermediary of an ASACO. The ASACOs manage CSCOM; both bodies were set up simultaneously in a thirteen-stage process codified by the Ministry of Health and culminating with a mutual assistance agreement signed by the ASACO and the State. This approach is based on shared responsibilities and financial commitments between the population and the State, which are formalized in the standardized mutual assistance agreement providing for the following: definition of the health and managerial missions of the CSCOM, 75% funding for the infrastructure and equipment, including the initial stock of drugs, with the ASACO funding the difference; the CSCOM operates with the revenue from fee paying. Lastly, the agreement sets the terms under which the Ministry of Health is to exercise its supervisory authority, through the district management team and the provisions applicable in case of non-fulfilment or termination of the agreement. Partnership based on contracting has thus been instituted as a principle of national health policy and is applicable to Mali's primary health care system as a whole, thus implying the need for a thorough review of the roles of the State and of the population, with the State abandoning its role of direct provider of basic health care. Nevertheless, there are numerous problems: i) zones that are not viable or barely viable, as the ASACOs have essentially developed in the financially best off districts, ii) the problem of the mutual assistance agreement which over time has become a standard contract restricting negotiations to a minimum and with too many grey areas (such as poorly defined methods of evaluation and control and no details of the qualifications required of the staff hired). If it is to last, this model must evolve, and in particular incorporate the new partner

to have emerged from administrative decentralization: the local communities.

There is a similar experiment in Côte d'Ivoire: the community-based health facilities (FSU-Com) whose management association has signed an agreement for the "concession of a public service" with the Ministry of Public Health[22].

Delegated management of public health facilities, i.e. of facilities performing a public service mission, may adopt a diversity of forms which are themselves determined by national contexts and legislation. We shall focus on two situations determined by the degree of involvement of the private entity (the assignee) in the infrastructure and equipment:

- The private entity receives from the Ministry of Health the existing resources - the buildings and equipment- as they stand in order to perform the public service mission. As a rule, responsibility for the upkeep, maintenance work, and renewal are shared by the delegator and the assignee in the manner laid down by the contract. Technically speaking, and in legal systems inspired by French practice, this is known as *affermage*; in the English legal system, it is referred to as *lease contract.* The resources remain the property of the State;
- The private entity takes responsibility for erecting the buildings and procuring the equipment. These will revert to the State when the agreement (which is generally a long-term one) expires. Under French law, this is known as *concession*; under English law, it is referred to as *Build, Operate, Transfer (B.O.T.).*

In all cases, the State remains the client; it negotiates directly with the contractor. This type of contractual relationship does not necessarily entail the withdrawal of the State, but a change in its level of involvement; the contract will in particular need to ensure that the operator undertakes to fulfil the public service mission characteristic of the care facility. Besides, in most cases, the State remains the owner of the infrastructure (land, building, major equipment) and is thus better able, if necessary, to reconsider the delegation of management.

. Contracts for the concession of a geographical area

As with an oil or forestry concession, the State may grant the exploitation of a geographical area it considers to be inadequately served and which it does not wish or is unable to serve itself. For example, contracts to provide primary health care services in certain parts of Bangladesh,[23] contract leasing a whole health district to an NGO in Cambodia,[24], [25].

Concession of an entire health district to an NGO in Cambodia

Beginning in 1999, and with the support of a loan from the Asian Development Bank, the Cambodian Ministry of Health started drawing up four-year contracts with NGOs to provide health services for an entire health district. The contract covers health workers' wages, recurrent costs, drugs and consumable medical supplies. As for activities, the contract stipulates that the health services must deliver the minimum package for health centres and the supplementary package for district hospitals.

The local administration, which depends on the Ministry of Health, retains responsibility for supervision of the health facilities under contract and for data collection. It is also required to report on the implementation of the contract and its smooth operation.

From initial analyses, it would appear that the changes in the methods of work are so far-reaching that the NGOs given the contract by the Ministry of Health have difficulty in fully appreciating their new roles. The analyses show that by adopting this geographical approach the Ministry of Health offers the assignee the possibility of adopting a systemic approach to the district for which it is responsible, thus making it better able to organize the local health system.

This rationale also underlies certain measures designed to help young physicians set up their practice in rural areas where health facilities are lacking. For example, in Mali and Madagascar, the Ministry of Health has helped young physicians to set up practice by signing with them a contract specifying that they are the only health personnel in a specific geographical area, and that in exchange they must provide primary health care as defined by the national health policy.[26] Analysis of these experiments has shown that even if it initially meets with difficulties, the introduction of private medicine under contract is nevertheless possible, even in poor rural areas, and is a possible solution when the conventional approach using health facilities is not possible for financial reasons.

2. Contract of association with the public service: a private organization, which owns its structures and possesses its own resources, collaborates, is associated with and performs a " public service mission"; under contract to the State; it thus becomes a public service concessionaire For example, the church hospitals in Tanzania[27] and Ghana[28] are contractually the only referral facilities in a determined geographical area. In Zambia, the Memorandum of Understanding signed in 1996 by the Ministry of Health and the Church Medical Association of Zambia stipulates that the boards of management of the church-owned hospitals have the same powers as those in the public sector.[29] In many countries, these are actually implicit contracts. Thus, in Chad, the country's health map is organized around existing health facilities, whether public or private; the health map assigns to a private health facility responsibility[30] for the health of the area's population, although the responsibility remains implicit. In order to avert numerous problems, it would often be worthwhile formalizing such recognition in contractual arrangements.

Significantly, it is possible that these private institutions, which own and manage health facilities, may not perform a public service function. This does not prevent the Ministry of Health, in addition to recognizing their activities through a system of accreditation, from developing contractual arrangements with them in order to determine what collaboration or support they require in exchange for the activities they perform.

It is also significant that delegated management concerns not only the function of health services provision, but also that of health administration. One of the main functions of devolved health administration is to manage health facilities operating within its area. This is a relatively simple function when the Ministry of Health manages health facilities directly (in which case they are merely administrative services), it becomes more difficult when the health facility has autonomous status. When the management of the public health facility has been delegated, it is rare for habits to have become established. In contrast, the contract associating private health facilities to the public service makes devolved health management easier.

Contracting out health facilities, whether in the form of delegated management or association with public service, means that certain actors, especially the NGOs, will place their action more within the public service framework. The contract signed by them concerning this delegation will determine their role in the provision of health services.

However, these entities may wish to commit themselves still further and to participate in the devolved health administration. The rationale is the following: as they are already managing health facilities in the area, they also wish to become involved in the devolved health administrative function. This role may remain on the level of coordination, although it may also lead to a specific contractual relation:

- this contractual relation may define the modes of collaboration or of participation in the in the running of the devolved health administration. For example, NGOs already running health facilities will define, in this ad hoc contract, their relations with the district management team, and in particular the role of each entity;

- the same contractual relationship may also adopt the form of delegated management: in this case, the manager of the health facilities in the area is given a contract to assume the devolved administrative function. This may be done in two ways: either by drawing up specific contracts for each function (management of health facilities and devolved health administration) or by drawing up a single contract simultaneously defining both the roles assumed by the manager. It should be emphasized that, as with any principle of delegated management, the manager assumes responsibility for the devolved administrative function. Contractually, the manager takes over the State's regalian functions.

This type of contractual approach is determined by the vision held of the health district. Simultaneous contracting out of both functions - the provision of health services and health administration- corresponds to integrated models, i.e. systems in which both functions, while clearly identified, are closely linked or highly dependent on one another. In such systems, it is assumed that it is impossible for the two functions to be taken on by different entities. For example, under the "classical" model of the health district, sole responsibility for the administration and management of health facilities is assumed to lie with the Ministry of Health.

3. Contract binding the State to the local authorities

Within the broader framework of State administrative reform, the trend is to bring the administration closer to the population whenever possible (principle of subsidiarity). Thus, in the field of health, numerous countries have transferred or are in the process of transferring responsibility to the local authorities. The State's health facilities are transferred to the local authority, who becomes responsible for running them. This is currently under way in Madagascar and in Senegal.

The contractual arrangement in Mahajanga district in Madagascar[31]

In Madagascar, a 1995 law and the 1996 decree bringing it into force entrusted management of basic health care centres to the communes. The instructions determining the extent of the responsibilities and resources transferred are however somewhat vague. The GTZ project in Mahajanga province is designed to put into practice this political desire for decentralization. The aim of the project is to develop collaboration between the district management team (technical oversight) and the communes to which the centres are handed over. In addition, the project proposes management models for these health facilities, in the form of two types of agreement: under the first of them, the health centre is managed by a users' association which enters into a lease contract with the Commune and in the second the centre is managed as an autonomous communal administration on whose board of management the commune is represented. The contractual framework, which is relatively complex as it involves several tiers of contractual relationship, was thus determined from the outset. It is subsequently interpreted through as many contractual arrangements as are necessary.

Evaluations carried out by the GTZ team responsible for the support have shown that decentralization brings about a far-reaching redefinition of the actors' roles and that contracting is a potential tool for understanding the new relationships that emerge between these actors, although it is not always easy simultaneously to control institutional reform (decentralisation) and use of a new tool (contracting).

Because local authorities generally lack the financial resources required carrying the burden of these new responsibilities, and also because the central State wishes to maintain its capacity to harmonize practice within its territory, the need to set up links between the central State and

the local authorities responsible for these basic health care facilities is recognized. While such links may be of a conventional administrative nature, they increasingly take the form of formalized contractual relations designed to serve as tools to assist with the transfer of responsibility to the local communities.[32]

4. A contract binding the State and its autonomous institutions

An alternative approach is to grant autonomous status to public institutions. Acceptance of the fact that one of the weaknesses of the way public services are organized lies in the concentration of all functions in the hands of a single entity -the central State- leads to a proposal to set up distinct entities. Because they are closer to the ground, these entities are directly responsible either for a specific field (such as drug procurement and distribution) or for a health facility (such as an autonomous hospital). For example, in Morocco, the Ministry of Health is currently drawing up performance contracts with the autonomous hospitals. Similarly, in Tunisia plans are afoot gradually to introduce target-based contracts (covering several years) between public health establishments (autonomous establishments) and the Department responsible for supervision at the Ministry of Health, for the purpose of developing a performance-based contractual relationship.[33]

However, such situations lead to a particular type of arrangement, because they involve only public actors. For a public actor, autonomy does not mean independence: supervision is always present. In many cases, this approach remains experimental: numerous countries are steering towards reforms granting autonomy to their local hospitals without simultaneously setting up the contractual relations that will unavoidably emerge from this new institutional set up. When these contractual relations are already in place, as in Zambia where the autonomous hospitals have signed agreements with the Minister of Health,[34] the State, because it too is faced with overriding budgetary constraints, tends not to meet its financial commitments thus somewhat undermining the credibility of the contractual relationship.

5. Internal Contracting

Delegation of responsibility may be internal, in other words it may operate within what for legal purposes is a single unit. The adjective "internal" needs to be defined depending on whether:

- there is only a single entity in the legal sense, but contracting operates between distinct parts of the unit. This is the case, for example, when the central echelon wishes to enter a contractual relationship with the peripheral level (province, region or health district). For example, in Burkina Faso, the central echelon has drawn up performance contracts with the health districts, which have no distinct legal status. Under the contract, the central echelon delegates its responsibility for attaining specific results to the level to which it has been devolved.

Programme-budgets in Morocco

The new results-based budgetary management which the Ministry of Health is endeavouring to introduce may be defined as a formalized process designed to determine each year, albeit within the framework of a sliding three-year programme and with annual budgeting, the respective responsibilities of the central administrative departments and of the departments of the Ministry of Health to which responsibility has been devolved and which are coordinated by health regions to which power has been delegated for the attainment of mutually defined objectives. The process thus concerns the relationship between the central echelon and the services to which responsibility has been devolved, i.e. the health regions. In order to encourage the actors to assume their individual responsibilities, it is intended to formalize this relationship through a contract between these two levels of the health administration.

In strict legal terms, this is not really a contract, because it is not "enforceable". Nevertheless, it is a contractual relationship because it involves negotiation and agreement between the parties concerned.

- there is only a single entity for legal purposes and the relationship is established between elements of this entity answerable to the same authority. For example, internal contracting inside a hospital. In this case, each of the services is answerable to the same management authority: the contract is established between the management and the different services. In this way, France has developed internal contracting within public establishments on the basis of the 1996 reform. The contract is binding on the head of the establishment and the heads of the medical and non-medical services. Under the internal contract, management authority is delegated by the Director of the hospital to the centres of responsibility, i.e. the services. This contract determines the objectives, the means and the indicators for monitoring the centre of responsibility, the incentive to interest them in the results of their management and the consequences of failure to fulfil the contract.

This type of internal contracting has numerous advantages but also poses its own specific problems: what type of incentives (individual or collective) will persuade the actors effectively to implement the contract? What contract monitoring mechanisms are sufficiently effective?

The first two categories above involve relations between the public and private sectors. The State considers that it is vested with a public service mission but entrusts management thereof to private bodies. The contractual relationship governing this delegation of responsibility falls within the scope of B.O.T., and will adopt specific legal forms depending on the national context. In contrast, the latter two categories concern relations between the State and public enteritis that possess legal status (autonomous structures or territorial communities). Transfer of responsibility is effected by the law. However, responsibility is not transferred in full; there are still links between the State and these entities. It is difficult to regulate these links through a conventional hierarchical relationship: the contractual relationship offers itself as the tool for addressing them and making them operational. However, in all cases the State will ensure that the contractee complies with the public service mission: the contract exists to ensure this.

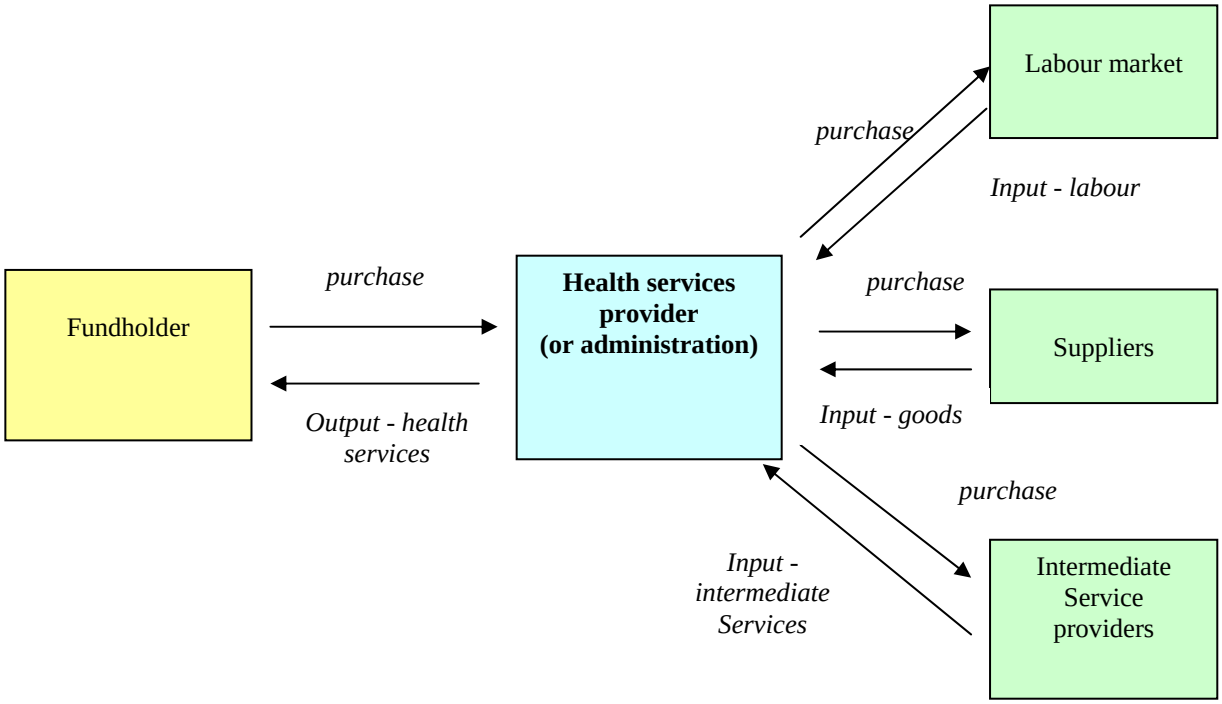
2.2. CONTRACTUAL RELATIONS BASED ON AN ACT OF PURCHASE

This category corresponds to situations in which a fundholder prefers to purchase the provision of services rather than itself producing them. In this case, the rationale is based on a simple principle: rather than *"doing"*, in other words providing the service itself, a health actor will entrust a partner with providing it, in exchange for remuneration. Thus, the object of the contractual relationship is the financing of activities. The fundholder seeks to make the best possible use of them by entrusting the performance of an activity to the partner offering the best service (the same service at a lower cost or a better service for the same budget). To do or to buy that is the question. This strategy may take different forms. In particular, we shall need to distinguish between cases in which the actor used to perform the activities itself and has decided to cease doing so (generally known as *outsourcing*[35]) and those in which the activity is new.

This purchasing strategy applies at two levels, depending on the object of the purchase:

- it concerns itself with how fundholders (individuals, but also their representatives (the State, health insurance systems)) use their funds to procure health services from health service providers; in this case, the purchase concerns a finished product – the health service provided by the provider;

- it also concerns itself with the mode of production chosen by the health service providers; in this case, the purchase concerns production factors.



