Different approaches to contracting in health systems

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Abstract Contracting is one of the tools increasingly being used to enhance the performance of health systems in both developed and developing countries; it takes different forms and cannot be limited to the mere purchase of services. Actors adopt contracting to formalize all kinds of relations established between them. A typology for this approach will demonstrate its diversity and provide a better understanding of the various issues raised by contracting.

In recent years the way health systems are organized has changed significantly. To remedy the under-performance of their health systems, most countries have undertaken reforms that have resulted in major institutional overhaul, including decentralization of health and administrative services, autonomy for public service providers, separation of funding bodies and service providers, expansion of health financing options and the development of the profit or nonprofit private sector.

These institutional reshuffles lead not only to multiplication and diversification of the actors involved, but also to greater separation of the service provision and administrative functions. Health systems are becoming more complex and can no longer operate in isolation. Actors are gradually realizing that they need to forge relations. The simplest way to do that is through dialogue, although some prefer a more formal commitment.

Interaction between actors may take various forms and be on different scales. There are several types of contractual relations: some are based on the nature of the contract (public or private), others on the parties involved and yet others on the scope of the contract. Here they are classified into three categories according to the object of the contract: delegation of responsibility, act of purchase of services, or cooperation.

Bulletin of the World Health Organization 2006;84:859-866.

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Contractual relations based on delegation of responsibility

Contractual relations based on delegation of responsibility are set up so that rather than directly managing the health services it owns or undertaking to develop health coverage itself, the state delegates an entity to take over this task.

Contracts delegating responsibility to private actors

In some instances, rather than setting up and managing the health service itself, the state negotiates with a private actor and adopts one of the types of contract discussed below.

Contracts for the devolution of a public service

A private organization (company, association, foundation or mutual society) manages a public health service on behalf of the state. On the basis of an agreement, this entity runs the public service and is furnished with terms of reference specifying the conditions. Examples include contracts for the management of public hospitals awarded to a private firm in South Africa and the Ménontin health centre in Benin. Mali has adopted a more systematic approach since its national health policy stipulated that the state should no longer manage primary health centres but confer the management functions on community health associations.

Delegated management of public health establishments may take various forms which are linked to national legislation:

The private entity receives existing resources from the ministry of health — in the form of buildings and equipment — in their current state, to carry out the public service mission. In general, maintenance and renovation work are shared between the authority delegating power and the entity to which it is delegated in accordance with the arrangements provided for under the contract. In technical terms, and under French law, this is referred to as *affermage* (leasing) and under common law as a "lease contract." These resources remain the property of the state.

The private entity undertakes the construction of buildings and acquires equipment. These revert to being the property of the state at the end of what is generally a long-term contract. In French law, the term used is *concession* (concession) while common law refers to "build, operate, transfer" (BOT).

In all cases, the state remains the owner and negotiates directly with the executing agency. This type of contracting does not necessarily lead to a withdrawal of the state but to a change in its involvement.

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Ref. No. **06-034314**

(*Submitted: 5 July 2006 – Final revised version received: 11 September 2006 – Accepted: 11 September 2006*)

Contracts relating to the concession of a geographical area

Much like an oil exploration or forestry lease, the state may grant a lease for an inadequately covered geographical area: examples include contracts to set up primary health care services in urban areas of Bangladesh,[1] a concession contract for an entire health district awarded to a nongovernmental organization (NGO) in Cambodia,[2,3] and contracts for setting up young physicians in rural areas lacking health facilities in Madagascar and Mali.

Public–private partnerships

Since the early 1990s public–private partnerships (PPPs) have been set up in certain developed countries. (Note that the public–private partnerships described here are unrelated to the use of this expression in the context of contractual relations between a ministry of health and NGOs or associations.) PPPs differ from the types of contracting described above mainly in that the private operator is not paid by users or the general public but by the public entity which entered into the contract with it. For example, a ministry of health wishing to build a new hospital may turn to a private partner (or a group or consortium of private actors) who in turn will take on all of the following functions: financing, design, construction and maintenance. To use that infrastructure, the public actor will pay a fee to the private actor. In this way, the hospital is able to free itself of all its "administrative" activities related to building and maintenance obligations and to concentrate fully on its principal care function.

This method has certain advantages. The burden on public finances is lessened. The state does not need to find funds to make its investments and also avoids two ideological pitfalls: it can reduce state influence and at the same time avoid privatization. There are various examples of public–private partnerships: since 1992, the Private Finance Initiative has been operating in the United Kingdom; there are similar schemes in Australia; Canada (Quebec province) via law 61, passed at the end of 2004; and France, where the Hospitals Ordinance of 4 September 2003 authorized the use of "long-term (*emphyteutic*) hospital leases," a particular type of partnership contract. This form of contract has also attracted much criticism, in particular that it leads to greater privatization of the health system.

