

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>