2.2.1. Relations between fundholders and health service providers

Individual fundholders may decide themselves to purchase from a health services provider the health services they require. Generally speaking, this purchase does not give rise to a specific contract; however, in certain cases (such as plastic surgery), the client may insist on drawing up a contract. Individuals may also entrust their funds (voluntarily in the case of non-compulsory insurance systems or involuntarily in the case of mandatory or tax-based ones) to an institution that will decide whether to provide the health services itself or to purchase them from a provider. In the public sector in particular, the functions of fundholder and health services provider have long been integrated and still frequently are. However, recent trends in health systems have show a growing separation of these functions. Fundholders will adopt "strategic purchasing" to use the expression used in the World Health Report 2000[36] whereby they will decide that they are best able to supply the service or that a provider is best able to do so. In the latter case, individuals delegate to the fundholder authority to represent them in all their relations with health service providers. However, these relations between the fundholder and the service provider are determined by the status of the fundholder:

- **The Ministry of Health:** the Ministry of health which, through its budget, holds public funds, may decide that it will no longer undertake certain activities itself but use its budget to purchase services from providers. This approach is common for certain specific and focused activities; for example, tuberculosis, leprosy, malaria and AIDS control,[37] immunization, integrated management of childhood illness or elimination of malnutrition.[38] in Namibia, the Ministry of Health signs contracts with private practitioners to perform surgery in isolated rural areas.[39] Such contracts may be signed with all types of actor. In some cases, the Ministry will purchase services from NGOs. In this way, contracts have been drawn up between the Ministry of Health and NGOs to provide reproductive health or AIDS control services within the framework of the World Bank funded PDIS project in Senegal. In Latin America, several countries (Colombia,

Costa Rica, Guatemala, Peru and the Dominican Republic) have implemented contracts with NGOs in order to expand health coverage or improve the quality of care.[40] In other cases, the Ministry of Health will reach agreements with private physicians: for example, the draft agreement between private physicians practising in rural areas of Mali and the Ministry of Health to provide immunization as part of the EPI programme. In the field of reproductive health, Ministry of health officials contract private providers to perform certain activities (such as antenatal care).[41]

It is also important to consider who takes the initiative for this contractual relationship. In some cases, it will be the fundholder, i.e. in this case the Ministry of Health; the latter, holding funds, wishes to have certain activities performed and makes proposals, through a call for tenders, to providers wishing to carry them out. In other cases, the providers take the initiative of offering to perform certain activities for the Ministry of Health and the Ministry responds to the proposal.

Administrative decentralization and the ensuing transfer of funds to the local authorities introduces a new dimension into this type of contracting. In particular, whereas providers such as NGOs previously had a single correspondent - the Ministry of Health - they now have to deal with a multitude of deciders, each of whom potentially has its own rationale, and to adapt to each local context.[42]

- **Government funding agencies:** this approach is based on the following principles: i) within the State itself, in this case the Ministry of Health, the separation of the provider and purchaser function, ii) the creation of State-run funding agencies as autonomous entities within the public sector and that receive allocated public funds, of which they have to make the best possible use to purchase services for their population from the best service providers. In developed countries, the English model is without a doubt the best-known example and has given rise to numerous publications.

  In England, this trend is part of the new public-sector management and the concept of "managed competition", (Enthoven 1993).[43] The public sector endeavours to introduce market inspired[44] operating mechanisms that are capable of improving the system's efficiency. According to the authors, this involves introducing into the public sector the concepts of "planned" markets, (Saltman and von Otter 1992),[45] "internal" markets, (Enthoven 1985),[46] "quasi markets", (Le Grand et Bartlett 1993),[47] "managed competition"), and "manacled competition", (L.E.Brown, V.E.Amelung).[48],[49] More or less controlled competition should lead to greater efficacy and consequently provide the population with a better service.

The British National Health Service (NHS)

The national health service reforms introduced by the former Prime Minister Mrs Thatcher, are based on a clear distinction between providers and fundholders or purchasers and on the introduction of competition among the actors through "quasi-markets". The purchasers are either district health authorities or groups of general practitioners who purchase hospital services for their community from providers whom they pit against one another. Contracts are then signed by the actors. The general framework and principles of this reform were laid down a 1990 act. Numerous evaluations have been made of these contracts.[50] Many of them emphasize the difficulty of creating authentic competition and the possible negative effects (collusion between providers, selection of low-risk patients, etc.)

In 1997, Tony Blair's Government established the "new NHS" based on the search for a third way. The principle of the internal market was abandoned; competition was replaced by cooperation and trust between partners[51].

However, the most recent reform to date[52] has reintroduced a degree of competition among

providers and extended the "concordat" between the public and private sectors (collaboration between the two sectors is encouraged); this reform bears a strong resemblance to the "internal market" introduced by Margaret Thatcher in 1990.[53]

A series of articles published in 2001 by the journal *Social Science and Medicine* highlights the difficulties encountered by countries that have implemented these reforms during the past decade.[54] These reforms have been introduced with the primary aim of reducing health-care expenditure; however, the experience analysed shows that this has not been the case. However, the reforms have transformed the institutional culture, no longer based on an administrative hierarchy but on competition, and have led to a redefinition of the role of the State, especially at the level of health-care providers. Sweden has also begun reforms based on the separation of service providers from purchasers and the introduction of market-inspired mechanisms. After a period of competition (1989-1993) Sweden, without calling into question contracting, is moving towards more cooperative relations between health-care purchasers and providers.[55]

In the developing countries, reforms of this kind are few. In Ghana, the "Ghana Health Service", a Ministry of Health implementing agency, was established in 1996, one of its roles being to procure health care services from providers on behalf of the Ministry of Health. The implementation of this reform is still in its infancy.[56] In Zambia, the results of a similar process are equally ambivalent.[57]

- **Insurance systems:** in developed countries where the health service is not State-funded, health care is financed by insurance systems that are semi-official, autonomous or private. The population is required to contribute towards these insurance systems.[58] Differences are visible in the way health care expenditure is covered. There are three main models:[59], [60]

  - The reimbursement model: the patient pays the health-service provider and is reimbursed by the insurance system. This model is analogous to the French social security system: there is no link between fundholder and provider;
  - The integrated model: the population chooses an organization that is both purchaser and provider: a show-case for this is Health Maintenance Organization (HMO) in the United States;
  - The contractual model: the insurance system purchase the health services directly on behalf of the policy-holders: the German model is a prime example.[61]

In developing countries, insurance systems are only at an incipient stage and are characterized by the fact that they are not obligatory and provide cover only for a small part of the population. Nevertheless, these systems are taking shape.[62] Once they have been created, such insurance systems will look into the practical details of how to cover their members' health-care expenditure. One current method is to draw up agreements with public or private health-care facilities as well as private practitioners. Such agreements cover rates, terms of reimbursement, admittance of policy holders, quality of care etc. One example is the agreement signed by the mutual insurance societies belonging to the support fund for remunerative activities by women (Fonds d'Appui aux Activités Rémunératrices des Femmes – FAARF) and public health centres in Burkina Faso.[63] The first evaluations of this experiment highlight the importance of contracting as a tool for improving the quality of care, since it has forced the health services to take a hard look at themselves and to adapt to the needs of the population. As for mutual health insurance societies, contracting has forced policy-holders to clarify their needs and priorities. In Romania, since 1994 for eight

districts, and as of 1998 for the entire country, the health authorities and the health insurance systems have drawn up contracts with independent physicians for the provision of primary health care.[64] Another example is the PRIMA in Guinea, where the mutual health insurance society has established contracts for the provision of services with the prefectural hospital on the one hand and the health centre on the other.[65]

Whether the State itself, official agencies (such as Regional Health Authorities in New Zealand or Health Authorities in Great Britain) funded from the State budget or health insurance funds financed by contributions, all these entities are gradually becoming "pro-active" purchasers.[66] They are no longer content with simply distributing budgetary allotments or reimbursing their members' expenses. Through contractual arrangements, they negotiate conditions with providers (private or public) for access to care either for the population under their responsibility or their members.

Moreover, it is worth taking a closer look at what purchasing actually encompasses. It is extremely simplistic to look at this in purely monetary terms. When institutional purchasers purchase a health service from providers, they naturally agree on the price of the transaction, while taking into account the quality of the service provided. However, it is worth keeping in mind that the act of purchasing is a complex one involving many elements. Economic theory, especially marketing, shows that the act of purchase, even for relatively simple goods, brings a number of elements into play; for example, purchasing a car does not only depend on the relatively objective criteria of its transport function, but equally on subjective characteristics such as the image produced by the car (age, social class, and gender of the owner are characteristics that are linked to a car). The same goes for health. For instance, when a health-insurance company agrees a contract with a health-care facility, it is likely that the negotiation will not relate to the rates for medical procedures (these will already have been set) but to the service « purchased »: conditions of admittance of policy-holders, terms of payment by policy-holders, etc. In this way, purchasing health services is a powerful means of addressing the quality of care. Through contractual arrangements, purchasers can put quality of care first in their dealings with providers.[67] These quality elements may be addressed either in the initial stages of the relationship with the provider (in which case, quality standards can help to choose the provider) or later on in the relationship (in this case, part of the provider's remuneration depends on the results in terms of quality of service).

Lastly, it is worth highlighting that this type of contractual arrangement between a fundholder and a health-service provider is necessary in all health systems that adopt capitation.[68] The contract specifies the obligations accepted by the health-service provider in exchange for the lump sum it will receive in advance for each registered member in any given system. Many developed countries have adopted capitation (USA – HMO and Great Britain); others are considering introducing it, or at least partially (Canada and France for example); there has been a considerable growth in this method of payment in middle-income countries: several Latin-American countries have developed such procedures,[69] (Argentina and Nicaragua) and also Thailand.[70] However, in developing countries, capitation is rarely used on account of the weakness of their insurance system.

2.2.2. Health service-providers' production processes

The health-service provider, and the same applies to the administration, has at its disposal funds received directly from individuals or from fundholders that have received them from individuals, to carry out its key core functions. The health service provider or operator can act as a conventional producer that assembles items to produce the product it wishes to supply to its clients. These items will be bought either on the labour market, as far as human resources are concerned, or on the goods and services market, for other supplies; to achieve this, conventional contracts will be negotiated. It may also approach specific providers for

certain intermediary services. In this case, a contract will be drawn up in which one party undertakes to perform work for a fee which the other undertakes to pay; this is known as **sub-contracting** in the field of business. Examples are: maintenance contracts (a scheme in Papua- New-Guinea), catering (schemes in Bombay, India), laundry services provided for a hospital by a service firm (a scheme in Thailand).[71] The aim of this approach is to improve the use of resources which moreover, are often very scarce in developing countries. Assessments of these arrangements, though in need of further evaluation, are yielding valuable lessons.[72] These evaluations show that signing a contract with a reputable business does not necessarily guarantee good service; the entity proposing the contract should also be capable of monitoring each stage.

Contracting of non medical services in public health facilities in Tunisia *

Public Health Establishments (PHE) are university teaching hospitals under the supervision of the Ministry of Public Health; they were set up under an act adopted on 29 July 1991; they have a high degree of managerial autonomy, are governed by commercial legislation and run by a board of directors. Since 1993, EPS have resorted to contracting for certain non-medical activities: catering. Cleaning, security and assistance with accounting. In 2001, 16 of the 21 PHEs resorted to contracting.

There are a number of reasons why the EPS decided to subcontract some non-medical services: i) the mediocre quality of catering and cleaning services in hospitals is a source of discontent for patients and of wasted resources, ii) the shortage of skilled staff on account of budget cut-backs, iii) the commitments made as part of support for hospital reform, iv) the bandwagon effect, fashion and mimicry, which have played a significant role, in the mistaken belief that private health care is of a higher standard than public.

In conjunction with the central Ministry of Health administration, the EPS have set out terms and conditions of contracts as a reference guide to help each establishment draw up specific contracts. These terms and conditions stress the following : i) specific technical considerations for each activity, ii) the requisite resources to be provided by each party, iii) the division of labour between the contracting parties, and, iv) the control mechanisms to be adopted by those hospitals concerned.

Each EPS is required to monitor work being carried out by external firms and to train its staff properly to take on these new tasks. Technical and administrative services are involved in day-to-day monitoring of the contractual arrangement. An administrative and technical monitoring committee is charged with regularly following-up the progress and evaluation of services, improving the internal administration of subcontracted services and with reviewing the terms and conditions of contracts. We may draw the following conclusions from this experience:

- According to general professional opinion, the quality of services from subcontracted providers, especially catering and cleaning, has improved. The costs, however, are relatively high, leading to successive increases in unit costs;
- The staff freed by contracting have filled other roles, thus resolving problems of labour shortages in other areas;
- While in the majority of EPS, contracting is the subject of close follow-up and regular supervision on the basis of the terms of the contract, negligence also occurs in subcontracted work;
- Relations between subcontracted staff and the institution's staff are often strained, primarily on account of the lack of a clear definition of roles and responsibilities;
- Patients, confused by the differences in staff, may complain about the service provided by subcontracted staff who are unqualified for certain tasks, thus creating tense relations with the institution;
- The lack of experience of hospital staff from agencies, their lack of supervision and precariousness are the main risk factors that should be addressed by those in charge of drawing up EPS contracts.

To conclude, experience of subcontracting non-medical services in public hospitals in Tunisia reveals certain advantages in terms of improved quality as long as it is accompanied by efficient and rigorous monitoring by those in charge of the hospital. However, costs are still relatively high since the number of potential providers is too small to allow real competition to take place.

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This outsourcing of auxiliary services does not always yield the expected results: for example, in the Czech Republic, hospital catering services were recently subcontracted to SODEXHO a French international company; however, in the light of the high cost of subcontracting, these services have once more been taken over by the public hospitals.

These service contracts can also apply to other areas. For example, in Chad, as part of the health-sector support project (HSSP) funded by the World Bank, the Ministry of Public Health has signed contracts with partners such as international NGOs, United Nations agencies (UNICEF), bilateral cooperation organizations (Germany) to enable them to provide their technical support to prefectural health directorates (at regional levels): supervision, management, drug supply, cost recovery, etc. In Cambodia, as part of a project funded by the Asian Development Bank, a contract gives an international NGO authority over staff from the Ministry of Health, in particular for the award of bonuses (linked to giving up private practice and the improvement of services).[73] As part of decentralization, NGOs such as BEMFAM in Brazil, CEMOPLAF in Ecuador, MEXFAM in Mexico, and CARE in Bolivia, have signed contracts with local councils to train their staff in areas such as reproductive health.[74]

Lastly, the autonomy granted to public institutions allows them, with major differences depending on the local context, to change the rationale of public service. These autonomous structures are able, moreover, to call on specific labour through contracts: they may choose their staff or resort to casual or independent employees.

It is worth looking at the way in which these contractual relations are established. The literature on the procurement function has increased considerably in recent years.[75] The debate on the issue may be summarized by two main trends: competition and partnership.[76] Competition is the traditional approach to relations between purchasers and providers: each party keeps its distance and the purchaser encourages competition in order to obtain the best possible service for the lowest price during the transaction and then renews the competition as often as possible during the competition: "Arm's length relationships; frequent tendering which is risky and costly; reliance on price; spot contracts or complex contingent claim contracting; multi-sourcing; lack of trust; reluctance to share information; adversarial attitudes ("win-lose" outcomes)".

Conversely, in the partnership or "co-maker" approach, the purchaser forms relations based on confidence and trust with specific providers: -: avoiding unnecessary costs of excessive tendering and frequent competitions; fewer, dedicated suppliers; long-term contracts; coordinated strategies between buyers and suppliers; a sharing of risks and rewards; trusting relationships; single sourcing; resulting mutual benefit ("win - win" outcomes). The evolution of the British NHS reveals the transition from relations based on competition to those based on trust;[77] instead of "purchasing", we will refer to "commissioning" i.e. the act whereby an authority hands over responsibility and power for a limited period, to an entity who acts on its behalf. "Commissioning is thus a strategic activity for assessing requirements, resources and existing services and for making the best use of available resources in order to satisfy the needs identified. Commissioning involves defining priorities, purchasing the appropriate services and evaluating them.[78]

As a rule, relations based on competition are suited to the first of these categories, purchasing raw input. However, the available evidence on the provision of intermediate services reveals the limitations of relations based solely on competition and that a degree of partnership is proving a prerequisite for satisfactory results. The resulting contractual approach will be related to this: in the first category, we will find mainly enforceable contracts which will fully set out all the conditions of the relationship; in the second, we will adopt" head of agreement" relational contracts.[79]

2.3. CONTRACTUAL RELATIONS BASED ON COOPERATION

In the previous two types of contractual relations, we have as far as possible referred to the "actors involved" rather than the "partners". This latter term can have two meanings. In one sense, a partner is your counterpart. This tells us nothing about the situation of that actor: he may just as easily be an enemy as a friend. The term "partner" simply indicates with whom he has a relationship. This is the meaning that corresponds to the two types of contractual relations above. In the second sense of the word, the partner is the person with whom you are associated. To be a partner means to work together towards a common goal while respecting each partner's identity. The contractual relations to which we will now turn our attention are based on this meaning of "partner".

At the heart of contractual cooperation lies a desire for organizational interpenetration. This can be interpreted in many ways. Firstly, it is generally characterized by lasting commitments by the actors; relationships take time to form, but equally to develop and produce results. The actors, aware of their past relations, meet to exchange ideas and look ahead to continuing a relationship in the future. Secondly, and most importantly, the degree of cooperation between actors varies. Therefore, after having identified their synergies, the actors work together towards a common goal. However, in some cases, each actor, in its own way, will play an active yet autonomous part, in producing this result, while in other cases, the actors will work together to perform all or some of the tasks needed to reach the objective.[80] Lastly, this contractual cooperation implies that at each stage in the contractual relation, the actors are fully involved in decisions concerning the implementation of the contract and in making the necessary adjustments for unexpected circumstances that may arise during the contract; the complexity of these contracts makes it impossible completely to finalize them and demands a certain degree of flexibility, calling for constant decision-making.

