ANALYSIS OF ALLOCATION OF FINANCIAL RESOURCES WITHIN HEALTH SYSTEMS

DISCUSSION PAPER
NUMBER 1 - 2002

Department “Health System Financing, Expenditure and Resource Allocation“ (FER)
Cluster “Evidence and Information for Policy“ (EIP)
ANALYSIS OF ALLOCATION OF FINANCIAL RESOURCES
WITHIN HEALTH SYSTEMS

by

JEAN PERROT

WORLD HEALTH ORGANIZATION
GENEVA
2002
INTRODUCTION

PART I. THE FUNCTION OF HEALTH CARE SERVICE PROVISION

1. The health care demand models approach

2. The relation between fundholder and health care provider
   2.1. Framework for assessing the demand for health
   2.2. Contractual relations between purchaser and provider

3. Modes of production for health care providers

PART II: THE FUNCTION OF STEWARDSHIP

CONCLUSION

ANNEX: CRITERIA FOR ASSESSING THE PLACE OF CONTRACTING
INTRODUCTION

Health systems have changed significantly in recent decades. It was only in the 20th century that health systems in the modern sense of the word – a coherent body of practices, methods and institutions working towards the same goal - really started to emerge. Over time, health systems have become more and more complex and two main restructuring trends can be observed. The first is characterized by a greater number and a wider range of actors involved in the health sector as a combined result of private sector development as well as of democratization and decentralization which have given way to the emergence of a civil society and organized, responsible national entities. These changes go hand in hand with greater separation of functions. The second trend is characterized by actors increasingly specializing in one specific function of the health system, be it service provision, purchasing, management of health care establishments, health financing or health system regulation.

The emergence of complex health systems, compounded by greater demand for health care services, implies greater financial resources for the health sector. Currently, total health spending expressed as a percentage of GDP is close to 10% in developed countries. Some fifty years ago, this figure was only around 5% for developed countries and today is even lower for developing countries. This considerable increase in health expenditure is problematic and increasingly, health system administrators are taking a closer look at health financing in order to better assess the health system’s performance.

Examining health financing consists, first of all, of studying all financial resources allocated to the health sector, along the lines of national health accounts. Yet once the recipients of those resources are identified, it also involves understanding exactly how fundholders allocate their financial resources.

Schematically, health systems carry out two main functions. The first, health interventions or health care services, is the older and more common of the two. Health care services have been provided ever since people became concerned about protecting their health and treating their illnesses. Provision of these services requires financial resources which need to be mobilized and effectively used. Yet a health system cannot perform well if it is merely a juxtaposition of providers. A health system, therefore, is a coherent body constantly seeking self-improvement. Stewardship is the kingpin of any health system. As highlighted in the World Health Report 2000, “Stewardship encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information” (p.117). Stewardship is, therefore, a determining factor and requires considerable financial resources which, yet again, should be used effectively. These two functions can now be examined from the perspective of their influence on the goals of the system (improving the health of the target population, responsiveness to people's expectations and ensuring financial protection against the costs of poor health. Two issues are raised in this regard, namely:

- How those responsible for carrying out these two functions obtain the financial resources they need to do so? The mechanisms through which these entities obtain financial resources, in the sense of collecting, should be examined. Yet this question can also be viewed from another perspective, i.e. how those who hold the financial resources allocate them to those who carry out these functions. The manner in which fundholders allocate financial resources to producers is, therefore, the cornerstone of this first issue.

- The second issue has to do with actual performance. In other words, how a producer, using the financial resources at its disposal, i.e. the funds allocated or collected in the sense given above, effectively organizes his production activity.

In reply to these questions, this paper is divided into two parts. The first part deals with the provision of health care services and the second with stewardship in the context of health systems. An appendix complements this study by proposing a
framework for assessing in greater detail the role of contracting within the health system.

PART I: THE FUNCTION OF HEALTH CARE SERVICE PROVISION

Health care services and providers that produce them are at the heart of this study. On the one hand the service is purchased by a user, i.e. an individual, who purchases directly from the service provider or through his agent, the fundholder. On the other hand, to guarantee this product, the health care service provider should organize itself and look at the opportunities to use inputs or intermediary services.

An individual (or his agent) PURCHASES a health care service from a health care provider who, within his production structure, may PURCHASE intermediary services from specific providers. In exchange for the funds he mobilizes, the individual (or his agent) obtains a health care service. Similarly, the provider obtains labour, raw inputs or intermediary services.

"Money for services" exchange          Organization of the production

\[\text{- purchase} \quad \text{labour market} \]
\[\text{- input – labour} \quad \text{providers} \]
\[\text{- purchase} \quad \text{input – goods} \]
\[\text{- purchase} \quad \text{intermediary services} \]
\[\text{Fundholder} \quad \text{HEALTH CARE SERVICE PROVIDERS} \quad \text{intermediary service providers} \]

The analysis, therefore, should make a clear distinction between the relations depending on their purpose. For instance, is the purpose of the relation to obtain an output, i.e. a health care service or, inversely, to obtain an input, i.e. factors of production? The health care service provider is therefore at the heart of this analysis, for it is either linked to fundholders by way of providing them with a health care service or to providers to organize its own production. According to the agency theory, the health care service provider plays the role of the \textit{agent} in its relations with the fundholder and the role of the \textit{principal} vis-à-vis its providers. This service provider may also be linked to other service providers. In this case, he is no longer in a relation of agency but he is in a relation of co-operation with other actors carrying out similar functions and collaborating in order to perform specific activities.
1. The relation between fundholders and health care service providers

1.1. Health care demand models approach

Underlying every health system are individuals who, in the interest of preserving their health, need health care services. Delivering these health care services has a cost for those providers who are responsible for producing them. Yet individuals who wish to obtain these services have limited and unequal financial resources.