Public service association contract

In a public service association contract, a private organization that owns its own facilities and disposes of its own resources collaborates with, is an associate of and discharges a "public service mission" by signing a contract with the state; it thereby becomes a public service licence-holder. Church hospitals in Ghana[4] and the United Republic of Tanzania[5] are contractually the only referral facilities in given geographical areas. In Zambia, the memorandum of understanding signed in 1996 between the Ministry of Health and the Church Medical Association of Zambia stipulates that the boards of directors of church-owned hospitals shall have the same powers as public sector ones.[6] In several countries, tacit contracts are in place: in Chad the country's health map comprises existing health facilities both public and private; through this health map, the responsibility for the local population's health be may conferred on private health facilities in the absence of a contract.

As a result of the contracting arrangements that govern health facilities — whether delegated management or a public service association — certain actors, in particular NGOs, integrate their action more closely with the public service. However, they may want to extend their commitment and become involved in the administration of the decentralized health facility by way of a contractual arrangement.

Contracts binding the state and its autonomous institutions

Institutional reform frequently leads to autonomy for certain public institutions. In the United Kingdom, public hospitals may acquire the status of "trusts"; they may enter into a contract with care purchasers (health authorities and Primary Care Trusts) and are allowed some leeway in determining staff remuneration. However, these trusts are non-profit organizations which remain public property and must comply with the directives laid down by the National Health Service authorities. In France, the July 1991 law established the status of "public health establishments," conferring upon them management autonomy. However, the April 1996 ordinance obliges these establishments to draw up a "long-term contract setting out objectives and means" with their Regional Hospital Agencies, thereby establishing a partnership between the state and health insurance bodies. Since 1998, Spain has been granting its hospitals the following types of status: consortium, public enterprise, public foundation and trust. In Morocco, the Ministry of Health draws up framework contracts with autonomous hospitals. Similarly, Tunisia has been gradually introducing long-term contracts between public health establishments and the relevant department under the Ministry of Health, setting objectives with a view to developing performance-based contractual relations with the establishments.[7]

Internal contracting

Delegation of responsibility may occur within the same entity in the legal sense of the term, for example, in cases where the central level wishes to establish contractual relations with the peripheral level. In Burkina Faso, the central level has established performance-based contracts with the health districts, which do not enjoy any particular legal status. The same is true in Morocco, where "programme budgets" have been used. This type of internal contracting may also be entered into at the hospital level, with a contract being drawn up between the administration and the various departments. France has been developing internal contractual arrangements within its public establishments since 1996. Although these contracts cannot be "enforced," they do have features in common with contracting.

Contractual relations based on an act of purchase

The rationale behind contractual relations based on an act of purchase is based on a simple principle: rather than providing the service itself, a health actor entrusts a partner with providing it in exchange for payment. The fundholder seeks to make the best use of its resources by entrusting the undertaking of the activity to the partner who can offer the best terms (the same service but at a lower cost or a better service at the same price). The option is thus between doing it and buying it. A distinction should be made, however, between cases in which the actor used to carry out the activity itself and then decides that it will no longer do so (outsourcing) and cases in which the activity is altogether new.

Relations between fundholders and health service providers

An individual fundholder may decide to purchase the health services he or she requires from a health service provider. Such a purchase does not usually give rise to a specific contract. But the individual may also hand over his or her funds (voluntarily in non-compulsory insurance systems or involuntarily in compulsory insurance systems or tax-based ones) to an institution that will decide whether to provide the health care service itself or to purchase these health services from a provider. Such an arrangement would bring into play a "purchase strategy."[8]

The ministry of health may decide that it will no longer provide certain services and instead will use the funds at its disposal to purchase those services from providers. This is an approach commonly used for specific health services involving tuberculosis, leprosy, malaria, acquired immunodeficiency syndrome (AIDS), immunization, integrated management of childhood illness and malnutrition.[9] In Namibia, the Ministry of Health enters into contracts with private practitioners to conduct surgical operations in remote rural areas.[10] In Senegal contracts have been drawn up between the ministry of health and NGOs involved in reproductive health services or in AIDS control under the Integrated Human Development Project funded by the World Bank.