In this way, cooperation can be defined as a "long-term agreement which involves interactions between members of independent organizations that combine or pool their forces".[81] In concrete terms, contractual cooperation can be expressed in different ways: we shall distinguish between the two main categories according to the degree of organizational interpenetration.

2.3.1. Weak organizational interpenetration agreements

These agreements correspond to situations when actors reach an understanding on the framework of cooperation (aims, means); however, putting these into practice affords each actor a high degree of autonomy. Without going into too much detail, we can place the following agreements in this category:

- **Franchising:**[82] a franchise differs from a classic contractual arrangement between two partners in the following ways: i) the franchiser must be able to offer something to the franchisee (a financial and material contribution, know-how), ii) the concept of the network: at the heart of the system is the idea that a higher authority wishes to harmonize a network of legal entities sharing a common goal. The franchiser is the coordinator of the network and therefore endeavours to ensure consistency. The franchisees know that they all belong to the same network: this identification with a network is important. In this way, the Ministry of Health can resort to franchising to further involve the private sector. Even if the State is not the service or health-care provider, it may wish to maintain its role as a leading actor in the proceedings.

> **Implementing the DOTS strategy**
>
> The "Directly Observed Treatment Short-course" strategy, DOTS is now considered to be one of the most effective and low cost means of controlling tuberculosis. It involves providing TB screening tests and ensuring that patients follow a course of antibiotic treatment. In developing countries, the National Tuberculosis Control Programmes have

difficulty coping with the situation and the private sector, when operating alone, is inefficient (misdiagnosis, late or non-existent referrals, inappropriate treatment, etc. Collaboration has become indispensable. Several countries such as India, Bangladesh, Cambodia and China are trying out types of franchising. The National TB Control Programme (NTP) in each country i) defines a standard treatment protocol and ii) signs contracts with private practitioners who monitor the treatment of a certain number of patients following the treatment protocol. The NTP applies its know-how and supervises the system. The franchisees form a network of health-service staff that works under the hallmark of an NTP contract.

The contractual tool has become an efficient device that helps the Ministry of Health and private practitioners jointly to analyse the mutual costs and benefits of their relationship.

Some countries have tested franchise networks for first-level private health facilities: for example the PROSALUD network in Bolivia and the ZamHealth network in Zambia.[83] There are also experiments with family planning activities[84], [85] and social marketing activities for adolescents.

- **Collaboration between health-care institutions and voluntary associations**: since 4 March 2002, French law has authorized public and private hospitals to sign agreements with non-profit associations to enable them to intervene in hospitals: for example, the activity of non-profit associations in the field of palliative care for patients, or associations that provide extracurricular activities for hospitalized children.[86]

- **The network approach**: if, in the past, continuity of care was almost exclusively assured by the medical profession, today, the involvement of many professional health-care and social categories is sought. Recognition of the multiplicity of factors determining health leads to multidisciplinary approaches. Comprehensive case-management of patients is becoming more and more necessary; the aim is to coordinate the range of care provided to patients by health-care actors either at the same time or successively. The operational response to this is increasingly taking the form of a care network. The ensuing contracting formalizes the role of each actor in a global and coherent system for dealing with patients. France is currently developing this type of contracting [87]. Within this defined framework, each practitioner maintains a high degree of autonomy for his or her activities.

- **Strategic planning at the local health system level**: the organization of health systems at the district level is currently undergoing a profound transformation with entities that do not belong to the world of health coming into play, i.e. local governments. Administrative decentralization is leading to the emergence of an authority with generally very weak expertise in health issues (except in big cities).

  Legislation on administrative decentralization more or less defines the role of local authorities at the level of health facilities. However, the links with the health district, and consequently with the core team that ensures consistency, are rarely addressed. Through administrative decentralization, health will find itself confronted with two rationales:

  - the systemic rational, adopted by traditional health-care actors (the Ministry of Health but also the health care service providers) which is based on technical considerations;

  - the rationale of politics, where health is but one of the mandates of the non-specialized elected representatives of local governments and where the geographical area rarely corresponds to the health district.

The question is how to reconcile the systemic coherence of the health district's traditional health actors with the political rationale of actors responsible for administrative decentralization. The solution is no longer to be found in the channels of centralized and dirigiste government coordination, as was often proposed by the administration through health district plans. It is here that the approach developed through the concept of "strategic planning"[88] takes on its full significance. It involves bringing together all the actors in a given area (here a health district) and, through negotiations, drawing up a strategic plan that defines the district's main orientations. On the basis of an analysis of the situation and taking into consideration the needs of the health district, the strategic plan establishes the priorities, determines the strategies that will enable it to attain its objectives and indicates the financial implications. It offers a framework, a guide for future actions that will be put into place. This approach, which separates the strategic vision of the evolution of local health systems from the planning of operations, allows different health actors to reach agreement on basic issues before taking action.

However useful it may be, this approach may nevertheless be nothing more than a gentleman's agreement between the actors. Contracting makes it possible to go further by introducing a binding element of formalization into relations. The "performance contract" tool is part of this rationale. While preserving the strategic planning approach, the contractual agreement or "contractual cooperation"[89] binds the actors that have signed to a legally enforceable commitment and to respect the obligations they have freely and jointly accepted. It also has the virtue of establishing a stable relationship between partners and mutual standards of behaviour; in this sense, a contract is a method of organization.

In the sphere of administrative decentralization, some go even further and question the advisability of adopting a sectoral approach which has the drawback of singling out health problems. They advocate the adoption of an approach that starts from the decentralized geographical area and encompasses all sectors at the same time. The resulting contractual cooperation between actors and the central authority allows priorities to be set and creates better inter-sectoral harmonization.[90] However, it is also clear that the main drawback of this approach lies in its complexity and time-consuming nature.

- **"Sector-wide approach (SWAp)" mechanisms:** in conventional negotiation mechanisms between a Government and its development partners, such as UNDP Round tables, the search for a consensus on national health policies does not lead to any formal commitment. One of the characteristics of SWAPs is precisely to overcome this situation and secure a real commitment from both parties, i.e. the Ministry of Health and the development partners. In this way, both parties formally undertake to respect the national health policy which they have jointly approved. In particular, and this is one of the characteristics of the SWAp approach, they agree to pool their financial resources and to entrust responsibility for managing them to the Ministry of Health. Consequently, the spirit of SWAps is one of contractual cooperation, since it involves formalizing partnerships through contractual relations. These conventions essentially bind the parties to obligations bearing on means rather than on performance.

Health "SWAp" in Tanzania[91]

Tanzania has recently undergone a fundamental health-sector reform; this has been conducted through a SWAp process. Up till now, this SWAp has been set forth in three contractual documents:

- A *Declaration of intent* in June 1998, signed by the Ministry of Health and the development partners, showing their commitment to a reform programme of the health system based on common implementing mechanisms;
- A *Memorandum of Understanding*, in October 1999: this preliminary agreement defines the procedures for the "common-basket" funding arrangements and the obligations and commitments of partners;
- A *Side agreement*, between the Ministry of Health and those partners who wished to add funds to

the basket, in March 2000.

These documents are fully consistent with contracting; they show a commitment to clearly defined responsibilities that goes beyond conventional cooperation mechanisms. However, the first analyses to have become available show that however useful these different documents may be, they merely constitute commitments based on good faith between partners, and not enforceable and binding commitments. Thus, even if good faith is present when the documents are signed, it does not mean that it will actually be there in reality.

Furthermore, actual implementation of SWAp at the health district level is part of the spirit of contracting. The approval of an action plan for a health district by a committee that is responsible for the "basket" of funds both from the State budget and the development partners is one of the prerequisites for receiving the funds needed for the district to operate.

"SWAp" in Bangladesh[92]

In Bangladesh, over the last twenty years, development partners have spun an extensive NGO network in the area of reproductive health, which they have often financed directly, thus by-passing the Ministry of Health. The SWAp that was introduced aims to change this situation. After having jointly decided on a health strategy, the funding from the development partners is pooled and its management entrusted to the Ministry of Health. The latter signs contracts for the implementation of the strategy with the NGOs. It should be pointed out that the results are ambivalent due to a certain inflexibility in the development partner's procedures.

- **Partnership agreements:** admittedly, this often-used term frequently crops up in very different situations and can even include some of the cases described above (for example, SWAps can be considered to be partnership agreements). In general, the following agreements are included in this category:

  - Partnership agreements between States: these are generally agreements on cooperation between a developed country and the Ministry of Health of a developing one;
  - Partnership agreements between a pubic entity and a private entity: for example, the European Union frequently signs partnership agreements with NGOs; the agreement between the Bill and Melinda Gates Foundation and the United Nations Foundation also fall into this category;
  - Partnership agreements between private entities: for example, two laboratories from the Merck KGaA group (Théramex, the leader in treatment for the menopause, and Monot, number one at the chemists: these two laboratories have signed a partnership agreement in the area of women's health for the joint promotion of Evestrel (tablets and cream) among doctors as well as in Chemists and at supermarket drug counters;
  - Partnership agreements between health establishments: for example, a hospital in a developed country signs a partnership agreement with a hospital in a developing country to conduct training for its medical staff. These agreements can lead to twinning arrangements, where interpenetration is greater.

2.3.2. Strong organizational interpenetration agreements

These agreements correspond to situations in which actors reach an understanding on the framework of cooperation (aims, means) and carry out some, if not all activities together, allowing them to fulfil the objectives of the contract. Once again, without going into too much detail, the following agreements can be classified under this heading:

- **Joint management:** joint management, understood as a sharing of authority and responsibility, can be seen on a macro-level: where France is concerned, we can point to joint management of the social security bodies by the employers and unions. However, it can also be seen from a micro-level: for example, managing a health institution. Such is the case of a certain approach to community participation: this vision is along the innovative lines of the Bamako Initiative. At the health-facility level, we find a joint management committee or a board of management that is made up both of members of the health staff (manager) and representatives of institutions representing the community: town councils, associations. There should be a balance between, on the one hand the health administration, which should ensure that health facilities fulfil their public service commitments, and on the other, the population, which, insofar as it significantly contributes towards their financing, should be able to decide and control how its financial contribution is being used. In practice, this joint management is expressed in different ways: (i) in everyday administration (for example, shared management of cost recovery revenue by members of the administrative committee and the manager of the health centre), or (ii) with regard to the main policy trends of a health institution (for example, users' associations sitting on a hospital's board of management). Thus, the contract, in its broadest sense, is made up of joint management procedures which are defined by the actors involved.

- **Alliances:** this lies at the heart of "working together". The agreements deriving from this are based on active participation by partners and rely on complementarity between resources, technology and know-how. These alliances can take two forms:

  - The first is what the world of industry refers to as "strategic alliances":[93] these are agreements whereby partners determine the terms of their cooperation, i.e. how they pool their resources on a day-to-day basis to reach the target they have set;

  - In the second, two entities decide that to carry out a given activity, they will set up a joint subsidiary. This contractual cooperation is not set out in a contract, but rather in the articles of association of their joint subsidiary. For example, i) two hospitals may decide to share some of their services: specific laboratory tests, specific aspects of accounting, etc. ii) health-care providers may decide to share drug supply facilities; to do so, their alliance may take the form of a joint subsidiary, for example, an economic interest group (GIE).[94] In some countries, public institutions are authorized by law to create joint services which enjoy a certain degree of autonomy (separate management and budget). The spirit of contractual cooperation is evident in the articles of association of a joint subsidiary or entity in which each parent entity defines its involvement.

Thus, contracting proves to be far broader and much more elaborate than the concept of a contract in the legal sense of the term. It defines any agreement between actors, whether in the form of a contract, or through other means, such as those examined above.[95].

2.4. Summary

To summarize this section, it is worth noting that all the contractual relations described above have the same objective: improving the performance of health systems. Partners' individual interests are transcended by a collective general interest, and it is because of this that contracting is of importance to health systems. Nevertheless, the examples given above differ as to the ways of attaining this objective. Some approaches adopt the hypothesis that competitors and competition between actors is a *sine qua non* for contracting to work; it infers *a priori* that the absence of competition, which is usually the case in developing countries, necessarily acts as a restraint on use of the contractual tool. In contrast, a precondition for an alternative approach posits the need for reliable actors and seeks to make the most of their synergies. A contractual relation can be drawn up without negotiations, or on

the contrary, through extended and open-ended negotiations. In the first case, there is no room for negotiation; an actor prepares the specifications and standard contract, and those actors who agree to enter this contractual relation merely sign the proposal. The other extreme is when nothing is predetermined and everything must be negotiated; the actors, without any *a priori* assumption, jointly decide on the terms of the contract.

This diversity of means of attaining an objective should be recognized, and is undoubtedly one of the strengths of this tool. However, before resorting to either one or the other method, an in-depth study is required to determine the most appropriate strategy. This is where national contexts are of importance, and to advocate one strategy rather than another is a mistake.

We also need to take into account the degree of **enforceability**. Generally speaking, a contract is a binding commitment – enforceable is the legal term – which means that non-fulfilment of the clauses by one of the parties can lead to penalties, and above all the parties can invoke the commitments before entities not party to the contract (the courts). The contract will contain provisions for these penalties and for the means of enforcing them.[96] Some contractual arrangements, however, cannot be placed in this category; for example, it would be difficult to force parties to a SWAp to honour their commitments. Rather than talking of an enforceable contract, it is preferable to talk of a "relational contract".[97] This is a negotiated agreement between actors, generally belonging to the public sector,[98] which sets out each actor's role in the joint venture or action. The underlying strength of these agreements does not derive from the possible imposition of penalties by a court, but rather from the fact that the parties must work together.[99] Relational contracts attach great importance to the relationship between the contracting parties, thus waiving a certain degree of detail in favour of the spirit of the agreement reached, leaving a certain leeway for unexpected incidents (this is referred to as the incompleteness of the contract[100],[101]). Relational contracts call principally on trust, flexibility and the use of across the board solutions to guard against uncertainties in the (political and economic) climate as well as against the difficulty of defining precise objectives and measuring the results. Even if the actors' commitment cannot be enforced by law, it is no less real. It simply follows other procedures and relies on other mechanisms: the value of the actor's word, credibility and reputation derive from respect for commitments, but also social control. If a relational contract is to produce the expected results, it must form part of a framework of continuous management of relationships, dialogue and negotiation. These are the elements that ensure actors respect their commitment to continue their cooperation[102] and avoid opportunistic behaviour. The theory of "signalling" is based on the idea that contracting parties should permanently send each other signals, whereby they each seek to reassure the other of their intention to cooperate.[103] In some cases, too detailed a contract, which forcefully outlines the dispute settlement procedure, can be a sign that the contracting parties have no confidence in each other.[104]

The following table brings together the information covered so far:

		Delegation of responsibility	Purchase of service	Contractual Cooperation
Degree of enforceability	High	. Devolution of public service . Contract covering a geographic area	. Service contracts, Sub-contracting	. Joint management of a health facility . Franchising
			. Health activities purchased by the State, public agencies or insurance institutions	. Health-care network
		. Association with the public service		
		. Contracts binding the State and autonomous institutions or local communities		. Performance contract
	Low			.Framework agreement . SWAps

It is worth mentioning that so far in the document, we have mainly focused on examples in which the actors in contractual relationships have had a high degree of responsibility: in delegated management, the manager is responsible for the results obtained; the same goes for an NGO that carries out medical activities on behalf of a ministry of health, a subcontractor that provides intermediate services, or partners in a health-care network. Contracting consists above all of giving shape to the actors' role to exercise responsibility. Some actors, such as development partners (e.g. multilateral or bilateral international organizations and international NGOs), may also play a different role, namely providing technical and/or financial support to the service providers, whether medical facilities or activities beyond the realm of medical facilities or to the health administration.