According to the neoclassical theory of health care demand, which encompasses the national health accounts approach, patients are, above all, consumers which buy goods and medical services delivered by health care providers (independent establishments or practitioners). They express a demand for health care. According to the assumption of rationality, the patient can rationally rank his preferences for the utility of either various medical goods and services (M) or non-medical goods and services (Z). He can optimize his utility function $U[Z,M]$ in accordance with the price (P) of these goods and services and his income constraints (Y) as below:

\[
\begin{align*}
(1) & \quad \text{Max } U[Z,M] \\
(2) & \quad P_Z Z + P_M M \leq Y
\end{align*}
\]

Using this framework, an evaluation of expenditure on all activities affecting health (classified according the official nature of the expense) must be made. This accounting framework is useful for studying health expenditure and, by extension, deriving health policy. Yet it does not provide an understanding of the economic behaviour of agents.

In the sixties, theoreticians of the new domestic economy or what is still called the new consumer theory proposed a radically different approach. According to Becker (1964) and Lancaster (1966), consumption is an act of production. Individuals are no longer
consumers of goods and services but producers their own satisfaction. In 1972, Grossman applied this approach to health. Individuals are thus considered as producers of their state of health. Based on the proposed model, one can identify the choices individuals make in order to determine the time they allot to health care and the amount of medical and non-medical goods and services they purchase depending on a number of variables such as age, rate of depreciation of their health capital, revenue, initial wealth, work time and possible time spent sick.

“Consumers produce gross investments in health and other commodities in the utility function according to a set of household production functions:

\[ I_t = I_t (M_{ti}, TH_{ti}; E_t) \]
\[ Z_t = Z_t (X_{ti}, T_t; E_t) \]

In the equations, \( M_t \) is medical care, \( X_t \) is the goods input in the production of commodity \( Z_t \), \( T_t \) and \( TH_t \) are time inputs and \( E_t \) is the stock of human capital”.

Under this approach, consumption of medical goods and services merely plays an instrumental role. The act of production causes individuals to take a number of decisions which are important in order to understand how health care deliverables are obtained.

The first issue is aimed at ascertaining whether individuals purchase inputs (supplies or intermediary services) or health care services. In other words, in the first case scenario, the individual purchases goods such as drugs, plants or intermediary services such as laboratory tests or body building sessions. In so doing, he becomes a provider of health care services which he combines with his time to produce his state of health. In the second case scenario, on the contrary, he believes that he cannot be a good provider of health care services and prefers to purchase them instead.

1.2 Framework for assessing the demand for health

In this framework, the individual is always the initial fundholder. When he decides to purchase health care services, he must ask himself how he can use his funds to make the purchase. He is faced with the following choice: keep his funds or entrust them to an entity who will do as he asks with the funds. In the latter case, the entity becomes the fundholder on the orders of the initial fundholder, i.e. the individual.
In both cases, the individual acts as the principal. By deciding to keep his funds, his agent directly is the provider of health care services. By entrusting his funds to a fundholder, the latter becomes his agent. The decision to entrust one’s funds to an entity may, however, be:

- Voluntary: The decision is left entirely up to the individual. Whether it is voluntary comprehensive or complementary health insurance, it is entirely up to him to decide;

- Indirect: in this case, the individual is obliged to entrust his funds to an entity either for compulsory health insurance (as is generally the case in developed countries which have adopted the insurance system) or make a contribution to health coverage through a general taxation system. The individual’s decision is, therefore, indirect. Indeed, he is no longer free to decide to participate in the contribution scheme but can, through his vote, indicate his preference and support, if any, for such a system. In this way, when a majority of individuals is unhappy with the proposed system, they can demand that it be changed or even replaced altogether.

In exchange for the money he has handed over, the individual receives a service from this entity. The money-for-services exchange depends on the mandate given by individuals, directly or indirectly, to the fundholder. In fact, these fundholders act in his name, whether the individual has voluntarily and explicitly given mandate by way of a contract or whether he has acted through a social contract. He can give five different mandates in this regard, namely:

- **Mandate to insure/pay:** The individual exercises his right to resort to a health care service provider to obtain the services he considers to be useful in order to improve or regain his state of health. He requests that the fundholder acts on his behalf to pay the health care provider. This may take several forms: the fundholder can reimburse the individual entirely or in part for the expenses which the individual has incurred or directly pay the provider (third-party payer). However, in all of these cases, it is still up to the individual to decide whether or not to purchase the health care service. This mandate may simply consist of drawing on the savings accumulated by the individual in a specific account with the fundholder, a medical savings account. He may also give mandate to this fundholder to share the risks between unhealthy and healthy persons, large and small risks and carry out the traditional insurance function which, for the insured party, defies the logic of direct exchange of a health care service for immediate and complete payment.

- **Mandate to provide a service:** In this case, the fundholder, at the request of the individual, also carries out the function of health service provision. This is the reasoning used by States which collect funds through taxation to ensure that their health care institutions provide services. The National Health System (NHS) in England prior to 1990 in particular, and all systems based on the Beveridge school of thought in general, follow this reasoning. Moreover, several developing countries, particularly in the post-independence period, set up health systems in which the ministry of health, using public funds, plays a direct managerial role over the vast majority of health services in the country. In much the same way, insurance schemes set up their own health care facilities such as the Health Maintenance Organization (HMO) in the USA or the health centre set up by the Mutuelle des Travailleurs de l’Education et de la Culture (MUTEC) in Mali.
insurance scheme, such as the case of Bwamanda in Zaïre. This pattern of vertical integration has its strengths and weaknesses. The difference between the two has to do with the notion of solidarity. Public health care facilities are obliged to treat everyone whether or not the patient made a financial contribution during the collecting phase, whereas health care facilities under a particular insurance scheme, in general, only admit individuals who have made a financial contribution. When these two functions are completely integrated, those responsible for collecting and using funds are one and the same, which is all the more reason to establish internal mechanisms to improve the use of budgetary funds. However, there is an increasing trend for the fundholder and the provider, both of whom fall under the same umbrella entity, to become separate entities. This is what happens when public hospitals acquire autonomous status vis-à-vis the State.

