

## Contracting and health



WHO

David Evans

David Evans earned his PhD in economics from the Australian National University in 1980. He started his academic career in the economics and medical faculties at universities in Singapore and his native Australia. During this time, he specialized in the economics of household decision-making in developing countries, including decisions relating to health, and worked as a consultant for WHO, the World Bank and Australian Development Assistance Agency. He joined WHO in 1990 to help develop research into social and economic factors relating to tropical diseases. In 1998, he became Director of WHO's Global Programme on Evidence for Health Policy. Since 2004, he has been Director of the Department of Health Systems Financing.

Contracting in public health — the subject of this month's theme issue — is more than just managing the privatization of services previously provided by governments. In 2003, the World Health Assembly adopted a resolution in recognition of the huge untapped potential of contracting in public health, as well as the risks and pitfalls. In this interview, David Evans argues that if poorly implemented, contracting may harm health systems performance, but if managed well, the benefits can be immense.

*Q: What is a contracting approach to health?*

A: Contracting is a tool that formalizes the relationships and obligations between the different actors in the health system, though it is clearly not limited to health. Many people think of it only as a tool to manage the "privatization" of health services previously provided by governments, such as cleaning or catering services in hospitals, or even the overall management of hospitals. While contracting has been used to specify the relationships between government and the private sector, its potential uses are much broader. For example, it has been used to encourage private providers to participate in DOTS treatment for tuberculosis or to define clearly the relationships between and the obligations of different layers of government. The overall aim is to improve health system performance by clearly specifying the obligations and expectations of the different actors in the health system.

*Q: What are some examples of contracts between different levels of government?*

A: Contracting is used more and more to formalize the relationships between different levels of government. For example, in order to improve the performance of the public health system, the Ministry of Health in Morocco has just developed a strategy document

in which the programme budget for a decentralized regional health authority will be subject to a contract between the region and the central government. These contracts specify the actions that regions need to take to obtain the agreed resources and develop the relationships between two levels of the same organization. Another example: Mali, is in the process of establishing performance contracts between the central level of government and public hospitals that have a degree of autonomy. These contracts again specify the obligations of both parties, but particularly the performance levels expected of hospitals in order to obtain central government funding. Such contracts are in the early days of development, and it is important that a system is established to monitor and evaluate their impacts.

*Q: Why did WHO call on Member States to take up a contracting approach to health in a 56<sup>th</sup> World Health Assembly resolution (WHA 56.25) in 2003?*

A: The idea of contracting had been gaining increasing attention among both donor agencies and governments before the resolution. The resolution recognized the potential value of contracting to improving health system performance, perhaps bringing it to the attention of some governments that had not previously considered it. It also recognized that there is a great variety of possible

forms of contracts, which offer a wealth of potential to countries seeking to improve their health systems. However contracting, if poorly managed and implemented, also has risks. It might not improve and could even harm health system performance. Accordingly, WHO called on Member States to consider their needs carefully, and where they decided to use contracting, to introduce it with professionalism. It requires close government stewardship, which would be helped if countries developed a clear policy and strategy on contracting which clearly defined the rules of the game.

*Q: What were the problems this resolution was trying to address? What kinds of problems with contracting health services were there in developing and developed countries? Where these different problems?*

A: All countries, at all stages of economic development, are interested in improving the performance of their health systems. Some feel that health service delivery can be more efficient if some logic of the market place is introduced while at the same time recognizing that health has many public good characteristics and requires strong government stewardship. Contracting allows this to happen. Other countries aim to improve performance by making it very clear what each level of government is expected to achieve as we have seen with the examples of Mali and Morocco. In

Canada, contracts are between the central and provincial governments, which have different constitutional mandates in a federal system, but it is clear what is expected of provinces in return for federal funds, and what provinces can expect from the central level. The overall goal is to introduce more efficiency, transparency and accountability into health systems.