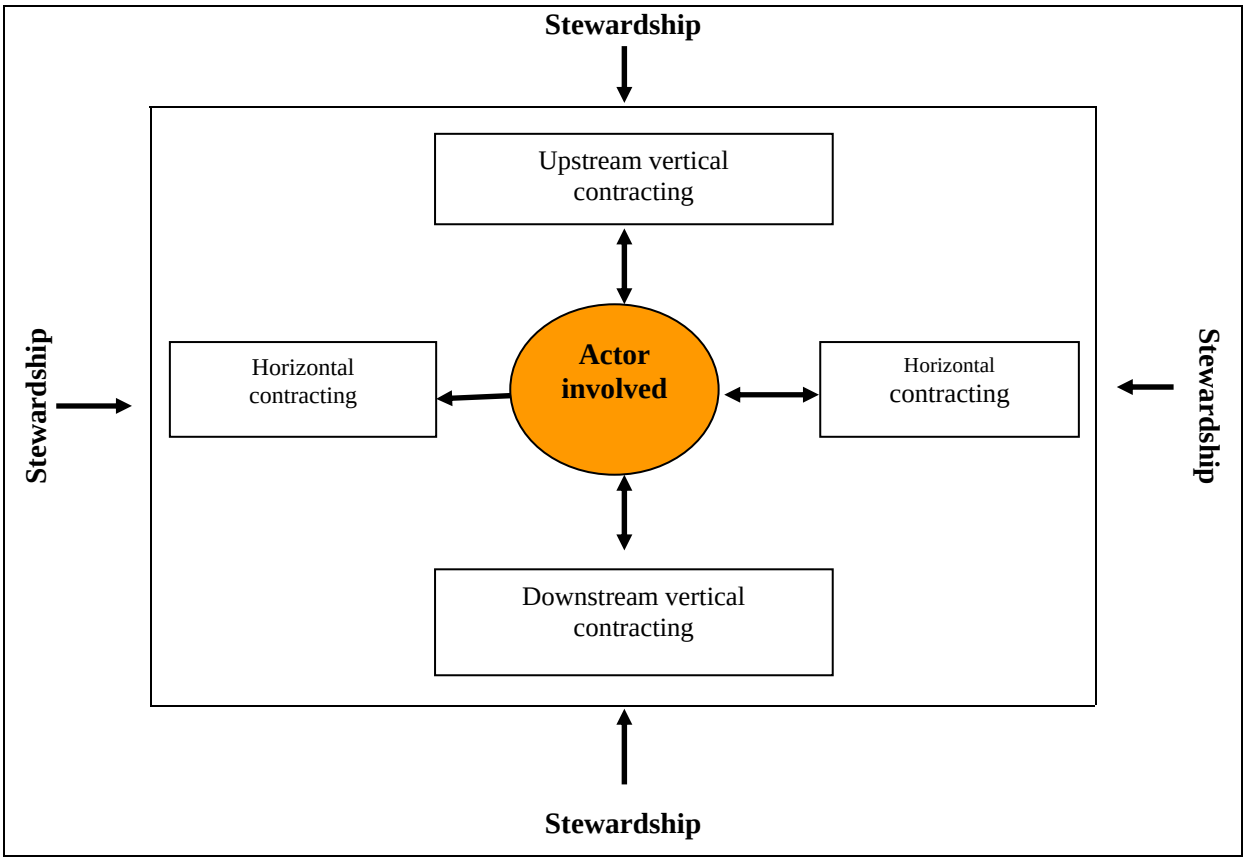
These partners are not responsible for the management of the medical facility or of the entity carrying out the activities; they merely provide support for the entity's managers, who remain responsible for the structure and the activities it performs.

The *support contract* defines the responsibilities of the partner in terms of means; in return for these means, the health service provider (either from a health facility or outside) undertakes to reach the objectives that are clearly defined in the contract: these determine the actual support received.

Finally, each actor who intervenes in the field of health can be seen as an organization at the hub of a web of contracts linking it to all those counterparts with whom it is likely to enter a relationship. This array of opportunities lies along two axes:

- a "vertical" axis: to explain this, it is useful to refer to agency theory and the concepts of "principal" and "agent". "Downstream" contracting is when the actor involved is in the position of principal; this includes all service and subcontracting contracts. "Upstream" contracting is when the actor involved is in the position of agent, in other words, on the basis of a contract, the agent the pursues the objectives defined by the principal;

- a "horizontal" axis: agency theory is no longer relevant here because there is no longer a relationship based on hierarchical dependency. Instead, there is a mutually dependent partnership. In economic theory, we talk of cooperative game theory.



Each actor, and consequently the decision-makers above him, should examine the formal links that they may maintain with their environment. In order to use its full potential, they should consider all the opportunities available to them, that is to say, study each one and, depending on their strategies and abilities, develop those which offer them the greatest benefit. To illustrate this point, we refer to the case study of three Colombian hospitals.[105]

Obviously, the contractual relationship will exist only if the potential counterparts aim for similar results. There must be a meeting point between two individual sets of interests and intentions, making it possible to formalize the planned relationship. The approach is pragmatic; it involves the implicit assumption that what is advantageous for each actor is equally advantageous for the system, in other words for the collective interest.

3. CONTRACTUAL POLICY AS A STRATEGIC MEASURE TO IMPROVE THE PERFORMANCE OF HEALTH SYSTEMS

The preceding paragraphs have not only shown the very diverse range of experience of contracting; they have also shown that it falls into three main categories. Each of them refers to a specific objective of the contractual relations that develop between health actors and to certain modes of implementation. However, in each of the three categories, the experiences are at different levels. Some concern very specific and straightforward situations involving two actors, while others concern more complex contractual relations.

Many experiences involve ad-hoc contractual relations, resulting from local initiatives or needs which do not, however, fall within a global strategy. Let us take the example of a ministry of health which, owing to insufficient means, decides to subcontract the running of a district hospital that has recently been renovated with financial support from a development partner. Without going into the grounds for the decision, it has to be recognized that it is an isolated one. It is not part of a voluntarist policy by the ministry of health, but rather an isolated act. For reasons of pragmatism, the Ministry of Health sought the best solution for a specific problem but did not wish to set the decision within a broader framework. Thus, contractual arrangements frequently remain ad-hoc, step-by-step and often fragmented responses to links that develop between two or more actors, depending on the turn of events.[106] Interesting as it may be, this is a simplistic approach. Sustainability is not always taken into account (for example, some service contracts signed thanks to external funds may have short-term benefits but uncertainty over the long-term availability of funds may lead to the development of activities that will come to an end when funding is withdrawn). In other cases, public interest may be disregarded in a contractual arrangement (for example, a mutual health insurance may have negotiated priority of treatment for its members with a medical facility; although an advantageous arrangement for both parties, it is less so for the health system and the population as a whole).

Such ad hoc contractual arrangements should not be rejected out of hand, but their influence will remain marginal both quantitively and in terms of organizational change within the health system. Many countries allow contractual relations to develop on the basis of individual interests. Others do the opposite; having decided that conciliation of two individual sets of interests does not necessarily guarantee the collective interest, they will attempt to channel this strategy by providing a frame of reference for individual decisions: contractual policy. .

However, by setting up contracting as the principle around which the health system gravitates and by harmonizing contractual policies, do we not acquire a strategic tool capable of bringing about a genuine improvement in the performance of the health system? This is what is really at stake in contracting and explains the interest shown in it by those responsible for the health system. The changeover from a pragmatic to a systems approach entails definition of a frame of reference. The contractual arrangement will cease to be an isolated act in response to a particular need; it will be part of a coherent framework from which it draws its strength.

Higher up, this framework needs to be clearly linked to a country's national health-care policy. Incorporating contracting into the national health-care policy confers on it legitimacy and recognition. From being an ad-hoc, even covert tool, contracting thus becomes a tool whose use is advocated and whose potential and limits as a means of improving the performance of health systems are recognized.

By this framework, we mean the definition of contractual policies at the level of a country's entire health system or at that of each of its elements: a health measure assigned priority (such as integrated management of childhood illness), a health problem (malaria or TB control), a particular population (AIDS victims), a different function of the health system (risk-sharing systems, drug distribution), a geographical area (the organization of a health district). The purpose of a contractual policy is to define relations between actors; it defines the role of the contract in the relationship between actors working in the same sphere, sets out the principles and objectives of the contractual relation, defines the priorities and actions covered by the contract, proposes preferred types of contract and sets the rules of the game (for example, procedure for registering contracts).

The different contractual arrangements agreed between actors are the practical expression of a collective and concerted strategy. A contractual policy ensures control of and harmonizes contractual practices. It avoids the lack of coordination that results from the juxtaposition of ad-hoc contractual arrangements.

These contractual policies may be represented in various ways:

- National contractual policies: under State supervision and with more or less broad cooperation from other health actors, documents laying down the country's contractual policies are put together. In this way, Chad now has a document on contractual policy which defines the fundamental principles and scope of contractual policies as a whole and at the health district level on the one hand and in the area of drugs on the other. The status of these documents may be anything from a simple policy statement which is not binding on the health-care actors to legal texts or regulations which are binding on the parties to them. In any case, the approach is unilateral; it is the State, through the exercise of its authority, that sets the framework with which the actors will have to comply.

One example: contracting of public and private hospitals in France

The order of 24 April 1996 reformed public and private hospitals and instituted Regional Hospital Agencies (ARH) which are public interest groups, legal enteritis under public law with administrative and financial autonomy, set up by the State and the health insurance bodies. The agencies are under the direct responsibility of the Ministry of Health. Their tasks include ensuring that public and private hospitals have drawn up contracts specifying objectives and means.[107] This contract documents each actor's commitments: it is generally based on an "institutional project" and sets out the institution's strategic orientations and conditions for their implementation, objectives in terms of quality and safety of care, provisions relating to human resources management, the objectives of implementation of the orientations adopted by the regional health conference, the deadlines for applying accreditation procedures, participation in care networks, the institutions pooling their resources and financial considerations – in particular the State and local government contributions. ARHs adopt different strategies: some favour an individual approach to contracts, each contract being drawn up independently, while others adopt a collective approach, each contract being part of the whole. Under the first strategy, contracts are developed through a gradual process, whereas under the second, all the contracts for a region are agreed upon and drawn up simultaneously.

- Framework conventions (or framework agreements): these are documents put together by actors; a framework agreement is the result of negotiations between actors, and consequently applies to those who have put them together. In practice, framework agreements reflect different objectives.

  - Some framework agreements lay down contractual terms which the actors are free to accept or reject. In France, this is the case of the agreements between the health insurance funds and the associations of private practitioners: the general practitioner sends a letter stating that he accepts the overall agreement defining relations between the funds and general practitioners; there is thus no specific contract linking the practitioner to a health insurance fund.

  - Other framework agreements are intended more as instruments that determine the broad lines of contracts, leaving it to the actors to define, within this framework, their specific contractual relations. For example, the major national NGOs and the religious organizations that own and manage numerous health facilities in developing countries have realized that their isolation neither helps to make their work more efficient nor benefits the health system as a whole.[108] In order to escape this isolation, some of these organizations have entered into contractual arrangements with health authorities in order to obtain official recognition for their health facilities. However, here again they have realized that the impact of such contractual arrangements is limited and that they themselves are institutionally fragile. For these reasons, they wish to incorporate these contracts into framework agreements that will serve as a reference for the negotiations on their specific contractual arrangement.

The relationship between the State and the Catholic Church in Burundi[109]

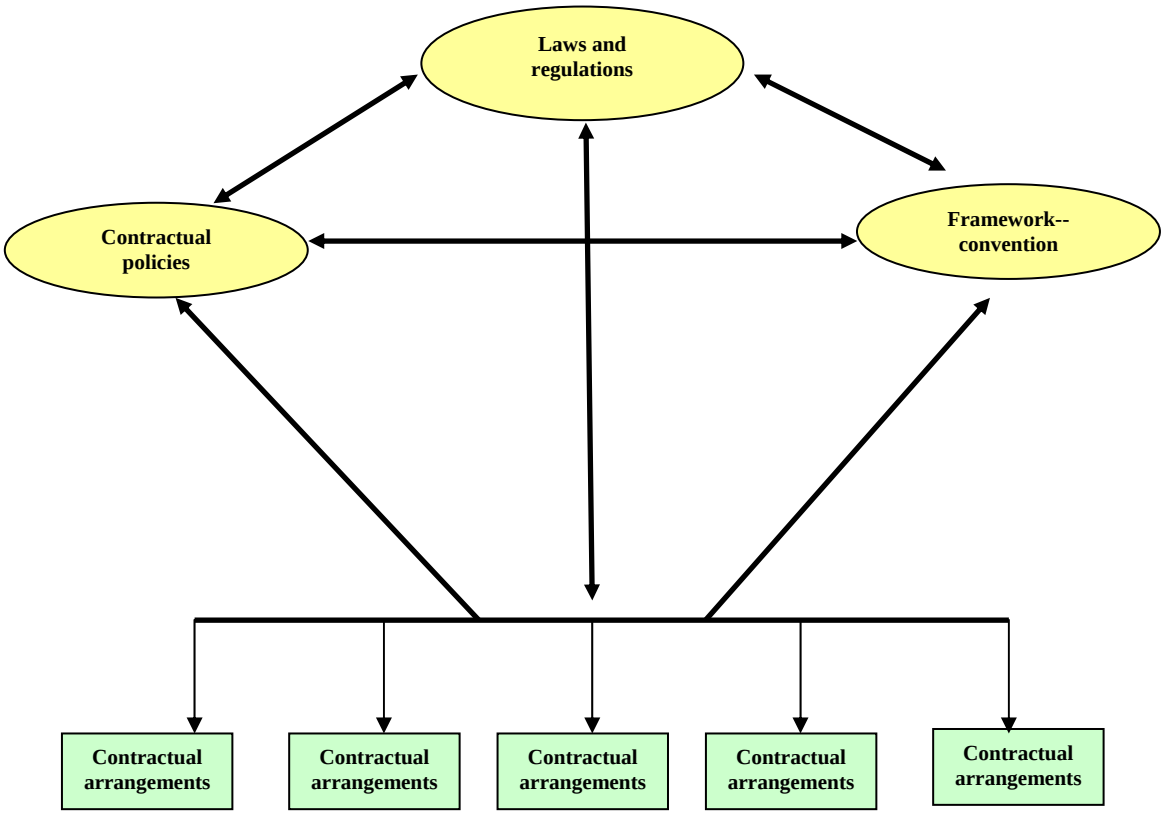
In Burundi, the Catholic Church operates 20% of health facilities; the State and the Church collaborate. The State: i) automatically approves the facilities and supervises them, ii) provides access to training, iii) exempts drugs from tax and iv) provides subsidies. Despite this, relations between both partners are fraught: subsidies have remained at the levels established in the 1960s, there is a deadlock within the Government and as for the Church, it is not particularly open about its activities. Both partners wish to overcome these difficulties by normalizing and formalizing their relationship in an agreement currently under negotiation. Once this framework agreement has been signed, it will provide each actor with a reference that will allow them to establish contractual relations in the field. This joint reference is important, because it legitimizes the specific contractual arrangements.

Even if the length of the process can be partly explained by the country's internal problems, it should be emphasized that negotiations between partners as different as the Church and the Ministry of Health take time, since it is essential to create an atmosphere of trust necessary for a smooth dialogue.

Once again, these documents bind the actors involved in different ways. Even if a French general practitioner is free not to join the agreement, this choice can have enormous consequences in practice. These framework agreements sometimes take the form of a Memorandum of Understanding (MOU): for example, under the DOTS TB control strategy, Stop TB at WHO Headquarters advises the Ministry of Health to sign an MOU with private practitioners, setting the terms of collaboration between the public and private sectors. It is then up to private practitioners to sign the contract for the implementation of the DOTS strategy.

The choice between one view or the other rests on the concept of *subsidiarity*: which capacities do the mutual insurance societies want to hand over to their union or federation? Either they confer on the latter a large part of their bargaining power, at the risk of depriving themselves of many of their prerogatives in negotiations with care providers, or they simply subscribe to a mandate vesting in them responsibility for coordination and overall guidance, while preserving their own negotiating prerogatives.

- These contractual policies, just like framework agreements, also need to mesh with an array of legislation and regulations that enable them to operate. For example, a contractual policy defines the main terms of contracting with NGOs by stipulating that contracting may involve either delegation of management authority or association with a public service. One solution might be to require an NGO managing a health facility to create a subsidiary NGO simply for the purpose of managing that facility; alternatively, it might create a separate accounts department associated through a reciprocal account with the parent NGO.

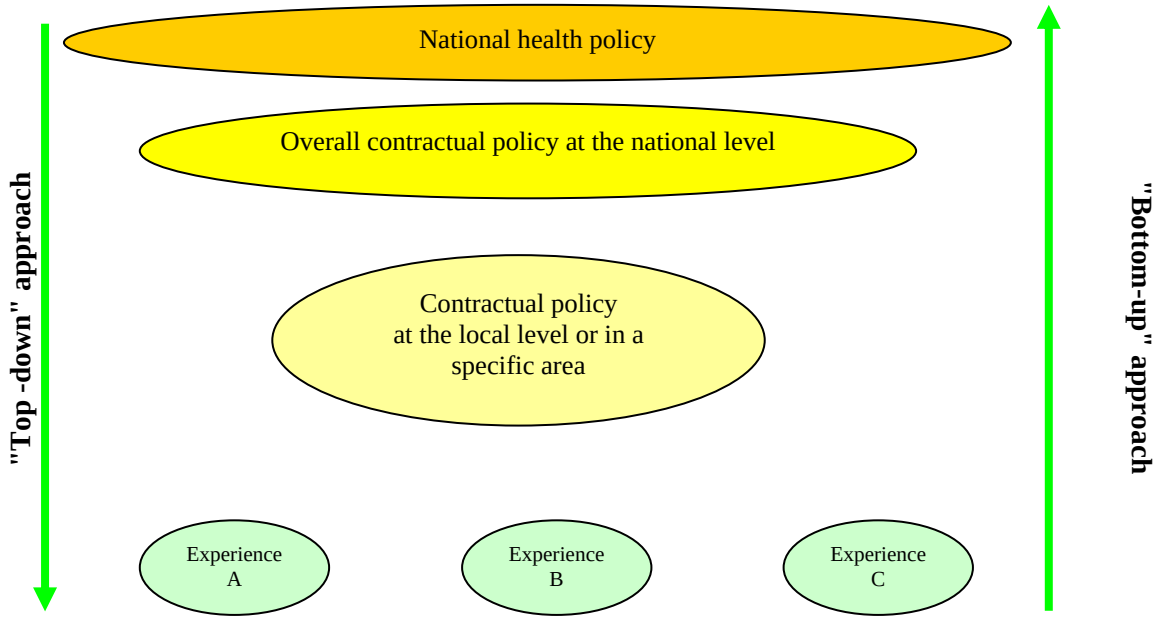


Once this necessary linkage between specific contractual arrangements and contractual policy has been accepted, we need to examine the strategy that leads to this situation. A "top-down" approach consists of initially setting contractual policy and then turning it into specific contractual arrangements. While this strategy is certainly coherent and Cartesian, it is not always effective: there is a risk of the policy being put into practice *ex nihilo.* An alternative, "bottom up" approach consists of allowing specific experiments to go ahead and on the basis of their successive evaluations, gradually to consolidate increasingly broad contractual policies.