- **Mandate to provide supervision:** The individual retains his right to select a provider but the conditions attached to that right are clearly defined. The fundholder receives mandate to negotiate the conditions of the purchase which the individual will make. Negotiations can involve the following elements: 1) accreditation of providers to which the member must resort if he wishes to be covered by the fundholder; 2) price: the fundholder, on behalf of the individual, negotiates the rates which the provider must apply to members (In France: social security negotiates the rates which physicians under agreement must charge for visits); 3) services covered: the fundholder does not necessarily cover all health care services (he may cover primary health care but exclude comfort care or overly expensive drugs (for example, coverage of triple therapy in developing countries); 4) quality of service: for instance, the fundholder negotiates admittance and access to the provider so that the individual, on producing his membership card for example, does not need to pay an advance before being admitted to hospital (Australia);

- **Mandate to purchase:** In this case, the individual delegates authority to the fundholder who purchases health services in his place. The individual might opt for this course of action for a number of reasons, namely: 1) the individual might feel that the fundholder is more powerful than him to purchase the best health services at the best price; 2) the individual acknowledges his limitations and believes that the fundholder has a better feel for his needs (information asymmetry); 3) the individual feels that non-individualized activities can be effectively performed only through collective action through the fundholder (e.g. cleaning up a mosquito-infested area). Through this delegation of authority, the individual agrees for the fundholder to act on his behalf and represent him in all his relations with health care service providers. He needs to rely on providers in order to obtain the service he needs. The purchase may concern a pre-determined package of services, for example, the fundholder negotiates with a service provider to obtain a certain number of pre-determined surgical procedures for his clients or a given number of children requiring vaccination and it is the fundholder who will decide which clients benefit from this service. In this case, the provider is well aware of the demand and runs no risk. However, the fundholder can also negotiate access to specific services for his clients, for example, by negotiating with a particular service provider so that all its clients are provided with appropriate services. This is how systems which pay service providers through capitation work. In this scenario, the provider is unaware of the volume of demand and assumes a portion of the risks. This case deals with a specific type of purchase whereby the conditions of purchase are stipulated in the contract. The package of services defined therein is covered in terms of quality.
and control but not in terms of quantity. Therefore, there are conditions attached to this purchase.

In addition, when the fundholder is the State, the individual’s mandate expressed above is complemented by the solidarity factor. In this case, the fundholder not only exercises purchasing power for individuals who have contributed financially, but also for those who could not.

- **Mandate to co-operate**: The fundholder may also receive mandate to develop partnerships with health service providers. This mandate is based on the “do it together” reasoning. Both fundholder and health provider, bearing in mind the comparative advantages of each in their respective areas of specialization, will find a common ground to carry out concerted action. When funds come into play, co-financing is the logical choice. Each party makes a contribution towards achieving the commonly defined goal.

These mandates are not necessarily mutually exclusive. In this way, the individual can give mandate to purchase specific health services, particularly those which are non-individualized, while retaining his purchasing power over all curative treatment. Similarly, mandate to insure/pay usually go hand-in-hand with mandate to provide coverage concerning purchasing modalities.

The scenario described above may be illustrated in the figure below:
1.3 Contractual relations between fundholder and provider

This framework offers an explanation of the production modalities for health services and the role of each of the actors involved. The role of the individual is central thereto for it is he who, either directly or as a last resort, decides which health services will be produced. This understanding would be incomplete, however, without an explanation of the mechanisms used by the individual to formalise his decisions. The contractual relation is the basis and may take various forms.

Purchase and contractual relation

The act of purchasing may be defined as a voluntary exchange between actors. When this exchange is instant, the conditions of the exchange which have been negotiated are implemented immediately and, therefore, do not need to be formalized. Indeed, a contractual relation is established but by virtue of its instant nature, a formalisation of this relationship is averted. However, when there is a lapse between negotiation of the purchase and the act of purchase, the relation needs to be formalized through a document (contract) intended to reduce the uncertainty surrounding the behaviour of the other parties and elaborate on the consequences of events which may affect the resources of the parties to the exchange. As a result, all purchases imply a contractual relation, but the question is whether this relation will be formalized or not.

Moreover, the contractual relation is two-way: when the first actor purchases a service from a second actor, this implies that simultaneously, the second actor sold this service to the first. It is up to the analyst to select the perspective from which to present his study. This case deals with health services purchased by individuals or their agents but, working backwards, could equally have dealt with the sale of health services by providers.

1 Inversely, not all contractual relations necessarily imply a purchase.

To obtain health services, the fundholder turns to a provider.

- The direct contractual relation between individual and provider

When an individual directly seeks a health provider and covers the total cost of the service, a contractual relation is established between these two actors. Frequently, this contractual relation is instant, e.g. when an individual goes to his GP who is a private practitioner. This purchase does not require the drafting of a specific contract, all the more since the act is backed by usage and custom or the civil code which obliges the client to pay for services rendered. Non-compliance entails consequences for the individual which will never be to his advantage if it can be proved that the service was actually delivered.

Nevertheless, the relation between individual and provider is by no means simple. It is a relation of agency by virtue of the information asymmetry regarding diagnosis and care in which the individual is in the weaker position. Given this state of affairs, the individual can cover himself by delegating his purchasing power to an entity he commissions to so do (see below). But he can also attempt to redress the information asymmetry in the following ways:

- By going to an association dedicated to defending the interests of individuals or providing them with the best possible information to inform their decision;

- In certain cases, the client could request a contract beforehand. For instance, the client could request an estimate of the costs to be incurred as a result of his
demand. More and more, service providers are called on to give an estimate of services to be rendered and a contract is signed by the parties involved prior to delivery of the service. Similarly, clauses on the expected outcome could be included in the contract as is often the case with cosmetic surgery. These practices are ever increasing. The single “patient-practitioner” equation based on mutual trust is fast losing ground. The contractual relation and its legal ramifications come into play here as regards an obligation to pay and increasingly, an obligation to provide results.