*Q: How has WHO supported countries interested in the contracting approach?*

A: Since the resolution, there has certainly been increased demand from countries for information and for technical support on ways of developing contracting policies. WHO has responded to these requests using a process which begins with national workshops where information on the different forms of contracting, their advantages and disadvantages, and the technical requirements for implementing them is presented to a variety of stakeholders (government, NGOs, private sector etc.). If countries decide to proceed, technical support is provided to develop a policy or strategy and to guide on its implementation. Special attention has been given to supporting countries that have decided to develop national policies on contracting, including Burkina Faso, Burundi, Chad, Madagascar, Mali, Morocco and Senegal.

*Q: Tuberculosis and provision of DOTS treatment is one area where public-private*

*partnerships are very active. What other diseases would be amenable to being treated with a similar public-private mixed model?*

A: The important issue is how to engage the private sector in activities that are important for the health of the population for which there is no financial incentive. DOTS is one example, but there are many others. Prevention, in fact, is a particular concern in countries where the private sector plays an important role in delivering services, and there are many innovative ways governments have tried to encourage the private sector to engage more in prevention.

*Q: Are performance-based contracts used in public health?*

A: Performance-based contracts have gained increasing attention, where payment to the contractee depends, at least partially, on the achievement of particular outcomes. For example, in Haïti, NGOs contracted to government initially receive 90% of the money the contract specifies for the delivery of particular services. They receive the final 10% only if they achieve the specified results in a particular period, and can receive an additional 5% payment if they significantly exceed the targets. There are also interesting examples of "performance-based contracts" between government and the public. In Nigeria, some microcredit schemes provide credit conditional on children being

enrolled in school or vaccinated. These "demand-side" contracts are now receiving considerable attention with some people arguing that the health returns from such expenditure is higher than if the same funds were spent on improving the supply of services.

*Q: Sometimes contractors do not observe rules on work conditions and quality of services provided, but how can health services or authorities monitor this in developing countries where resources are scarce?*

A: It is clearly important to have a means to "enforce a contract". This enforcement must be mutual, i.e. it must work in both directions. So it is not just a question of government monitoring the private sector, or higher levels of government monitoring lower levels, but of all parties being able to ascertain that the terms of the contract have been respected. Resources are required to do this, and skills. Countries elaborating a policy on contracting will also have to consider the skills needed to develop contracts, to monitor them, and to arbitrate any disputes. This might require different skills than are sometimes found in a ministry of health, in particularly good legal skills. But this is part of the changing role of ministries as stewards of health systems, something that applies to countries at all levels of economic development. ■

## Recent news from WHO

- WHO warned of potential shortages of **influenza vaccine**, should a pandemic occur, if production capacity is not increased soon. In the best case scenario, WHO said on 23 October that an estimated 2 billion doses per year could be produced by 2009 or 2010 relying on market-driven forces alone, far short of two doses needed per person for the world's population of more than six billion.
- The world's success in **eradicating polio** now depends on four countries: Afghanistan, India, Nigeria, and Pakistan, the Advisory Committee on Polio Eradication (ACPE), the independent oversight body of the eradication effort, said on 12 October.
- An estimated 153 million people have uncorrected **near-sightedness, far-sightedness and astigmatism**, according to new global estimates released by WHO on 11 October.
- sanofi-aventis has renewed its agreement with WHO to expand a programme to fight **neglected tropical diseases**. Under the new agreement, announced by WHO on 10 October, sanofi-aventis will donate US\$ 5 million of drugs to treat **sleeping sickness** and a further US\$ 20 million for **leishmaniasis, Buruli ulcer** and **Chagas disease**.
- A WHO Global Task Force on **extensively drug-resistant tuberculosis** (XDR-TB) said the emergence of the disease posed a serious threat to public health, particularly when associated with HIV. At its first meeting on 9–10 October, the Task Force also outlined a series of measures that countries must put in place to effectively combat XDR-TB.
- WHO has called on all governments to improve the **quality of the air** in their cities to protect people's health. According to a new set of Air Quality Guidelines, released by WHO on 5 October, a reduction in levels of a pollutant known as PM10 could reduce deaths in polluted cities by up to 15% every year.

For more about these and other WHO news items please see: <http://www.who.int/mediacentre/events/2006/en/index.html>