Recent examples of the use of these concepts and instruments reveal complex situations. In some cases, it is because the actors involved in specific contractual arrangements become aware of the limits of their approach that they suggest a more systemic one.

- This frequently happens with the "framework convention" approach; for example, in Burundi as well as in Uganda, the churches believe that specific contractual arrangements require case-by-case negotiations which are often arduous. What is more, each contractual agreement is considered exceptional, since the contractual strategy is not part of the national health policy. To offset these drawbacks, the churches want to set up a frame of reference for their negotiations that will provide force and credibility to the contractual arrangements that will subsequently be drawn up;

- In contrast, some prefer to perfect contractual relations through specific contracts, to show the worth of this approach and only then to establish it as the principle through which the health system operates through a contractual policy that is formalized in a national health policy (for example, GTZ in Madagascar and Swiss cooperation in Benin). Thus, specific contractual arrangements, by which we mean a stage that must be superseded, may prove to be a useful strategy, preferable to the prior development of a purely theoretical contractual policy that will not be followed by any acts.



However, reality no doubt lies somewhere in the middle. As with the chicken and the egg, it hardly matters what comes first. The process will be fuelled by mutual feedback. The gradual consolidation of these experiences will enhance the specific contractual policies which in turn will nurture experience in the field. Global contractual policy, based on these initial experiences, will be enhanced by reflection in each area, enabling it better to fulfil its guiding role. These approaches should not be set against each other, but used to develop a mutually beneficial dynamic.

Finally, it is worth highlighting the importance of cooperation in developing contractual policies. Contrary to hierarchical models that underlie certain relations, contractual policies presuppose cooperation, negotiation and the search for consensus. The more this cooperation is present during the development of a contractual policy, the greater the likelihood of contractual practices complying with it.

4. THE ROLE OF THE STATE

In response to the development of contracting, the State may adopt a “laissez-faire” strategy. It puts its faith in market forces to ensure that contractual relations that tie actors together are advantageous to the health system.

The State may also decide that the best outcome will not be achieved without its intervention. Contracting provides it with an opportunity to develop a form of intervention that follows other roads than those of direct health service provision. In line with this rationale, the State assumes the key role in contractual relations that tie all the system’s actors together. Contracting is therefore “neither privatization, nor State withdrawal”. It is a tool for organizing health systems; it is up to the State to ensure that it is efficiently and adequately used. The role of the State lies on two levels.

4.1. The State as an Actor in a Contractual Relation

For the reasons often invoked above, the State no longer wishes to be the sole actor, yet at the same time, neither does it wish to withdraw from providing and financing health services. Contracting is a means of enabling it to reconcile these positions. In this case, the State becomes the signatory of the contract it draws up with other actors:

- *Provision of health services:* the State wishes to maintain control of the country's medical cover without having to bear the full weight of financing and managing the health care facilities. In this way, while maintaining ownership of these facilities, the State delegates responsibility for their management. In the same way, the State can enable private providers, who own health services, to join the public service. In either case, the State will not be exploiting the health system, but, through the contractual tool, will nevertheless be the contracting authority for medical cover.

- *Out-sourcing health services:* rather than carrying out certain activities itself, the State decides to purchase them from an actor, generally from the private sector. The resulting contracts are of the "service contract" type, in which the State pays an actor to provide a given product. This purchase strategy can be applied at two levels depending on the object of the purchase:
  - purchase of a finished product, i.e. a health service which is provided by a provider who may or may not operate from a medical facility;
  - purchase of production factors: laundry, catering, maintenance, security, etc.

  By purchasing these services, even if the State is no longer the direct producer, it remains the contracting authority.

- *Procuring health services within the State apparatus*: to avoid the drawbacks of concentrating all functions within the same entity, the State may separate the functions of provision and funding by creating specific entities. This division, even if partly artificial, will have the virtue of enabling each protagonist – providers and financiers – to negotiate with the other. This negotiation based on competition or on trust,[110] should lead to contractual arrangements that will improve the efficiency of the health system. By creating specialized agencies with the public budget at their disposal, the State has the means of compelling public or private health service providers to compete with one another.[111]

Contractual cooperation: under this rationale the State remains active. Such contractual cooperation can take various forms, from joint management of medical facilities' through contractual relations such as "franchising", to even more complex systems such as "performance contracts", "framework contracts", or "care networks". In all these cases, however, the State is a directly and actively implicated actor. It comes down to combining each partner's efforts with the aim of jointly providing a product, even if each actor's contribution is specific.

This strategy, where the State becomes a joint-actor, has many merits in terms of improving managerial efficiency, especially in reducing the gap between decision-making and producing health services. Nevertheless, many analysts also draw attention to its limits and constraints.[112] For example, hospital autonomy, which without a doubt leads to better management within each structure, may at a higher level lead to the fragmentation of health policies and higher transaction costs if the State wants to be able play its supervisory role.

In addition, without being directly party to a contractual relation, the State may stand surety. In the case of a mutual health insurance that signs a contract with a health centre belonging to an NGO, the contractual relation does not directly involve the State and yet the latter cannot disregard it. In order to show the population that this contractual arrangement is part of the rationale of national health policy and that it works in their favour, the State can support it by giving official approval [113] to the contractual relation. In effect, the State will be the joint-signatory of the contractual relation, but not at the same level as the protagonists; the State will not interfere in the contractual relationship between the protagonists. It will not be held responsible for failure to reach the objectives, but it will be able to intervene at any time, especially by withdrawing its support.

4.2 The State as Regulator of Contractual Relations

The State's role in contracting does not end with its direct involvement in a specific contractual relation. Admittedly, this involvement may help to improve the health systems' performance. Nevertheless, States are also aware of the limits of their direct involvement, and measure the importance of action by all other actors, whether they belong to the public sector, such as decentralized local authorities, or to various private sectors, as well as populations themselves.

Increasingly, these various actors interact, sometimes by associating themselves with the State, but more often not. This diversification of actors, and the separation of roles that accompanies it, necessarily leads to the emergence of numerous interactions between actors, which they seek to formalize in contractual arrangements in order to protect themselves vis-à-vis their commitments. Can, or should the State wash its hands of any responsibility? Since health is a common good, it cannot and should not. There are several justifications for state intervention in this field:

- Non-intervention may lead to the sub-optimal use of contracting by actors: after years of being accustomed to operate in isolation, health actors have become used to this situation. For example, certain NGOs, out of fear of losing their independence, prefer not to enter into relations with other health actors.[114]

- Non-intervention may lead to contractual relations that are harmful to populations: unscrupulous health actors may agree on something to the detriment of the population; for example, actors with a sphere of influence in a certain geographical area may agree on the price of drugs, prescribe lab tests or X-rays, the length of stay in hospital, etc. Admittedly, blatant cartels that run counter to medical deontology can easily be controlled. However, these agreements are often insidious.

Regulating contractual relations is part of the rationale of State reforms that are taking place in several countries. The State's role is being reconsidered, particularly in social sectors; the thrust of this, after many years of privatization often advocated by particular international organizations, has now turned towards a strong State whose functions are more in line with pursuit of the general interest rather than providing or financing a service. The health sector, like education, cannot avoid this general approach; the State, through the Ministry of Health, must set out to perform this stewardship function. As stated in the World Health Report 2000: Health Systems – Improving Performance (WHO), the State should take the helm rather than row. This current reflection on the State's stewardship is not new. As R.B. Saltman and O. Ferroussier-Davies (2000)[115] point out, this issue had already been addressed by J.J. Rousseau in the 18th century, then by M. Weber at the beginning of the 20th century and more recently by the school of public choice in the United States during the 1970s. We will retain the suggested definition: stewardship is "a function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry"[116].

In keeping with this rationale, the State must regulate contractual relations so that they are in the general interest and improve the health system's performance. Before analysing the practical details of how the State performs this function, it is worth first of all agreeing on the concept. We will refer to the definition by L. Kumaranayaka (1998), *"Regulation occurs when government controls or deliberately tries to influence the activities of individuals or actors through manipulation of target variables such as price, quantity and quality"*[117]. Here we adopt this broad view of regulation, which also includes control and monitoring mechanisms as well as incentives.[118] We need to bear in mind the spirit of regulation; it should always keep sight of its objectives, which are to ensure the health system's performance, namely to provide efficient and equitable care, and to be mindful of the population's needs. Regulation should therefore not be a handicap; some say it should adopt the carrot and stick approach, while others refer to an iron hand in a velvet glove.

Although there seems to be broad agreement on this ultimate objective, the methods by which regulation can be carried out vary. Some fall under the rationale of agency theory, namely the State – the principal – seeks the means by which it can influence agents – autonomous institutions, local authorities, even private providers – in order to persuade them to achieve the aims laid down by its health policy.[119] Others place regulation within the rationale of cooperation, where actors seek to join efforts to achieve objectives they have defined together.

In practical terms, the methods which the Government uses to regulate contractual relations are the following:

A – Following-through contractual relations

- *A legal framework:* the State must ensure that the country's legislation permits contracting. It must also take the necessary steps to facilitate contractual relations. For example, it is not unusual for health actors to abandon efforts to establish contractual relations due to difficulties with a punctilious administration; relations remain informal, even though it would be more beneficial to formalize them. This legal framework will define the "decision space"[120],[121] available to each actor. This framework will undoubtedly vary considerably between countries, depending on the institutional reforms they are involved in. For example, in Colombia, the law authorizes newly autonomous hospitals to sign contracts with private health insurance systems, while a similar law does not allow this in Chile.

- *Competition:* competition is not always the most appropriate means of conducting a contractual relation. However, when it concerns service contracts by which an actor purchases health services from a provider, for example, it is up to the State to ensure that prior agreements are not the rule and that the field remains open. Formerly, economists referred to perfect competition as the guarantee of good competition. Today, the term contestable markets[122] is preferred; competing pressure can be exerted by the threat of a new actor entering the market or through actors who are already there. These actors may be few in number. It is up to the State to ensure a contestable market, both theoretically (the competing actors actually exist) and in practice (there is no prior agreement between actors).

- *Control:* the State may monitor the contractual relations established between actors. Without interfering in the implementation of contracts, the State may nevertheless ensure that their implementation goes according to plan and benefits all parties, including the population concerned. This contract monitoring can be carried out at the request of the parties involved, or by decision of the State.

- *Accreditation:* ahead of contractual relations, the Government may help to establish a system of accreditation which, among other things, facilitates contractual relations.

Accreditation

Accreditation is not:

- A planning procedure: this consists of determining the level of service to be introduced in a given geographical area and for a defined period of time, in accordance with the health needs and the installations already in place. Health maps are the main tool for this type of planning.
- An authorizing procedure (licensing[123]): this allows a health facility to carry out an activity. It is issued by a governmental authority; it defines the minimum standards that have to be reached by those receiving authorization. It can take different forms:
  - administrative: the State guarantees that activities undertaken by the said entity will not harm populations; generally, this authorization is granted by an official organization in charge of the "interior"; thanks to this authorization – some refer to "*habilitation*" or "*homologation*" – a health establishment may open its doors to the public. The authority issues the right to practice:
  - technical and/or financial: for example, procuring expensive equipment may require prior authorization from the administration in charge of health;
  - deontology: certain activities are prohibited: for example abortion after a certain number of weeks of pregnancy, human cloning, etc.
- A certification procedure: this ensures that the quality of a system conforms to ISO9000 norms, granted by a qualified and independent organization, and provides written confirmation that a product, process or service conforms to specific requirements*.

Accreditation, sometimes called "approval", started in the United States and has spread to countries such as Canada, Australia and France (since 1996). Despite certain differences between countries, accreditation aims to:

- provide recognition of the quality of an establishment; it is formal recognition of a health establishment's ability to carry out procedure of recognized quality; a normative function.
- ensure continued improvement in the quality and safety of care; an incentive function. In this sense, accreditation is a tool for change.

In addition, in order to guarantee its independence vis-à-vis the authorities (supervision), the health funding agencies and of course the health establishments, accreditation is generally entrusted to a specific entity: Joint Commission on Accreditation of Healthcare Organisations (JCAHO) in the United States, National Agency for Accreditation and Evaluation in Health (ANAES) in France, Australian Council on Health Care Standards (ACHS) in Australia, King's Fund organisational audit in England, Canadian Council on Health Services Accreditation (CCHSA) in Canada, Japan Council for Quality Health Care (JCQHC, 1995).

Accreditation is an external review of a health establishment, which takes into account the entirety of its operation and practices. While basing itself on standards set at each country's level, in general with the cooperation of health system actors, the accrediting organization evaluates:

- the medical facility's resources: the suitability of the facility (premises, equipment, etc.), control of production processes and allied processes (drugs, blood, etc.);
- procedures: professional practices (diagnosis and treatment, organization of work, etc.);

- results: results in terms of improvement of health, patient satisfaction, etc.

However, what really distinguishes it from certification, is that accreditation is the driving force behind the continued development of quality within the health establishment and is not merely a one-off external evaluation mechanism. Recommendations put forward by the accrediting organization are also guidelines for change that will lead to an improvement in quality.

What does accreditation involve for health structures? We can highlight the following situations:

- The first is when accreditation involves both the internal management and external reputation of the health establishment, without the result of accreditation necessarily having a formal influence on supervisory and financing organizations.
- The second is when accreditation is explicitly linked to obtaining a contract or funding, which are essential to its existence. In the United States, to be entitled to provide care for patients benefiting from Medicare (elderly people), hospitals must comply with health standards set by the accreditation system. On the whole, there is a clear tendency to establish a specific link between accreditation and procedures for financing establishments. In this way, accreditation has become a condition for developing contractual relations; before beginning negotiations, the actors involved must have received accreditation. It is thus possible that, in future, the capacity to develop contractual relations in general or in certain specific fields will be one of the indicators on which accreditation is based.
- The third is when accreditation is not formally used to plan or determine financing but forms part of the elements of the negotiation. For example, in France, an establishment's accreditation report is officially submitted to the Regional Hospital Agency (l'Agence Régionale d'Hopitalisation (ARH)) which also negotiates contracts specifying targets and means between itself and the health establishments; the accreditation report is not an official part of the contractual negotiation, but is part of the dialogue on which the negotiation is based. Thus, accreditation can play a vital role in contractual relations. As C. Mathy[124] points out, accreditation constitutes an *ex ante* signal which reveals the quality of the product and of the contracting structure. It reduces the risks for the other party, which is already assured of the "ranking", competence and even efforts of its future partner. It makes it possible to reduce the post-contractual checks, and so lowers the costs of cooperation.

* *Definitions:*

- *norm: a set of rules for conformity which are enacted by a standardization organization*
- *standard: a set of recommendations developed and recommended by a group of representative users*

- *An information system*: The State is responsible for setting up an efficient information system for contractual relations. This information system may consist of several elements: i) registration of contracts: since the contracts relate to a particular good – in this case health – the Government should at least have a copy of all contracts signed by health actors; ii) analysis of contracts: as with all sources of information, the Government should carry out statistical analyses of contracts (the number of contracts signed in the country, the actors involved, the value of the contracts involved, the type of contract, etc.); ideally, this analysis should be included in a national information system, which is rarely the case today.

- *Audit*: evaluating each step is a special feature of contracting. However, internal audit, i.e. that carried out by actors who are party to the contractual relation, is in adequate. It is advisable to carry out external audits which will provide an assessment both of the contractual relation and its impact and results. Only this type of audit makes it possible lay firm foundations on which to base future actions and persuade new actors to become involved for sound reasons.[125] Once again, the State must ensure external and neutral audit.

- *Training:* as with any new tool, users need to acquire skills. A closer look at some experiments, in particular analysis of certain contracts, shows a marked lack of professionalism, whose likely outcome is failure of the experiment, not because of contracting per se, but because of its misuse. Contracting calls on several concepts, developed by different disciplines (law, economics, public health, political and administrative science, etc.). A sound understanding of these tools is needless to say a prerequisite for successful experiences. The State should therefore ensure that each actor, including itself, has this understanding. Training, in all its forms, is the means of doing so.[126]

- *Mediation of conflicts:* conflict is inherent to contractual relations. Actors must, at their level, do everything possible to resolve conflicts. In extreme cases, they may resort to legal measures. Between these two extremes they can also resort to official mediation. The State must be capable of performing this role, which very often proves to be delicate. This role will be made easier whenever the State has the trust of the actors involved.

B – Incentives

The State may influence contractual relations through incentives. By adopting the definition of a contractual arrangement given above, through appropriate incentives, the State may influence actors' decision-making by inviting them to reconsider the value of entering into contractual relations. The Ministry of Health might decide to tie the award of subsidies, grants, or tax exemptions, to the signature of contracts. For example, the Ministry of Health will only allocate free vaccines to doctors who have signed a contract with it to set up practice in rural areas.

Incentives may be even stronger: in France, for example, the Ministry of Health will only grant certain subsidies to a hospital (public or private) if it signs a contract relating to targets and means with the relevant Regional Hospital Agency. The Hospital is then legally obliged to enter into a contract. This example is noteworthy; from a strictly legal angle, "obligation" and "contract" are paradoxical terms; obligation contradicts the concept of a contract, which is interpreted as a voluntary alliance between independent partners.