- **Contractual relation between individual and fundholder**

Situation ② figure 2:

When an individual entrusts his funds to a particular entity, a contractual relation is established between himself and this entity:

- Where the individual is free to choose or is under no obligation, the contract between the individual and this entity is a standard contract. In exchange for the funds he entrusts to this entity, he obtains a service which will depend on the mandate he gave.

- Where the individual is constrained in his choice or in essence, has no choice, the contract between the individual and this entity takes the form of a social contract. Whether it is the State directly or a specific entity such as a national health insurance scheme, there is an underlying contract much like the social contract defined by J.J. Rousseau. The individual agrees to entrust his funds to this entity which, in exchange, will carry out the mandate enshrined in this social contract. Obviously, the individual’s will is not expressed as directly or as immediately as in the previous case, but that is not to say that it does not exist. It is expressed through general elections or other ways of electing representatives to the social security authorities. It may also be expressed through various forms protest such as petitions, strikes, demonstrations and even revolution.

The contract between the individual and the fundholder is composed of two essential parts. The first has to do with the manner in which collection (taxes, contributions) and pooling of these funds (insurance function) are organized. The second has to do with the utilization of the funds made available to the fundholder and, consequently, refers back to the mandate given to the fundholder.

- **The contractual relation between fundholder and provider**

Situation ③ figure 2:

The role of the fundholder changes from being the individual’s agent in the previous case to becoming the principal vis-à-vis the health provider.

- **Mandate to insure/pay:** When an individual gives the fundholder mandate to share risks only, generally no relation between the two parties is established. The decision to buy or not to buy health services remains entirely up to the individual. The relation remains between the individual and the fundholder. However, in some cases, like the third-party payer scenario, the fundholder must enter into a contract with the provider in order to carry out the mandate it received from the individual. The contractual relation is merely technical and the fundholder must come to an agreement with the provider on the terms of payment.
Mandate to provide a service: The same applies when the functions of the fundholder and provider are fully integrated since, given that they are a single entity, no relation can exist. However, when, under the same umbrella entity, a legal separation of the functions of fundholder and provider is made, a contractual relation is established. This is the case of public hospitals with an autonomous status and the State as a fundholder. Gradually, they move away from the traditional budgetary allocations and move towards negotiating their ties. The autonomous hospital will attempt to exercise its power by seeking to obtain additional resources against improved provision of services (diversification or quality enhancement). The State will attempt to obtain the best service in exchange for its funding by negotiating performance criteria with the provider. The relation deriving thereof becomes contractual and a contract formalizes the relation.

Example: contracting involving public and private hospitals in France

The order of 24 April 1996 concerning the reform of public and private hospitalization established the Regional Hospital Agencies (RHA’s), which are public interest groups, legal entities with administrative and financial independence, constituted by the State and the health insurance organizations. They are supervised directly by the Ministry of Health. One of their tasks is to ensure that public and private hospitals have drawn up their objectives and resources contract. This contract sets out each side’s commitments; generally based on the institutional project, it covers the establishment’s strategic approaches and the conditions for their implementation, targets relating to health care quality and safety, measures relating to human resources management, implementation targets relating to guidelines adopted by the regional health conference, dates for implementing the accreditation procedure, participation in health care networks, hospital groups and financial aspects, especially the commitments of the State and local government.

For the two other types of mandate identified above, a contractual relation is necessarily established between the fundholder and the provider:

- **Mandate to provide supervision**: the fundholder receives authorization to negotiate the arrangements for a purchase which is done by the individual. On behalf of the individuals that it represents, the fundholder must establish a contractual relation with health service providers in order to supervise the purchasing act carried out by the individual. This contractual relation may be established with one particular provider; for example, a community funding scheme based on restricted geographical representation enters into a contract with a hospital in its area in order to determine the terms of acceptance of members and the rates that will apply to its members. This type of contractual relation can be more extensive, and can be negotiated with a group of providers or an organization representing them; for example, the social security organizations in France sign agreements with the bodies representing doctors in private practice. Likewise, several fundholders may come together to conclude an agreement with a group of providers. Thus, the mutual insurance companies combine and come to an understanding with the providers on the basis of a framework agreement. The latter may be understood in two ways:
  - the mutual insurance companies and the providers may draw up a framework agreement between them, establishing the main policies and rules governing their relationship; this framework agreement is followed by as many specific contracts
as are necessary to regulate relations between the two bodies. The framework agreement serves as a reference for the negotiation of specific contracts. This approach offers the advantages of standardizing contractual procedures and facilitating negotiations. Such controlled freedom allows great scope for adapting to actual conditions while maintaining consistent practice;

- the mutual insurance companies and the providers draw up a framework agreement establishing contractual terms which the parties have the option of accepting or not. Here, the framework agreement is synonymous with a standard form of contract for both mutual organizations and providers. In particular, there is no longer a requirement to establish a specific contract – it is simply sufficient to acknowledge that the framework agreement constitutes the contract linking the two organizations. This kind of framework agreement must be as explicit as possible in order to cover all situations.

- **Mandate to purchase**: an individual authorizes the fundholder to take his place in purchasing health services. The resulting contractual relation with the health service provider then revolves around the services which the provider agrees to place at the fundholder’s disposal. The negotiations thus focus on specific services. For example, the provider may undertake to supply so many caesarean sections at a given price for the individuals who are referred to it by the fundholder. The negotiation then focuses on a package of services whose quantity, quality and/or price will have been negotiated. For example, a provider agrees to supply the members of an insurance company with all the health services which have been identified in the contract drawn up, to the extent that those members are explicitly concerned by that policy.

Under the capitation system, the fundholder pays a provider (or group of providers) a fixed sum for each person, and the provider or provider group undertakes to supply all members with the health services defined in the contract. The contract defines the commitments which the provider must undertake in return for a fixed sum that it receives in advance for each of the members registered in a given system. The contracting is thus an integral part of the capitation process. Many developed countries have adopted capitation, such as the USA (HMO) and Great Britain; others are planning to introduce it, at least on a partial basis (for example Canada and France); this method of payment is becoming widely acceptable in middle-income countries, several Latin American nations, such as Argentina and Nicaragua have experimented with it; as well as Thailand. In Romania, beginning with eight districts in 1994 and on a country-wide basis since 1998, the health authorities have been entering into contracts with medical practitioners for the provision of primary health care. By contrast, mainly because of their relatively weak insurance systems, the developing countries make very little use of capitation.

In some cases, particularly in the public sector, there is a desire to separate the functions of fund collecting, service purchasing and service provision. An authority – an agency – is set up to purchase health services from providers on behalf of the fundholder. An additional player is brought into the arrangement. In this case, a contractual relation formalizing the purchase of health services is established between the agency and the provider; however, the agency is acting on behalf of the fundholder.

- **Mandate to cooperate**: the fundholder receives mandate to develop cooperation with health service providers. In order to fulfil this mandate, the actors develop contractual relations which define each participant’s role in the joint action. It often happens that fundholders and providers join forces in bringing certain public health problems to the public’s attention. For example, an insurance or micro-insurance system may conduct an
awareness campaign about child vaccination using advertisements prepared jointly with the health service providers.
### SUMMARY

<table>
<thead>
<tr>
<th>Type of contractual relation</th>
<th>Explanation</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Direct contractual relation between an individual and a care provider</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cosmetic/reconstructive surgery</td>
<td>Many developed countries</td>
</tr>
<tr>
<td><strong>2. Contractual relation between fundholder and health service provider</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Mandate to insure/pay</td>
<td>Third party payer or &quot;bulk-bill&quot; from a physician</td>
<td>Australia</td>
</tr>
<tr>
<td></td>
<td>Billing procedures for treatment performed by health facilities and for which the mutual health organization insures the payer directly with the health facilities (excepting patient contribution)</td>
<td>PRIMA project in Guinea¹</td>
</tr>
<tr>
<td>2.2. Mandate to provide supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. accreditation</td>
<td>Institution specifically responsible for accrediting health service provider</td>
<td>ANAES in France</td>
</tr>
<tr>
<td>. rates</td>
<td>Negotiation between physicians in private practice and fundholder</td>
<td>French social security, Denmark: negotiations between the professional organization and the National Health Security System</td>
</tr>
<tr>
<td>. services paid for by social security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. conditions of acceptance</td>
<td>The mutual health organization defines members’ acceptance conditions with the health centre</td>
<td>FAARF Burkina Faso</td>
</tr>
<tr>
<td>2.3. Mandate to purchase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. negotiating power</td>
<td>Purchase of a health service package</td>
<td>Germany: social security funds negotiate overall budgets with physicians associations to cover all outpatient care for a population (based on capitation) Netherlands: for hospitals, negotiation of a budget between insurers and providers India…: purchase of DOTS strategy from private practitioners Zambia: the authorities of a health district without a district hospital purchase those services from a regional hospital</td>
</tr>
</tbody>
</table>
2. The production methods of health service providers

In order to guarantee their provision function, health service providers have funds which come to them directly from individuals, or from fundholders whose resources are themselves received from individuals. The act of production can thus proceed by three methods:

- **The traditional way:** situation \( \mathbb{4} \), graph 2

  The provider acts as a traditional producer by combining inputs to achieve the product which it wishes to supply to clients. To do so, it obtains human resources and acquires the necessary goods. In accordance with its legal status, the provider either uses the workforce placed at its disposal or acquires one directly on the labour market. Goods are purchased in the marketplace; we are in the environment of contracts of procurement;

- **Intermediary services:** situation \( \mathbb{5} \), graph 2

  For certain intermediary services, the provider may turn to specialized providers. This can happen with non-medical services. For example, a hospital might use a company to provide meals for its patients or to clean the wards. It can also happen with medical services: a hospital might secure the services of a specialized surgeon who is not a hospital employee, or subcontract laboratory analyses to a particular institution. This outsourcing generally concerns specific functions which do not form part of the service provider’s core functions. What distinguishes this category from the previous one is that it involves an
“organized” intermediary service which itself combines different inputs. In this environment, the agency theory is particularly relevant; the health service provider acts as the \textit{principal}, and the specialized providers are in the situation of an \textit{agent};

- Other health service providers: situation \ref{graph2}, graph 2

The health services provider may also wish to come to an agreement with other providers in order jointly to establish collaboration procedures. Such partnerships can be relatively strong and involve some or all of the collaborating parties: networks, strategic alliances, even joint subsidiaries. In these cases, there is no purchasing act. The agency theory cannot be used to explain the relations between these partners; on the contrary, this is a relation in which those involved are on an equal footing and must define their cooperation.

Using the resources at its disposal (whether provided by the State, through fundholder purchasing or directly by individuals), the provider must organize its production.

Traditionally, the provider combines all its inputs to ensure production, just like a firm. In some cases, it must establish traditional contractual relations, such as employment contracts, with its employees, or supply contracts with the providers of basic inputs such as raw materials and various goods. However, in this scenario the health service provider is the only party engaged in the act of production.

In order to improve its productivity, the health service provider may secure the involvement of another provider in the act of production. This participation in the act of production may take the form of a purchase of intermediary services, either medical or non-medical. Such a purchasing act requires that a contractual relationship be established between the main provider and the intermediary service provider. The main provider delegates one or more tasks involved in the production of its health service to a provider which carries them out according to the contract established; thus, the intermediary service provider replaces the main provider for that part of the production process, but the main provider retains overall control of the work.

Several factors distinguish the above-mentioned two categories, including the following:

- the first category mainly involves limited exchanges, whereas in the second category exchange is virtually constant and long-term;
- only with great difficulty could a health service provider produce goods in the first category, whereas it could decide to produce intermediate services by itself (and perhaps will have been doing so beforehand);
- the first category concerns basic inputs that the provider uses to guarantee production of the health service, whereas the second category concerns an “organized” intermediary service which is only a part, and generally not an essential one, of the health service produced by the provider;
- in the second category, the purchase embodies the act of delegation made by the health service provider, whereas this concept is absent in the first category.