Incentives do not contradict contracting, provided they do not cause major imbalances in relations between actors. It is true that in some cases, these relations are so imbalanced that it is debatable whether they are still freely agreed-upon contractual arrangements.

Incentives are relevant in all contractual policies that aim to persuade the private sector to work together with the public sector. This strategy is, for example, adopted in certain Asian countries to implement the DOTS strategy: as an incentive to sign contracts with it, the Ministry of Health offers benefits to those who do.

The incentives that a Ministry of Health may use are mainly financial.[127] However, the Ministry of Health may also use other means: for example, official approval, which consists of the Ministry of Health recognizing a contract between actors.

C – Contractual policies

Developing, implementing and evaluation of contractual policies is the State's, and in particular the Ministry of Health's responsibility. The latter should be the prime instigator of contractual policies. This role reflects one of the primary functions of the health system: stewardship. This function, whose importance was highlighted in the World Health Organization's (WHO) World Health Report 2000, vests in the State legitimacy to direct national health policy, even though to do so requires the participation of all those involved. Thus the authoritarian State, acting through the general, impersonal and coercive rule of law, is less and less adapted to the context of modern societies which are characterized by their growing complexity. A modern State is one that no longer issues orders from on high, but agrees to negotiate with its social environment. Modern law should make greater provision for "regulating-legislation" (flexible, reflexive, responsive, etc.), and no longer claim to be all-regulating but simply create (open) frameworks of negotiation in which democracy can operate. In practice, this is no easy matter. The State must simultaneously guarantee the consistency of national health policy while allowing room for singularity. In this respect, it is difficult for it to be a real partner, that is to say an actor like any other. Even if it accepts contracting it is almost always a separate partner, beyond and above the parties, that reserves the right to intervene. Only practical experience, based on mutual respect, will make it possible to strike a balance.

The development, implementation and evaluation of contractual policies offers a powerful lever for regulating contractual practices because it provides the Ministry of Health with the means to supervise, channel and harmonize the contractual relations that develop between actors. Having accomplished that, the Ministry of Health reduces its expenditure on monitoring contractual practices and limits departure from the norm.

Regulation as such constitutes a far-reaching change in the Government's role; it should focus on taking the helm rather than on rowing. These different forms of regulation require many resources that are often not available in the Ministries of Health in developing countries; financial resources of course, but above all, human resources. Contracting is a demanding approach, especially in terms of skills. Thus developing countries – and especially their governments – rarely have the means to meet these new demands,[128] qualified human resources in this field are generally non-existent or lacking; the experience from which they derive their training, is often inadequate or non-existent; guidance materials for action in the field do not exist;[129] and training facilities are still at the planning stage.

In addition, the Ministries of Health, insofar as they plan to promote a redistribution of roles among health actors, should look at their own functional, administrative and financial organization in order to adjust it to the newly implemented policy. This revision of the organization chart, which can be carried out gradually, especially in the case of a process of decentralization, is often a source of internal conflict.

The stakes are high; if the Government is not able to perform its stewardship function, which is expressed in its capacity to regulate contractual relations, there will be every reason to expect contracting rapidly to become an ineffective, or even harmful, tool for the organization of health services. Contracting may fall into disrepute in the following ways:

- increased transaction costs: to protect themselves against malicious intent and opportunistic behaviour, actors will be forced to develop every aspect of their contractual relations and provide for all possible eventualities, leading to more protracted negotiations, drafting and monitoring of the implementation of contracts. This will result in increased transaction costs which may offset the expected benefits of the contractual relation;

- corruption: the weakness of the Government, but also that of other actors, opens the door to all forms of corruption. If they are aware that their contractual arrangements are not part of a "framework", actors may be tempted by all sorts of corruption. Corruption during negotiations, corruption while drawing up the contract (a skilled expert can easily use ambiguous wording), corruption while signing (whoever is authorized to sign, is corruptible), corruption during implementation (withholding information, false audits, etc.);
- new markets for the distribution of financial resources: if the State is not careful, contracting may quickly become a new market for the distribution of resources. In some countries we can already see that actors have realized that access to resources is passing through different channels. Previously, access to resources followed administrative routes. If today access to resources is via contracting, skilled actors will be quick to offer their services in a contractual form and exploit naive clients.

The State's role is therefore particularly important and shapes the future of this approach. In response to this dynamic, developing countries are without a doubt much less equipped than developed countries. They need to develop skills in this field as a matter of urgency. The international community must play its role and provide the means to take on these new challenges. To do this, resources and experience must be shared. As C. Ham (2000)[130] states in the conclusion to his work: " Most countries are dealing with health-care reform as if each was on Mars. Few have tried to learn from others… This indifference to the international face of doctoring is a huge mistake… there are lessons to be learnt from looking at different ways of paying for and delivering the goods. Instead of each country trying out its own experiments, they should be studying each other's for ideas and pitfalls". These remarks, that address the overall problem of health systems reform, are particularly appropriate to the field of contracting.

5. LESSONS DRAWN FROM EXPERIENCE

Development of contracting, particularly in the developing countries, is but recent. Experiments are still under way. However, they have frequently been begun on the fringes of the health system and of national health policy; this makes it easy for us to understand that their advocates have not sought to publicized their results. Besides, some of these experiments, and frequently the most innovative among them, are so recent that we lack the necessary detachment to assess their scope. Consequently, in the comings years as these experiments go ahead, we should expect more and more information and evaluations to become available to enable us to determine the appropriateness of this tool as a means of improving health systems performance. Each of the actors involved in these experiments needs to bear in mind that the experience he has garnered from the process needs to be brought to the attention of the international community in order to build up our collective capacity.

However, despite our present lack of distance, we are still in a position to draw some lessons from experiments involving contracting. They provide us with some valuable ideas about the areas in which action should be carried out if we want the tool offered by contracting to serve as a cost-effective means of improving health systems performance.

We shall now focus on ten points. This is not an exhaustive approach but rather an attempt to bring out those elements political decision-makers need to bear in mind when planning to use contracting as a tool for implementing their national health policy. Many of them take up elements already addressed in the text.

1. Commitment by the State

Contracting is an innovative approach that brings about a far-reaching change in relations between actors in health at all levels of the health system. If the State - by which we mean not only the decision-making authorities at the Ministry of Health but also the Government and all the components of the State apparatus - fail to lend their support to this new vision, any action undertaken in the field is at any moment likely to be called into question or at the very least remain at the experimental stage, in other words, an exception. At the very least, the State must make it possible for the experiments to go ahead without interference, i.e. without being under suspicion from the outset. Obviously, it will be preferable for the State to show that it strongly supports the approach so that all the actors receive a clear message encouraging them to adopt the same rationale.

However, it is also important that at the same time the State should make it clear that contracting does not entail either privatization or the State's withdrawal. If contracting is seen as a Trojan Horse for privatization, then there is every reason to expect some partners to be reluctant to agree to the State's playing a regulatory role. If Chad is able to begin with its partners a dialogue based on trust, it is no doubt because it has clearly set out its commitment to contracting by including it as one of the twelve strategic orientations of its national health policy[131] and by stating, in a slogan, that contracting is "neither privatization nor withdrawal".

2. The diversity of contractual arrangements

We should emphasize that all the contractual relationships described here possess one common objective: to improve health systems performance. The individual concerns of partners must be set aside in favour of the general and collective interest; herein lies the importance of contracting for health systems. Nevertheless, the experiments described diverge over how to attain that objective. Some approaches adopt the hypothesis that competition between actors is a *sine qua non* for contracting to achieve its aims; from this, it is assumed *a priori* that the absence of competition, which is common in developing countries, must act as an impediment to use of the contractual tool. However, several evaluations have shown that competition does not automatically guarantee satisfactory results from contracting. In contrast, one prerequisite for an alternative approach is the existence of trustworthy actors from whose synergy it seeks to reap the maximum benefit. Contracting thus assumes that better organization of health services through improved coordination of collective efforts will make it possible to attain the objective.

The diversity of means of attaining the objective must be recognized and is no doubt one of the tool's strengths. It is important for political decision-makers to take stock of this diversity so that they may take advantage of every opportunity. We have shown that while Cambodia is developing contracting across the board in its health districts, Mali is introducing it only in health centres, France is developing a form of contracting based on cooperation while New Zealand is basing it on competition. In some cases, this is a deliberate strategy based on the country's underlying cultural considerations. However, in others the situation is more fortuitous and the full range of opportunities offered by contracting has not been tapped because of ignorance. Nevertheless, the decision to resort to one or other of these means calls in every case for thorough study in order to determine the most appropriate strategy. It is in this respect that national strategies take on their full importance, and it would be mistaken to advocate one strategy rather than another.

3. Diversity in the development of contractual relations

At the origin of the idea of applying contracting to the health sector, at least in the form taken in the developing countries, lay belief in the market principle, in other words competition as a means of finding the best solution for the actors who had entered into a relationship. Competition was expressed by means of the tools conventionally used by the market, such as calls for tenders. Nonetheless, in the developed countries there were those who rapidly drew attention to the limits of such a relationship

based on pure competition and advocated a radical change in strategy based on trust; numerous analyses of the British National Health Service have underscored the detrimental consequences of pure competition; nowadays, the NHS is based more on cooperation and trust.[132] Where the developing countries are concerned, most analyses concur that, where the health sector is concerned, competitive and transparent markets are frequently conspicuous by their absence. Consequently, while offering the proper transparency, the developing countries, no doubt need to take the path of contractual relations based on negotiations between partners who already have a reputation in the health sector. Their reputation will be all the sounder if it is based on a system of technical accreditation of which all the actors in the health sector approve.

Moreover, we need to recall the concept of enforceability to make certain distinctions between contractual arrangements. Here too, political decision-makers need to bear in mind the diversity of contractual relationships and to examine, without any *a priori* assumption, the most suitable approaches for each situation. The society's cultural foundations will no doubt be an important consideration; some countries will emphasize competition and the market while others will be more sensitive to relations based on dialogue and negotiation.

4. The risk of under-estimating the difficulties

Once it has been adopted in principle, many actors see contracting as a tool which it is fairly easy to master. Here are two illustrations of this: i) two actors who get on well will say that there is no need for a complex contractual document, the existing good relations are sufficient a guarantee of good relations in the future, and, ii) why not adopt a standard contract applicable to every case?[133] Thus S.Bennett et al.,[134] have emphasized, in respect of evaluations bearing on relatively simple experiments with contracting, that the actors have frequently underestimated the difficulties of the contractual relationship.

- a contractual process takes time. There is a risk of the actors going too fast and wanting to apply miracle solutions. Under pressure from the need to show results, actors are often tempted to go far too fast, resulting in confusion and problems at each stage. It is important that each actor should have fully understood each stage before going on to the next one. For example, in Benin, the officials of the Health Development Support Programme (Swiss Cooperation) point out that it took twelve months' discussions between the different partners, although they also recognize that the period made it possible thoroughly to clarify each party's role in the agreement signed.[135]

  All the more time will be needed to direct each stage in the processes since contracting is a new phenomenon and the actors are unable to rely on well established recommendations and guidelines. They therefore have to invent at each stage. Although we might assume that the lessons garnered from the experiments under way will make it possible to shorten some of the stages, we must always bear in mind that it takes time to develop a contracting project, that this time needs to be taken into account at the outset of the process and that leapfrogging stages is always detrimental ;

- a contractual process is not over when the contract is signed: it is not uncommon for the partners to have made considerable efforts during the preparatory stage of the contract, only then to cease their efforts once it has been signed. For example, in Burkina Faso, the agreement signed by the Ministry of Health and the Camillien Fathers' Delegation for the establishment of new health facilities and determining their mode of operation has remained virtually unknown; the commitments made by both parties are not used as a basis for evaluating their relations. In fact, this agreement is more akin to accreditation that to a contractual agreement.

5. Transaction costs

Contracting is never cost-free. It always entails costs for the actors involved, and this is true of all stages in the process. During the preparatory phase of the contract, the future joint contracting parties will need to spend a lot of time in meetings, to seek information to analyse both their situation and that of their partners, prepare files etc. All of this involves expenditure, both direct and indirect. Once the contract has been signed, implementation also involves costs, it is necessary to make sure that the contracting parties are meeting their commitments, to settle conflicts, prepare reports, etc.

Ex ante, the actors will agree to a contractual relationship only if the benefits expected by each of them from such a contractual relationship outweigh the costs involved. *Ex post*, the results show that the costs, even when they have been taken into account, have been underestimated and are higher than expected. In some cases, the costs even exceed the benefits achieved. For example, analysis of the contracting of catering services for patients in some hospitals in Bombay (India)[136] shows that the reduction in the cost of catering services following the introduction of contracting was matched by a marked decline in the quality of the service.

However, while it is never possible completely to eliminate the transaction costs of a contractual relationship, we should nevertheless examine the methods by which they may be reduced. In this respect, the nature of the contractual relationship is important. Recent trends within the British health service towards greater cooperation rather than competition is in line with this trend.[137] It has been realized that a contractual relationship based on competition among service providers entails very high transaction costs and opportunistic behaviour. The aim of the present system is to reduce these transaction costs by placing greater reliance on cooperation and trust between partners. Similarly, transaction costs may be reduced by working not only with each individual private partner, but with groups of private partners where they exist.[138] For example, it is possible first of all to negotiate with a group or network of NGOs in order to determine the broad principles of contractual arrangements, which will then circumscribe each contractual arrangement with the NGOs belonging to the network. In the same way, the NGO network may exercise a degree of supervision over its members, thereby to the same extent discharging the main actor from its supervisory function.

6. The need to build up contractual policies

Specific ad-hoc contractual arrangements may help to improve relations between actors and contribute to improving the health system's efficacy. However, there is a significant risk of such specific contractual arrangements producing results that are limited, if not harmful in certain circumstances. A contractual policy, on the contrary, will provide a framework for specific contractual arrangements and ensure they possess the necessary coherence to be effective.

Some countries have opted to define a contractual policy before starting with large-scale experimentation (such as France and Great Britain, but also Chad and Mali); others, who are more numerous, prefer to conduct experiments before settling on a contractual policy. Each of these strategies has advantages and drawbacks; this makes it advisable to set a process in motion, rather than attempting to impose one or the other strategy. However, it is generally recognized that uncontrolled development of ad-hoc contractual arrangements results in disorganization of the health services. For this reason, the International Labour Organization (ILO), whose mandate covers social protection for workers (including protection of their health) and which has helped to set up micro-insurance schemes in the developing countries in order to achieve this, has realized the importance of these micro-insurance schemes, of establishing contractual relations with health care suppliers and above all, of setting these relations within a national framework rather than within a framework at the level of each micro-system.

7. The role of the State

Contracting is a tool for organizing the health services, responsibility for which, in the original and full sense of the word, lies with the State. Contracting should always be regarded as a strategic option for improving health systems performance. A systemic vision is alone capable of preserving this objective. As an actor, the State is in a position to make judicious use of the contractual tool through demonstration and the bandwagon effect, it will have a decisive influence on how the tool is used. However, the State also has a duty to regulate contractual practices by exercising supervision over contractual relations (definition of a legal framework, information, control, evaluation, training and mediation systems), incentives, particularly financial ones, and for developing, implementing and evaluating contractual policies.

As long as contracting remains an exception, its impact on the health system on the one hand will be limited, as will the risks on the other. However, once contractual practices begin to take shape, the risks deriving from lack of coordination increase and may ultimately destabilize the organization of health services. At the same time as it encourages the development of contractual practices, the State must ensure they are coordinated. Strengthening of the stewardship function, which is advocated in the WHO World Health Report 2000, takes on its full meaning in this respect. If contracting is to be a tool for improving health systems performance, the State must be capable of exercising its stewardship function in respect of the general interest, which is not necessarily a central concern for partners seeking to develop their relations.

8. The objectives of evaluation

Evaluation is one of the cornerstones of contracting, because of the need to determine whether the aim of the contract has been complied with and its objectives attained. However, contracts frequently fail to set out this need for evaluation. In this case, it seems as if the parties concerned have no desire to equip themselves with the means of checking that they have met their commitments. Evaluation remains outside the sphere of the contract, whereas it should be an integral part of it. For example, if we look at the "agreement on association to the public health and social service" between the Ministry of Public Health of Côte d'Ivoire and the Association for Community-Based Urban Health Facilities, we see that both parties are required to exchange information but that no explicit provision is made to evaluate the results, i.e. to compare the expected results and the actual outcome. As has already been observed, the terms of the contract must clearly set out the objectives to be attained and the means to be used to do so. As an integral part of this, the contract must define the indicators or performance criteria that will make it possible to assess whether the objectives have been attained. In a manner of speaking, if there are no methods of evaluation, then there is no contract because it is impossible to check up on the actual commitment of each of the contracting parties. The contract them becomes a declaration of intent, compliance with which rests solely on the good will of the actors. We should certainly point out that in many cases, it is difficult to measure the results, making it difficult to agree on performance criteria covering their multiple facets.[139]

Moreover, very recently, scientific journals have begun to publish articles on experiments that call on contracting. This literature is a means of informing the international community of innovative practices and of publishing information that has so far been non-existent. The literature also focuses on the contractual process that has been introduced and the difficulties encountered. This assessment is valuable and provides decision-makers with ways of avoiding the errors made by others. Nevertheless, with few exceptions these evaluations do not enable us to appreciate the impact of contracting on health systems performance. It is true that the experiments are in many cases so recent that we lack the necessary detachment to conduct an evaluation. As time goes by, we should expect to see more and more publications addressing this dimension. However, we should take steps now to fill this gap.