These factors are important to understanding the relations which are established between the health service provider (the purchaser) and a supplier. It is useful here to consider the literature concerning the purchasing function. The debate on this issue may be summarized in terms of two main ideas: partnership and competition. Competition is the traditional approach to relations between a purchaser and suppliers; the relationship is distant,
the purchaser makes the suppliers compete with each other so as to obtain the best service for the lowest price during the transaction, and starts a new competitive process as often as possible:

- 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).

By contrast, under the partnership or “co-makership” approach, the purchaser develops relations based on confidence in the specialized suppliers:

- Avoiding the unnecessary costs of excessive tendering and frequent competition;
- Fewer, dedicated suppliers;
- Long-term contracts;
- Co-ordinated strategies between purchasers and suppliers;
- A sharing of risks and rewards;
- Trust relationships;
- Single sourcing;
- Resulting mutual benefit (“win-win” outcomes).

There can be little argument that relations based on competition generally come under the first above-mentioned category where the purchase of basic inputs is concerned. On the other hand, analysis of the experience gained to date with intermediary service provision has revealed the limitations of relations based on competition, and the need for a measure of partnership if good results are to be achieved. The contractual forms which ensue reflect this: in the first category, the contracts used are essentially of the enforceable kind, and describe in full every aspect of the relationship; in the second category, the contracts are relational ones of the “head of agreement” type.

The act of production can also lead to collaboration. In this case, a health service provider seeks the collaboration of other providers which are trying to improve the productivity of the act of production by joining forces. The collaborative efforts between health service providers are no longer based on a purchasing act, as above, but on the definition of each party’s responsibilities in the act of production. This definition process entails a contractual relationship which is encapsulated in contractual documents that spell out everyone’s responsibilities.

- this contractual relation may require a contract to be drawn up; for example, networks or strategic alliances;

- the basis of this contractual relation may also be a joint subsidiary, created by two organizations in order to implement a given activity. Contractual cooperation of this kind does not require a formal contract, but is specified in the statutes of their joint subsidiary. For example, two hospitals might decide to pool some of their services: specific laboratory tests, specific accounting services, etc; or a few health service providers might decide to share a medical supplier. In order to do this, their alliance may take the form of an economic interest group (GIE). The nature of the contractual cooperation is made clear in the statutes of the joint subsidiary, in which each parent organization defines its commitments.
<table>
<thead>
<tr>
<th>Type of contractual relationship</th>
<th>Explanation</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Purchase of &quot;gross&quot; inputs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Labour</td>
<td>Work contracts</td>
<td></td>
</tr>
<tr>
<td>1.2 Supplies</td>
<td>Supply contracts</td>
<td></td>
</tr>
<tr>
<td><strong>2. Purchase of intermediary services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Non-medical services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Catering for patients</td>
<td>Hospitals contracting with private firms for catering services for patients</td>
<td>Bombay, India¹</td>
</tr>
<tr>
<td>. Upkeep of wards</td>
<td>Hospitals contracting for the upkeep of sickrooms</td>
<td>Tunisia</td>
</tr>
<tr>
<td>. Laundering</td>
<td>Hospitals contracting with private firms for laundering</td>
<td>Thailand¹</td>
</tr>
<tr>
<td>. Maintenance</td>
<td>Maintenance of a pool of vehicles or of medical and non-medical equipment</td>
<td>Papua New Guinea¹</td>
</tr>
<tr>
<td>. Accounting, human resources management</td>
<td>Contract for management by a specialist private firm</td>
<td>Cambodia²</td>
</tr>
<tr>
<td>. Continuing education</td>
<td>Service providers who, to make their staff more effective, negotiate continuing education sessions with a specialized firm</td>
<td>Brazil, Ecuador, Mexico, Bolivia³</td>
</tr>
<tr>
<td><strong>2.2. Medical services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Laboratory analyses, radiology</td>
<td>Service providers who have some laboratory analyses carried out in specialized offices</td>
<td></td>
</tr>
<tr>
<td>. Recourse to specialists</td>
<td>Hospitals hiring specialists for specific tasks</td>
<td>Namibia</td>
</tr>
<tr>
<td><strong>3. Contractual cooperation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Agreements involving little organizational interlocking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Franchising</td>
<td>Arrangement between a franchiser and franchisees</td>
<td>DOTS in India, Bangladesh, Cambodia, China</td>
</tr>
<tr>
<td>. Networks</td>
<td>Health service providers arrange among themselves to provide complete patient follow-up</td>
<td>Réseau Santé Sida Yvelines Ouest (RESSY), France</td>
</tr>
</tbody>
</table>
Partnership agreements

Hospitals which arrange among themselves to specialize each in a field but exchange their patients

In the IRIS (Interhospitalière Régionale des Infrastructures de Soins, Brussels, Belgium), specialist care, requiring high-technology equipment and advanced skills, is concentrated on specific reference sites.

3.2. Agreements involving much organizational interlocking

- Strategic alliances
  - Service providers pooling their resources to carry out an activity:
    - France, city of Evry: the city hospital, SOS Médecins and the Departmental Medical Emergency Association set up a joint association providing night consultations.

---


---

PART II: THE STEWARDSHIP FUNCTION

Apart from its implications, greater or lesser and more or less direct, according to health systems, in the provision of health services, the health administration also fulfils a stewardship function as described in the introduction. The first role was taken up in the preceding part since the relations between providers of health services and fundholders in the production of health services were covered: the role of the health administration was viewed from the angle of a fundholder maintaining relations with health service providers or from that of a health service provider. What we now have to do is look at the second role of the health administration, namely that of stewardship.

This stewardship role, whether discharged nationally or locally, is funded from tax revenue. For the developing countries this is supplemented by resources from the development partners. The State (or a local authority) can thus draw upon funds to perform this task; the requirement then is to examine how these entities are going to organize the production of this function. The diagram below provides a synopsis:
II.1. Forms of production of stewardship tasks

- The traditional way: the State (or local authority) acts as a traditional producer combining inputs to obtain the output it desires. To do this it enlists human resources, recruiting them directly on the basis of work contracts. The latter will be traditional for any contractual labour or of a special type in the case of civil servants. Furthermore, it will acquire supplies it purchases on the goods and services market, for which it will conclude public contracts generally giving rise to administrative contracts. In this context the administration remains the sole player in the act of production.

- For some intermediary services, the administration may turn to specific suppliers. Thus, rather than maintaining a permanent maintenance service for vehicles and for specific machinery, it may decide to conclude a contract with a service provider to carry out that assignment for it. It may likewise buy training services from a training institution or study services from a consulting firm. Such instances of outsourcing generally concern particular functions not constituting the underlying purpose of the administration. It is thus more difficult to buy the recruitment of officials or the inspection of personnel and institutions. These intermediary services account for only part of the output.
• The administration may also delegate some of these regalian tasks – namely those linked to the exercise of the power and prerogatives of the State – to autonomous entities. Thus, rather than exercise these tasks itself, the State delegates them, by decree, to an autonomous entity. However, in so far as that entity cannot derive resources from its activity, the administration will bear the financial charges resulting from the operation of the autonomous entity. It may then grant financial subsidies in accordance with standard government practices or draw up a contract making the subsidy conditional on performance. In the latter instance, we can speak of purchase of a specific output. A case in point in France is that of the Agence Nationale d’Accréditation et d’Evaluation en Santé (ANAES): pursuant to the Order of 24 April 1996, ANAES is responsible for accrediting public and private health establishments. The financial charges arising from the programme of work are covered by a contractual agreement with the central administration.

• The administration may also delegate some of these technical tasks to autonomous entities. For example, the administration may delegate some of its mandates to specific entities. It will thus establish a specific entity for the management of health districts or regions, or for the supply of medicines. These autonomous entities will nevertheless have links with the administration that will generally be contractual. In so far as these entities are mandated to perform certain activities on behalf of the administration, the latter will bear some or all of the financial consequences. The administration can then be considered to purchase from these entities the performance of certain services for which it provides funding.

• The function of administering health in countries is less and less a matter for a single central administration. It is with increasing frequency shared by various public authorities: the central administration but also the decentralized territorial communities, all of which are independent authorities statutorily responsible for specific functions within the health sector. This logic also holds good in countries with a federal structure, in which contractual relations are ever more frequently used to resolve relations between these levels. Yet the law does not always suffice to regulate the necessary relations between these public entities in charge of health. We then see the development of contractual relations intended to establish the necessary items of cooperation. These contractual relations are not based on a purchase but on the definition of forms of collaboration or even joint action involving a sharing or a pooling of funds. Each of these public actors provides its share of funding for an activity. There again, these various public entities may also reach an understanding to establish common entities to which they will delegate a mandate. For example, we have the establishment of a local agency in which the members of the board of directors come both from the central level and from the decentralized territorial communities (District Health Board in Zambia).
### Type of Contractual Relationship

<table>
<thead>
<tr>
<th>1. Purchase of intermediary services</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>. Upkeep, maintenance, etc.</td>
<td>Most health ministries have done away with their maintenance workshops and contracted private firms. This is particularly so where all non-medical equipment is concerned; in the case of medical equipment, practice still varies.</td>
</tr>
<tr>
<td>. Continuing education</td>
<td>NGOs such as BEMFAM in Brazil, CEMOPLAF in Ecuador, MEXFAM in Mexico and CARE in Bolivia have concluded contracts with the municipalities to train the latter's personnel, particularly in the field of reproductive health.</td>
</tr>
<tr>
<td>. Studies</td>
<td>In many developing countries, the necessary studies to prepare projects supported by development partners are carried out by consulting firms contracted for these assignments.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Delegation to autonomous entities</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>. Management of a health district</td>
<td>Cambodia: management of the human resources of the district by an international NGO.</td>
</tr>
<tr>
<td>. Provision of medical supplies</td>
<td>Ghana: an NGO is entrusted by the Ministry of Health with selling contraceptives as part of the social marketing initiative.</td>
</tr>
<tr>
<td>. Accreditation system</td>
<td>France: Agence Nationale d'Accréditation et d'Évaluation en Santé (ANAES)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Links between administrations</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>. Cooperation for specific tasks</td>
<td>As part of the decentralization process, contractual arrangements govern the relations between the Ministry of Health and municipalities, for instance on personnel matters or the supervision of health training.</td>
</tr>
<tr>
<td>. Common entities</td>
<td>Zambia: District Health Board</td>
</tr>
</tbody>
</table>

### Conclusion

This analysis has highlighted several important points:

- First, that there can be no talk of purchase without establishing a typology. The one that seems to be the most discriminatory rests on the distinction between the buying of health services by a fundholder and the purchase of intermediary services by health service providers in the act of producing health services;
• Once this typology has been established, it becomes easier to analyse the contractual relations within the health system and to characterize each of them.

If we now look at how contracting has evolved in the established setting, it can be seen that:

• Contracting within the act of production is developing, particularly in the public sector. Still a short time ago, the idea that a health service provider might call on providers of intermediary services for the sake of improved production of health services seemed practically impossible. For a health service provider had to be entirely alone in the act of production, since it concerned a specific product that was incompatible with the participation of an outside provider. Nowadays the specialization of tasks often makes it more judicious to have recourse to an outside provider for intermediary services in which the latter is more efficient. Such contracting is then based on market principles and competition; the aim for the health service provider is to secure the services of a specialized provider of intermediary services who is thus able to offer more competitive rates than those of the health service provider not specializing in the field concerned.