Haiti's experience of performance-based contracts with NGOs[140]

With the assistance of funding from USAID, since 1995 the Ministry of Health has signed contracts with local NGOs to carry out activities, especially in the field of maternal and child health, reproductive health and family planning. Very rapidly, the Ministry realized that paying the NGOs solely on the basis of proof of expenditure was highly inefficient; consequently, it introduced performance-based payment.

To do so, indicators were determined to assess the population covered and the quality of health service delivery. Reimbursement was then paid on the basis of performance.

The initial results show that not only has there been an improvement in the performance of the NGOs but also a change in their attitude towards the Ministry, with a shift towards collaboration, whereas in the past the relationship was that of "principal and agent".

Finally, as contractual policies are gradually introduced, the field of evaluation needs to shift from that of specific contractual arrangements to analysis of contractual policies. In the developing countries, this field is so far almost wholly unexplored. In the next few years an effort will need to be made, because it is essentially in this area that we are able to appreciate whether contracting has had any impact on health services organization and thus on the performance of a country's health system.

9. Technical capacity

Management of a contractual process, as well as the implementation and follow-up of a contractual policy call for technical capacities in which the partners involved are still lacking. The lack of technical skills in the fields of law, economics, public health and political science may prove extremely detrimental to effective use of contracting and result in doubts about the desirability of a contractual relationship, because of what is in fact a technical problem. For example, in South Africa, where the provincial health authorities have signed contracts with private surgeons to work part-time in public health facilities,[141], evaluations have revealed considerable shortcomings in the capacity of the authorities to draw up and then supervise the contracts signed. From an analysis carried out in five countries (Ghana, Zimbabwe, India, Sri Lanka and Thailand), Mills et al. highlight this need to take into account the ability of those involved at all levels if the contractual process is to bear fruit.[142]

It is therefore necessary to build up the technical capacity both of health actors and of the State, particularly as regards the latter's role in regulating contractual practices. Various handbooks or guides on this topic are starting to appear or being written. There are not yet enough of them. Many actors fail to take action for lack of guidance and support; although they have realized the value of resorting to contracting, they are also conscious of their technical shortcomings and prefer either to abandon or postpone the idea.

10. The dangers of contracting

The transition from a system in which actors' roles are kept separate to one in which there are interrelations between more and more actors brings about a far-reaching change in the actors' behaviour. While it is possible to consider that contracting is a tool for building better relations between the actors concerned, it may also have a downside that may cancel out its benefits. In this respect, we have emphasized how excessive competition that encourages opportunistic behaviour may fruitlessly overburden the transaction costs. In addition, there is always the possibility that corruption may at any time sneak into the contractual process. Finally, it is also possible to view contracting as but another rule of the game over access to health resources, in place of the traditional administrative channels.

Consequently we must avoid the belief that contracting is a miracle solution which, by a wave of a magic wand, will solve every problem that arises in the organization and performance of health systems. A long road no doubt lies ahead before this tool, which brings about far-reaching changes in the way health actors operate, manages to fully bear fruit. The gradual and collective learning process is a guarantee of success. Evaluation of the experiments under way will enable us to lay down firm foundations on which to build tomorrow's undertakings.

世界衛生大會 決議
قرار جمعية الصحة العالمية
RESOLUTION OF THE WORLD HEALTH ASSEMBLY
RÉSOLUTION DE L'ASSEMBLÉE MONDIALE DE LA SANTÉ
РЕЗОЛЮЦИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ
RESOLUCION DE LA ASAMBLEA MUNDIAL DE LA SALUD

FIFTY-SIXTH WORLD HEALTH ASSEMBLY **WHA56.25**

Agenda item 14.13 **28 May 2003**

The role of contractual arrangements in improving health systems' performance

The Fifty-sixth World Health Assembly,

Having considered the report on the role of contractual arrangements in improving health systems' performance,[1]

Noting that the performance of health systems must be strengthened in order further to improve the health of populations, ensure equitable financing of health, and meet the legitimate expectations of the population;

Considering that the reform of health systems has generally involved institutional restructuring, with a diversification of the agents involved in the field of health, in the public and private sectors, and among associations;

Noting that cultural change within health services, such as greater focus on patient needs, a broader population-health approach, and emphasis on addressing health inequalities, is often required to improve performance, and that health-system culture may be unaffected by structural change;

Recognizing the important role of government stewardship in regulation of contractual arrangements in the health sector,

1. URGES Member States:

(1) to ensure that contractual arrangements in the field of health adopt rules and principles that are in harmony with national health policy;

(2) to frame contractual policies that maximize impact on the performance of health systems and harmonize the practices of all parties in a transparent way, to avoid adverse effects;

(3) to share their experiences on contractual arrangements involving the public and private sectors and nongovernmental organizations in the provision of health services;

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[1] Document A56/22.

2. REQUESTS the Director-General:

(1) to create an evidence base so as to permit evaluation of the impact of differing types of contractual arrangements on the performance of health systems and identification of best practices, taking account of sociocultural differences;

(2) to provide, in response to requests from Member States, technical support in strengthening capacities and expertise in the development of contractual arrangements;

(3) to develop, in response to requests from Member States, methods and tools tailored to country realities to provide support to Member States in establishing a system of supervision to ensure the provision of high-quality health services, for example by accreditation, licensing and registration of public and private-sector and nongovernmental organizations in the health sector;

(4) to facilitate the exchange of experience among Member States;

(5) to report to the Executive Board at its 117th session and the Fifty-ninth World Health Assembly on the ways in which contractual arrangements and other strategies to strengthen health systems improve the performance of health systems in Member States.

Tenth plenary meeting, 28 May 2003
A56/VR/10

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NOTES

[1] For a detailed description of this integration of health systems functions, see Murray C.J.L., Frenck J. (2000) "A framework for assessing the performance of Health Systems ", Bulletin of the World Health Organization, 2000, vol. 78, p. 717-731.

[2] Muschell J. (1995): "Privatization in health", WHO/THE/TBN/95.1

[3] WHO- OMS (1984) "Glossary of Terms used in the "Health for All" series N° 1-8", p.13.

[4] The 1991 NHS reform inspired a multitude of articles in both the specialized and mass circulation press. Using the Internet and a search engine (entering simply "NHS"), it is possible to come up with several hundred documents. We shall simply mention a document on the redirection of the health service introduced when the new Labour Government took power: Department of Health, *The New NHS* (London: HMSO, 1997)

[5] Depending on the legal structure adopted, this management team will be more or less subservient to the regulatory authority (the State) or the board of management

[6] S.Affane, A.Allaoui (1998) "L'expérience de la République fédérale islamique des Comores", (the experience of the Federal Republic of the Comoros) paper presented at the technical meeting *Towards new partnerships for the development of health in the developing countries: contracting as a policy tool*, WHO/ICO, Geneva, 4-6 February 1998

[7] As part of new entrepreneurial theories, these considerations are addressed in what is known as the property rights theory. We should mention two seminal articles illustrating this theory: Alchian A.A: (1969) "Corporate Management, and Property Rights", in H.Manne (ed.) *Economic Policy and the Regulation of Corporate Securities*, American Economic Institute, Washington; Demetz H. (1967) "Toward a Theory of Property Rights", *American Economic Review*, May

[8] World Development Report 1999/2000 *Entering the 21st Century c*hapter 5 "Decentralizing: Rethinking Government".

[9] Musgrove P. (1996) "Public and private roles in health: theory and financing patterns", *The World Bank discussion paper n°339*, Washington

[10] Mills A, Bennett S, Russell S (2001) "The challenge of health sector reform. What must Government Do?" Palgrave. See, in particular chapter 1.

[11] N. Hafez Afifi (2001) "Harnessing private participation in the health sector through active regulation. In "Private participation in health handbook", module 4, The World Bank, (to be published)

[12] Rondinelli M, Iacono M (1996) "Strategic management of privatization: a framework for planning and implementation", *Public Administration and Development*, Vol. 16, 247 - 263

[13] A clear distinction needs to be made between ownership of a structure and that of an infrastructure. Ownership of an infrastructure concerns built items (buildings), non-built items (land and the principal investments). Ownership of the structure concerns a legally autonomous economic unit which is organized to produce goods or services. To take the case of a hospital: the structure may be that of an NGO which is recognized as the owner who runs the hospital as an enterprise. However, the enterprise may or may not actually own the hospital buildings, which may be someone else's property, for example another NGO. In this case, what matters, is ownership of the structure and not of the infrastructure.

[14] E.S. Savas (1990) "A taxonomy of Privatization Strategies", vol.18, n°2, 343-355

[15] This disequilibrium is inherent to contracts such as franchises under which the franchiser has real power over the franchisees; it is also present in a labour contract, where the power of the employer outweighs that of the employee and in certain supply contracts when a firm has a monopoly over its suppliers who are entirely dependent on it for their orders.

[16] We owe this distinction to I.Macneil (1978) "Contracts: adjustments of long-term economic relationships under classical, neoclassical and relational contract law", *Northwestern University Law Review*, 72: 854-905

[17] For a detailed examination of good faith in relation to contracts, see the internet document: www2.univ-lille2.fr/droit/documentation/pdf/jamet.pdf

[18] An interesting application of this is given in, C.K.Lail "Contracting without courts: reviewing the past to deal with the present in China", internet document.

[19] Because they are unenforceable through the courts, some jurists refuse to recognize relational contracts as contracts. However, this trend is changing and in recent years a considerable literature has developed. For a detailed analysis of this viewpoint, see L. Rolland (1999) "Les figures contemporaines du contrat et le Code civil du Québec", *Revue de droit de McGill*, Montréal, Canada

[20] Economists refer to "transaction costs" meaning that the contractual relationship - in this case the transaction- entails direct expenditure costs in money and time.

[21] The Bardot maternity centre (Côte d'Ivoire), an experiment presented by the European Community at the technical meeting *Towards new partnerships for the development of health in the developing countries*, WHO, Geneva, February 1998

[22] "Community-based health facilities (FSU-Com)", document of the Projet Santé Abidjan (PSA), Côte d'Ivoire

[23] A.M. Zakir Hussain (1998) "A New Direction Towards Management of Health Care Delivery System", Ministry of Health and Family Welfare, PHC Series - 31

[24] N.Fronczak (1999) "Description and Assessment of Contracting Health Services Pilot Project", Basic Health Services Project, MOH, Cambodia

[25] Soeters R, Griffiths F (2000) "Can government health workers be motivated? Experimenting with contract management: the case of Cambodia", communication presented at the international symposium on financing health systems in low-income countries in Africa and Asia", France, Clermont-Ferrand 30 November - 1 December 2000

[26] NGO "Santé sud" with the support of French Cooperation and the European Union. Assistance in setting up makes provision for basic medical equipment. The applicant may also request a loan to purchase a motor bike and a cash advance. The rural physician undertakes to comply with a set of «specifications» to satisfy the health needs of his or her area of reference (treatment and prevention). He is required to make rounds on specific days to the main villages and home visits.

[27] M. Bura (1998) "Church-related Hospitals contracted as Designated District Hospitals: Tanzanian Experiences", communication presented at the technical meeting *Towards new partnerships for health development in the developing countries, WHO*, Geneva, February 1998

[28] Y.Yeboah (1999) "Contracting: the case of Ghana from the perspective of the Christian Health Association of Ghana (CHAG)", paper presented to the meeting organized by Medicus Mundi International *Updating heath care development cooperation*, 5-7 November 1999, Dar Es Salam, Tanzania

[29] K.Hanson, L.Atuyambe, J.Kamwanga, B.McPake, O.Mungule, F.Ssengooba (2002) "Towards improving hospital performance in Uganda and Zambia: reflections and opportunities for autonomy", *Health Policy*, 61: 73-94

[30] Definition of the notion of public service or what others call, albeit with nuances, the general interest, is not an easy matter and depends on different national contexts. However, what is sure is that the notion of public service

is based on the fact that because of their nature, objectives and the interests involved, certain activities in society must be exempt from the rationale of the market and the search for profit, and be managed in accordance with specific criteria ensuring everyone has access to certain goods and services and thus helping to ensure the economic, social and cultural cohesion of society. (solidarity and equalization).

[31] C.Bodart, B.Schmidt-Ehry (1999) "L'approche contractuelle comme outil de mise en œuvre des Politiques nationales de santé en Afrique" (Contracting as a tool for implementing national health policies in Africa), GTZ, Division 43

Ph. Senant, T. Kirsch-Woik (1998) "Aspects juridiques de l'approche contractuelle comme outil de mise en œuvre d'une politique nationale de santé " (Legal aspects of contracting as a tool for implementing a national health policy), paper presented at the meeting "*Contracting as a tool for implementing national health policies in African countries",* Dakar, Senegal, 19-21 October 1998

Senant Ph, Kirsch-Woik Th (2000), "Evolution de l'approche contractuelle dans la province de Mahajanga (Madagascar)" (Evolution of contracting in Mahajanga province, Madagascar), Paper presented at the international symposium on Financing health systems in low-income countries in Africa and Asia, France, Clermont-Ferrand, 30 November - 1 December 2000.

[32] Andrews M, Schroeder L (2003) "Sectoral decentralisation and intergovernmental arrangements in Africa", *Public Administration and Development,* Vol. 23, pp. 29-40

[33] H.Achouri (2001) "Le projet d'appui à la réforme hospitalière: objectifs, impémentation, résultats et enseignements" (The hospital reform support project: aims, implementation, results and lessons), *La Tunisie médicale*, vol. 79, n°5

[34] McPake B, Hanson K, (2000) "A model of the equity implications of reforms in Zambia", Paper presented at the international symposium on "Financing health systems in low-income countries in Africa and Asia", France, Clermont-Ferrand, 30 November - 1 December 2000.

[35] Outsourcing: resorting to an outside operator to perform an activity which an actor has decided to cease performing itself.

[36] World Health report 2000: Health systems: Improving performance, p. 104 et seq.

[37] Several examples of agreements between youth associations and the National AIDs Control Programme of the Ministry of Health of Chad were presented at the Information seminar on contracting in the health sector in Chad, N'Djamena - 4 and 5 November 1998

[38] Marek T, Diallo I, Ndiaye B, Rakotosalama J (1999), "Successful contracting of prevention services: fighting malnutrition in Senegal and Madagascar", *Health Policy and Planning.* 14(4)

[39] As described by P.R. Shaw (1999) "New trends in Public Sector Management in health - Applications in Developed and Developing Countries", World Bank Institute, April

[40] Abramson W B (1999) "Partnerships between the public sector and nongovernmental organizations: contracting for primary health care services", study carried out by Abt Associates Inc. as part of LAC Health Sector Reform Initiative.

[41] Lubben M, Mayhew S H, Collins C, Green A (2002) "Reproductive health and health sector reform in developing countries: establishing a framework for dialogue", *Bulletin of the World Health Organization*, vol.80, n°8, pp. 667-674

[42] Kolehmainen-Aitken R-L (2000) "State of the practice: Public-NGO partnerships in response to decentralization", LAC Health Sector Reform Initiative, N° 22.

[43] Enthoven A C (1993) "The History and Principles of Managed Competition", *Health Affairs*, Supplement

[44] For a detailed presentation see, Sara Bennett, Barbara McPake, Anne Mills (1997), op. Cit.

[45] Saltman R B, and von Otter C (1992) *Planned Markets and Public Competition: Strategic Reform in Health Care.* Milton Keynes: Open University Press

[46] Enthoven A C (1985) *Reflections on the Management of the NHS.* London: Nuffield Provincial Hospital Thrust

[47] Le Grand J and Bartlett W (1993) *Quasi-markets and social policy.* The Macmillan Press, London

[48] L.E. Brown and V.E. Amelung (1999) ""Manacled Competition": Market reform in German Health Care", *Health Affairs*, Vol. 18, n°3, May/June

[49] Strictly speaking, these terms are not equivalent. In systems with internal markets (Great Britain, New-Zealand) purchaser and provider are considered t o be completely separate, and it is mandatory for the purchaser to make a contract with the provider; in contrast, in systems in which there is managed competition (Netherlands, United States), vertical integration of the purchaser and provider functions is possible (as is the case of the Health Maintenance Organizations (HMO). On this topic see, C.M. Flood (2000) "International Health Care Reform: a legal, economic and political analysis", Routledge Studies in the Modern World Economy, Routledge, London and New York

[50] For a recent evaluation, see Le Grand J (1999) "Competition, Cooperation, Or Control? Tales From The British National Health Service", *Health Affairs*, Vol. 18, N°3, May-June 1999

[51] The White paper for the new NHS may be consulted on the Internet: web site of the U.K. Department of Health on 2 October 2000: http://www.official-documents/doh/newnhs/wpaper.htm

[52] Department of Health. (2002) "Delivering the NHS Plan: Next Steps on Investment, Next Steps on Reform" Cm 55 03. Stationery Office, Norwich

[53] Lewis R. Gillam S. (2003) "Back to the market: yet more reform of the national health service", *International Journal of Health Services*, Vol.33, Number 1, pages 77-84

[54] Light D. W. (2001) "Comparative institutional response to economic policy managed competition and governmentality", *Social Science and Medicine*, 52: 1151-1166
Light D.W. (2001) "Managed competition, governmentality and institutional response in the United Kingdom", *Social Science and Medicine*, 52: 1167-1181
Lieverdink H. (2001) "The marginal success of regulated competition policy in the Netherlands", *Social Science and Medicine*, 52: 1183-1194
Andersen R., Smedby B., Vagero D. (2001) "Cost containment, solidarity and cautious experimentation: Swedish dilemmas", *Social Science and Medicine*, 52: 1195-1204
Cabiedes L., Guillén A. (2001) "Adopting and adapting managed competition: health care reform in Southern Europe", *Social Science and Medicine*, 52: 1205-1217
Gross R., Harrison M. (2001) "Implement ting managed competition in Israel", *Social Science and Medicine*, 52: 1219-1231
Fougere G. (2001) "Transforming health sectors: new logics of organizing in the New Zealand health system", *Social Science and Medicine*, 52: 1233-1242
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[56] Larbi G.A. (1998) "Institutional constraints and capacity issues in decentralizing management in public services: the case of health in Ghana", *Journal of International Development*, Vol.10, pp.377-386

[57] Cassels A. (1995) "Health sector reform: key issues in less developed countries", *Journal of International Development*, Vol.7, N°3, pp. 329-347

[58] In some countries, these systems are a virtual State monopoly, as in France, while in others, there are numerous insurance systems, as in Germany.