• On the other hand, the contractual relations between fundholders and health service providers follow different trends. The first has been that of separation between the fundholder and the health service provider with the introduction of competition between service providers based on market forces (real for the private sector or artificial in the case of internal contracts in the public sector). Nowadays several of the countries that had set out decisively on this path are adopting somewhat different strategies (United Kingdom, New Zealand). We thus move on from the notion of contracting based on competition to that of contractual cooperation, as in the cases of the United Kingdom and Sweden.
ANNEX

CRITERIA FOR ASSESSING THE PLACE OF CONTRACTING

It is important to gauge the place occupied by contracting in a health system in order subsequently to appreciate whether contracting is a tool contributing to improved performance. We can thus seek to establish an "index of recourse to contracting" for the purpose of indicating the place contracting occupies.

Devising a synthetic index for the entire health system is no doubt not easy. Furthermore, given the diversity of utilization of such a tool, it may be worth having information for each type of recourse to contracting. This index of recourse to contracting may thus be established for each of the categories picked in this document, namely (i) contractual relations regarding the provision of health services, with a distinction according to whether we are looking at relations between a fundholder and a service provider or whether the contractual relationship concerns the act of production, and (ii) contractual relations with respect to the stewardship function.

• Contractual relations concerning the provision of health services

With regard to contractual relations between fundholders and providers of health services, the index of recourse to contracting may attempt to assess the volume of funds passing from fundholders to health service providers via contracts for the purchase of services. Such an index can also be broken down by type of fundholder (State, compulsory insurance, voluntary insurance) or according to the nature of the health services purchased (health services that can be individualized as opposed to those that cannot).

• Contractual relations concerning the act of production of health service providers

With regard to contractual relations between health service providers and providers of intermediary services, the index of recourse to contracting will seek to gauge the volume of funds that health service providers devote to purchasing intermediary services. Such an index can also be broken down according to the type of health service provider: for example, whether it is a public or a private provider. An alternative approach consists in identifying the percentage of health care establishments that have concluded contractual agreements for patient catering, upkeep of premises, accountancy and equipment maintenance, but also for laboratory examinations.

• Contractual relations with respect to the stewardship function

With regard to contractual relations concerning the general administrative function, the index of recourse to contracting may be a mix of such components as:

- number of contracts concluded to obtain intermediary services;
- number of contracts concluded with specialized agencies;
- number of contracts concluded with autonomous entities to which responsibility has been delegated for specific tasks;
- number of contracts concluded with other public entities.

Different weightings can be assigned to each of these components.

With the use of regression techniques, these indices can be tied in with indicators measuring the performance of the health system so as to establish causal relations. It will thus
be possible to test whether recourse to contracting is a feature helping to make the provision of health services and stewardship more effective and thereby improving the performance of the health system as a whole. The place occupied by contractual relations in the health system could then be read in conjunction with the three health system goals as established in the World Health Report 2000: good health, fairness of financial contribution, and responsiveness.

Such quantitative relations will nevertheless be difficult to establish and they will no doubt have to be accompanied by qualitative analyses seeking to identify any changes in the behaviour of actors caused by more systematic recourse to contracting.
NOTES


5 In Grossman’s model, the initiator of a demand for health can only be the individual. In this paper, the individual remains the principal initiator of the demand for health. However, there are cases where this initial demand can come from other entities such as companies. The analysis developed in this paper for individuals can, therefore, be transposed to these entities. On the other hand, the State is never considered as an initiator of the demand for health because it always acts on the mandate given to it by individuals or these other entities.

6 In the present case, this distinction is not important. It would be, however, if one was interested in how the funds are pooled, namely through a tax system or by specific contributions paid to insurance companies. However, in certain cases, the fund pooling and insurance functions of the fundholder are separated. For example, in the Dekker Plan in the Netherlands, since 1987, the State has ensured that premiums are pooled, but the insurance function is carried out by insurance companies which, in exchange, receive a contractual endowment per client from the State.


8 Generally, the fundholder simultaneously carries out the fund pooling and insurance functions.


12 Compared with the figure underlying the study of health system financing presented in chapter 5 of the WHO World Health Report 2000, this figure is more complete in that:
- it fully incorporates direct payment of health providers by individuals whereas this can only be applied to the first function of the figure in the World Health Report, i.e. collection;
- it deals with all resources allocated to health providers, regardless of whether they come directly from individuals or pass through fundholders;
- it provides details of the various modalities involved in resource allocation by explicitly outlining the mandate given to the fundholder. Working backwards, one could start with the health provider and formulate the modalities through which his activities are purchased.

In this way, a complete study of financing activities carried out by health providers or, in other words, the purchase by individuals or their agents of these services, is provided.
13 J.J. Rousseau (1762) “Du contrat social”.


15 This 1996 order does raise a problem, however: it obliges hospitals to draw up a contract with RHAs. This legal obligation runs counter to the essential notion of contracting, which postulates the free will of the parties. It is appropriate to refer to this as “framed contracting”, since the law is intervening in the sphere of contractual relations by obliging the parties to contract, and even stipulates some of the contract’s clauses.

16 Capitation is a method by which a fundholder remunerates a health service provider: the former pays the provider a sum which is fixed in advance on a per capita basis for payment in the future. Using this one-time advance payment, the provider undertakes to supply all necessary treatment for the people covered by the amount in question.


1 B.Criel, A.N. Barry (2002) "The PRIMA project in Guinea Conakry. An experiment in organizing mutual health organizations in rural Africa", document published by Medicus Mundi Belgique, Ministry of Public Health of Guinea, GTZ, DGCI Belgium, Institute of Tropical Medicine, Antwerp


24 In particular, the « *European Journal of Purchasing and Supply Management* » has for some years produced reference articles. Although the field of application is only rarely health, the concepts and tools developed merit the consideration of the health sector.


4 For information, consult the Internet site: [http://www.iris-hopitaux.be](http://www.iris-hopitaux.be)
For information, consult the Internet site: http://www.renaudot.free.fr