[59] Hurst J.W. (1991) "Reforming health care in seven European nations", *Health Affairs*, Fall, 7

[60] van de Ven W.P.M.M, Schut F.T., Rutten F.F.H. (1994) "Forming and reforming the market for third-party purchasing of health care", *Social Sciences and Medicine*, Vol.39, N°10, pp. 1405-1412

[61] Von der Schulenburg J.-M. G. (1994) "Forming and reforming the market for third-party purchasing of health care: a German perspective", *Social Science and Medicine*, Vol.39, N°10, pp. 1473 1481

[62] For example, the Internet site set up by ILO for Africa is worth consulting: http://www.concertation.org

[63] A.Thiombiano (2000) "L'approche contractuelle et les services de santé décentralisés: l'expérience des mutuelles de santé du Projet FAARF et les formations sanitaires au Burkina Faso" (contracting and decentralized health services: the experience of the mutual insurance societies participating in the FAARF project and health facilities in Burkina Faso), paper presented at the meeting on "Contracting and decentralized health services in Africa, Dakar, 19-22 June 2000"

[64] C. Vladescu, S. Radulescu (2001)"Improving primary health care: output-based contracting in Romania", Ch.6 in "Contracting for public services: output-based aid and its applications", Edited by P.J. Brook and S.M.Smith, World Bank and International Finance Corporation

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[66] C.M. Flood (2000) Op.cit.

[67] In 1988, A. Donabedian suggested approaching quality from three angles: the inputs offered by the provider, the care-production process and the results obtained.

[68] Capitation is one manner in which a health-service provider is paid by a fundholder: the latter pays the provider an amount determined in advance on a per capita basis and paid for a period in the future. Using this amount, the provider undertakes to provide all the care needed by the individuals for whom the sum has been paid.

[69] Telyukov A. (2001) "Guide to prospective capitation with illustrations from Latin America", LAC- Health Sector Reform Initiative, N°5, http://www.americas.health-sector-reform.org

[70] R. Bitran (2001) "Paying Health Providers through Capitation in Argentina, Nicaragua, and Thailand: Output, Spending, Organizational Impact, and Market Structure", Partnerships for Health Reform (PHR), Major Applied Research 2, Technical Paper N°.1

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[72] Bennett S., McPake B., Mills A. ((1997) "Private health providers in developing countries", Zed Books, London and New Jersey. See, in particular, Chapter 12, pp. 189- 213.

[73] Soeters R, Griffiths F (2000) "Can government health workers be motivated? Experimenting with contract management: the case of Cambodia", paper presented at the international symposium "Financing health systems in low-income countries in Africa and Asia", CERDI, Université d'Auvergne, Clemont-Ferrand, France. Soeters R, Griffiths F (2002) "Improving government health services through contract management: a case from Cambodia", to be published

[74] Kolehmainen-Aitken R-L (2000) "State of the practice: Public-NGO partnerships in response to decentralization", LAC Health Sector Reform Initiative

[75] In particular, the journal *"European Journal of Purchasing & Supply Management"* has for several years been a source of seminal articles. Although the field concerned is only rarely health, the concepts and tools developed are of interest to the health sector.

[76] D.Parker, K.Hartley (1997) "The economics of partnership sourcing versus adversarial competition: a critique", *European Journal of Purchasing & Supply Management*, Vol.3, N° 2, pp. 115-125

[77] Gilson L (2003) "Trust and the development of health care as a social institution", *Social science & Medicine*, 56, pp.1453-1468

[78] Peacock S (1997) "Experiences with the UK National Health Service Reforms: A case of the infernal market?", Centre for Health Program Evaluation, Australia
James C, Dixon M, Sobanja M (2002) "Re-focusing Commissioning for Primary Care Trusts" An NHS alliance discussion paper, http://www.nhsallaince.org/docs

[79] In this respect, see A.Cox (1996) "Relational competence and strategic procurement management: towards an entrepreneurial and contractual theory of the firm", *European Journal of Purchasing & Supply Management*, Vol.2, N°1, pp. 57-70, et I.Thompson, A.Cox, L.Anderson (1998) (1998) "Contracting strategies for the project environment", *European Journal of Purchasing & Supply Management*, Vol.4, N°1, pp.31-41

[80] In the sphere of business economics, this issue arises in respect of "subcontracting partnership", where the sub-contractor producing the article on behalf of a principal helps to design the article.

[81] M.Ingham (1994) "L'apprentissage organisationnel dans les coopérations" (Organizational apprenticeship in cooperation), *Revue Française de Gestion*, N°97, pp. 105-121

[82] According to the European Code of Ethics for Franchising, franchising is *"a system of marketing goods and/or services and/or technology, which is based on a close and ongoing collaboration between legally and financially separate and independent undertakings, the Franchisor and its individual Franchisees, whereby the Franchisor grants its individual Franchisees the right, and imposes the obligation to conduct a business in accordance with the Franchisor's concept"*

[83] M.Makinen, Ch.Leighton (1997) "Summary of Market Analysis for a Franchise Network of Primary Health Care in Lusaka, Zambia", Abt Associates and PHR, Technical Report 15, Washington

[84] D.Montagu (2002) "Franchising of health services in low-income countries", *Health Policy and Planning*, 17(2), 121-130

[85] A. Ruster, C. Yamamoto, K. Rogo (2003) "Franchising in Health", The World Bank, Public Policy for the Private Sector, Note Number 263

[86] Ph. Jean (2002) "Les associations de bénévoles" (voluntary associations) , *Revue Hospitalière de France*, n° 487, p. 18-23

[87] For example, networks in the areas of perinatal care may be consulted on the Internet site of the Rhone-Alps regional hospital agency: http://www.satelnet.fr/arhra

[88] A.Green (1992) "An introduction to health planning in developing countries", Oxford University Press, Reprinted 1995, 1996, 1997, 1998, 1999

[89] G. Marcou, F.Rangeon, J.L. Thiébault (eds.) (1997) "La coopération contractuelle et le gouvernement des villes"(Contractual cooperation and municipal government), L'Harmattan, Paris, France

[90] In accordance with this approach, what matters is avoiding the errors made in the past. For example, the introduction of cost recovery into the health sector without any coordination with the Ministry of Finance or other sectors has led to many problems.

[91] A.Brown (2000) "Current Issues in Sector-Wide Approaches for Health Development: Tanzania Case study", OMS, WHO/GPE/00.6

[92] DFID (2000) "Making the most of the private sector" Report to DFID (Department for International Development), Seminar on 11 and 12 May 2000

[93] In the world of industry, this strategy is increasingly common, and offers an alternative to that of merger/buy out.

[94] An economic interest group (GIE) is a legal entity under French law whose purpose is to employ, for a specific period, of all the means necessary to facilitate or develop the activities of one of its members.

[95] A.Telyukov, K.Novak, C.Bross (2001) "Provider payment alternatives for Latin America: concepts and stakeholder strategies", N° 50, LAC-HSR, Health Sector Reform Initiative, http://www.americas.health-sector-reform.org

[96] This is quite akin to the notion used by Walsh, who distinguishes between contracts based on penalties and those implying cooperation between the actors. Walsh K. (19985) "Public Services and Market Mechanisms. Competition, Contracting and the New Public Management", Basingstoke: Macmillan

[97] There is a wealth of literature on relational contracts. There are two seminal articles on the subject: I.Macneil (1978) "Contracts: adjustments of long-term economic relationships under classical, neoclassical and relational contract law", *Northwestern University Law Review*, 72: 854-905, et, O.Williamson (1979) "Transaction cost economics: the governance of contractual relations", *Journal of Law and Economics*, 22: 233-261. The following may also be consulted: N.Palmer (2000) "The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries", Bulletin of the World Health Organization, 78, (6)

[98] A noteworthy analysis of relational contracts between the health administration and general practitioners in South Africa is to be found in: N.Palmer, A.Mills (2003) "Classical versus relational approaches to understanding controls on a contract with independent GPs in South Africa", *Health Economics*, forthcoming

[99] For a detailed analysis, see J.McHale, D.Hughues, L.Griffiths (1997) "Conceptualizing contractual disputes in the National Health Service internal market", chapter 8 in "Contracts, co-operation, and competition", S.Deakin, J.Michie, (1997), Oxford University Press

[100] For the application of these concepts to an analysis of the British health system, see P.Allen, B.Croxson, J.A. Roberts, K.Archibald, S.Crawshaw, L. Taylor (2002) "The use of contracts in the management of infectious disease related risk in the NHS internal market", *Health Policy*, 59 pp. 257-281

[101] N.Palmer, A.Mills (2003) "Classical versus relational approaches to understanding controls on a contract with independent GPs in South Africa", *Health Economics*, vol.12 pp.1005-1020

[102] Within the framework of games theory, and with particular reference to the prisoner's dilemma, economists have shown that the actors' reputation is an element which favours cooperation. By not cooperating in the contractual relationship, an actor damages his reputation and credibility and the trust placed in him by the other actor, thus eliminating himself from the contractual process in the future and losing the future benefits of the contractual relationship. See, for example, O.Williamson (1993) "Calculativeness, trust and economic organization", *Journal of Law and Economics*, Vol.36, pp. 453-486 et D.Kreps (1990) "Game theory and economic modelling", New-York Oxford University Press.

[103] C. Chaserant (2002) "La coopération se réduit-elle à un contrat? Une approche procédurale des relations contractuelles" (Can cooperation be reduced to a contract? A procedural approach to contractual relations), *Recherches économiques de Louvain, n°68 (4)*

[104] B.Lyons, J.Metha (1997) "Private sector business contracts: the text between the lines", chapter 2 in "contracts, co-operation, and competition", S.Deakin, J.Michie, (1997), Oxford University Press

[105] L.Saenz (2001) "Managing the transition from public hospital to "social enterprise": a case study of three Colombian hospitals", LAC-HSR, Health Sector Reform Initiative, N° 46, http://www.americas.health-sector-reform.org

[106] This point is emphasized in the article by B.McPake, A.Mills (2000) "What can we learn from international comparisons of health systems and health system reform?", *Bulletin of the World Health Organization*, 78 (6)

[107] This 1996 order nevertheless poses a problem; it makes it mandatory for hospitals to draw up contracts with the ARH. This legally imposed contractual requirement conflicts with the very notion of a contract, which is based on the free will of the parties. This justifies use of the expression "supervised contracting" because the legislator intervenes in the sphere of contractual relations by obliging the parties to form a contract and even stipulating some of the clauses of the contracts.

[108] Medicus Mundi International "Un contrat pour la santé: passer des contrats État - ONG: une stratégie proposée par MMI pour améliorer les soins de santé" (A contract for health: State-NGO contracts: a strategy put forward by MMI as a means of improving health care).

[109] F.Bigirimana (2000) "Collaboration entre l'État et l'église catholique du Burundi dans le domaine de la santé" (Collaboration between the State and the Burundi Catholic Church in the health sphere), paper presented to the meeting "*L'approche contractuelle dans les services de santé décentralisés en Afrique*", Dakar, 19-22 June 2000

[110] See, in this respect the evolution of the British Health Service.

[111] Cassels, A (1995) "Health sector reform: key issues in less developed countries", *Journal of International Development*, vol. 7, N°3, pp. 329-347

[112] R. Bartley (1999) "The new public management in developing countries: implications for policy and organizational reform", *Journal of International Development*, Vol. 11, pp 761 – 765

Ch. Polidano (1998) "Introduction: new public management, old hat?", *Journal of International Development*, vol. 10, pp 373-375

[113] Definition of a label: recognition of the quality of the services provided by an actor, or of the quality of a contract between two actors; however, the State will not substitute itself for one of the actors should they fail to comply.

[114] S.A. Zaidi (1999) "NGO failure and the need to bring back the State" Journal of International Development 11, pp. 259-271

[115] R.B.Salman, O. Ferroussier-Davis (2000) "The concept of stewardship in health policy", *Bulletin of the World Health Organization*, 78(6)

[116] WHO World Health Report 2000: Health Systems – Improving Performance, p. 119

[117] L.Kumaranayake (1998) "Economic Aspects of Health Sector Regulation: Strategic Choices for Low and Middle Income Countries", Ed: Departmental Publication N° 29, London: London School of Hygiene and Tropical Medicine

[118] Some make a distinction between regulation, seen as a form of government control, on the one hand and incentives on the other.

[119] Th. Bossert (1999) "Decentralization of health systems: decision space, innovation and performance", LAC Health Sector Reform Initiative, n°17

[120] Th.Bossert (1999) op. cit.

[121] Th.J. Bossert, J.C. Beauvais (2002) "Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space", Health Policy and Planning, 17(1), pp. 14-31

[122] W.J.Baumol (1982) "Contestable Markets: an Uprising in the theory of Industry Structure", *American Economic Review*, vol.72, n°1. See also, J.P. Foirry (1997) "Économie publique" Les fondamentaux, Hachette, Paris- France

[123] A L Rooney, P R van Ostenberg (1999) "Licensure, Accreditation, and Certification: Approaches to Health Services Quality", USAID, Quality Assurance Methodology Refinement Series

[124] C Mathy (2000) "La régulation hospitalière" Médica Éditions, Paris, France

[125] To simplify things these items have been presented separately. That does not mean that they are not related. For example, it is obvious that advocacy is easier to carry out when there are solid factual grounds and the most effective practices can be identified.

[126] Although it is the State's duty to make this training available to actors, this does not mean that it has to do it itself. Once again, it can resort to contracting to perform this task.

[127] Although Ministries of Health make little use of these tools, development partners are beginning to use them. Thus, in Haiti, USAID, which finances medical activities through contracts with NGOs, has introduced incentive mechanisms in the form of subsidies for NGOs that fulfil the performance criteria set out in the contract. Eichler R, Auxila P, Pollack J (2000) "Performance based reimbursement to improve impact: evidence from Haïti", LAC Health Sector Reform Initiative, 44

[128] Saltman R.B (2002) "Regulating incentives: the past and present role of the state health care systems", *Social Science and Medicine*, 54, 1677-1684. One of the main conclusions of the article highlights that contracting is not for a poor government.

[129] There have nevertheless been a number of recent initiatives; J.E. Rosen (2000) "Contracting for reproductive Health Care: a guide", Health, Nutrition, and Population, The World Bank, December 2000

[130] Ch. Ham (ed.) (2000) "Health care reform: learning from international experience", State of health series, Open University Press, Buckingham, Philadelphia

[131] Chad: National Health Policy. Ministry of Public Health, 1998.

[132] See, M.Goddard, R.Mannion (1998) "From competition to co-operation: new economic relationships in the National Health Service", *Health Economics*, vol. 7

[133] WHO has frequently received requests from actors in the field for standard contracts which, in the mind of the applicants, could not but exist.

[134] Bennett S, McPake B, Mills A (1997) "Private health providers in developing countries", London and New Jersey, Zed Books.

[135] Programme d'Appui au développement de la Santé (PADS). Les centres de santé communautaires (CSCOM): concepts, hypothèses, viabilité et évaluation (Health-sector Development Programme (PADS). The Community Health Centres (CSCOM): concepts, hypotheses, feasibility and evaluation). Swiss cooperation in Benin, Institut Universitaire d'études du développement, Geneva.

[136] Mills A (1997) "Contractual relationships between government and the commercial private sector in developing countries", Ch. 12, in "private health providers in developing countries", Bennet S, McPake B, Mills A. Zed Books, London and New Jersey

[137] Goddard M, Mannion R (1998) "From competition to cooperation: new economic relationships in the National Health Service", *Health Economics*, 7: 105-119

[138] In the series "Notes for decision makers" by Partnerships for Health Reform (PHR), see the file entitled "Collaboration with private providers in order to improve provision of priority services"

[139] K.Slack, W.D. Savedoff (2001) "Public Purchaser - Private Provider contracting for health services. Examples from Latin America and the Caribbean", Inter-American Development Bank, Sustainable Development Department, Technical Papers Series

[140] Eichler R, Auxila P, Pollock J (2000) "Performance Based Reimbursement to improve Impact: Evidence from Haïti", LAC, Health Sector Reform Initiative, n°44.

[141] Palmer N, Mills A (2000) "Serious contractual difficulties? A case study of contracting for PHC in South Africa", *Paper presented at the international symposium on Financing health systems in low-income countries in Africa and Asia, France, Clermont-Ferrand, 30 November - 1 December 2000.*

[142] Mills A, Bennett S, Russell S (2001) "The challenge of health sector reform. What must Government Do?" Palgrave.