Several countries in Latin America (Colombia, Costa Rica, Dominican Republic, Guatemala and Peru) have drawn up contracts with NGOs to extend health coverage or to improve the quality of care.[11,12] In Mali, the Ministry of Health has signed contracts with private physicians who have set up their practices in rural areas to cover immunization under the Expanded Programme on Immunization. In the area of reproductive health, the Ministry of Health signs contracts with private service providers to conduct certain activities such as antenatal care.[13] In some countries, public financing agencies have been set up. In England, reference is made to "managed competition."[14] The private sector is attempting to introduce market-based operating mechanisms with a view to enhancing the efficiency of the system. They include: "planned" markets,[15] "internal" markets,[16] "quasi" markets,[17] "managed competition" and "manacled competition."[18] These terms are not strictly equivalent. In domestic market systems (e.g., New Zealand and the United Kingdom) it is considered that the distinction between buyer and service provider is complete and that the buyer must necessarily conclude a contract with a provider; whereas in managed competition regimes (in the Netherlands and the United States), there may be a vertical integration of the purchasing and delivery functions.[19] Through fairly controlled competition, it is possible to seek the greatest efficiency possible and therefore provide people with better services. A series of articles published in 2001 in *Social Science and Medicine* describes the difficulties encountered by the countries that have implemented this type of reform over the past decade or so.[20–27] Sweden, which between 1989 and 1993 undertook reforms based on the separation of care providers and service buyers and competition, is today moving towards greater cooperation in relations between buyers and service providers.[28] Ghana established the Ghana Health Service in 1996, an implementing agency under the Ministry of Health, one of whose roles was to act as an agency to purchase health services from providers on behalf of the Ministry of Health.[29] In Zambia, the results of a similar process have been less impressive.[30]

In those countries where health financing passes through autonomous or private insurance systems, contracting is used to define the relations between these insurance bodies and the service providers. These relations cover rates, reimbursement arrangements, customer care and quality of care. In Romania since 1998 the health insurance systems have entered into contractual arrangements with physicians in private practice for the provision of primary health care throughout the country.[31] In Guinea, under the PRIMA project, the mutual health insurance company has drawn up service provision contracts with the district hospitals and health centres.[32]

Whether the state itself or its agencies (e.g., regional health authorities in Australia or health authorities in Great Britain) are drawing funds from the state budget or health insurance funds are drawing resources from premiums,[33] all these entities gradually become "proactive" buyers.[34] They are no longer content to distribute budget allocations or reimburse their members' expenses. Through contracts, they negotiate with providers (public or private) the conditions under which the population they have been entrusted with, or their members, have access to care.[35] This type of contractual relation is not only necessary in all health systems which opt for capitation, such as those in the USA for health maintenance organizations (HMOs) and Great Britain, but also in those countries that intend to adopt it, such as Canada and France and several Latin American countries[36] as well as Thailand.[37] In Africa, the experience of the Nouna health district in Burkina Faso is also noteworthy.

Health service providers' production processes

Health service providers and administrations have at their disposal funds to carry out their core functions. Like conventional producers, they assemble the items necessary to produce the product they wish to supply to their clients. These items must be purchased either on the labour market (human resources) or on the goods and services market (other supplies). For this purpose, conventional contracts are drawn up. For certain intermediary services, however, they may also approach specific providers. Hence the notion of *subcontracting* or *outsourcing*: examples include maintenance contracts (in Papua New Guinea), catering (in Bombay, India) and laundry services provided for a hospital by a service company (in Thailand).[38] Evaluations of these experiments are starting to become available and show that this type of outsourcing does not always yield the expected results.[39] For example, in the Czech Republic, hospital catering services had been subcontracted to SODEXHO, a French international company, but these services had to be taken over once again by the public hospitals owing to their high costs.

These service contracts may also apply to other areas. In Chad, under the Health Sector Support Project funded by the World Bank, the Ministry of Health signed contracts with international NGOs, United Nations agencies [the United Nations Children's Fund (UNICEF)], and bilateral cooperation agencies (in Germany) to enable them to provide their technical support to prefectural health directorates (i.e. at the regional level) in the following areas: supervision, management, drug supply, cost recovery and others. In Cambodia, as part of a project backed by the Asian Development Bank, a contract gives an international NGO authority over staff from the Ministry of Health for

the award of bonuses.[40,41] As part of decentralization efforts, 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, particularly in the area of reproductive health.[42]

It is worth looking at the ways in which these contractual relations are established. The literature on the procurement function has become more abundant over the past years.

The debate on the issue may be summarized by two main trends: competition and partnership.[43] Competition is the traditional approach to relations between purchasers and providers: relations remain distant, the purchaser encourages the providers to compete with each other to obtain the best possible service for the lowest price during the transaction, and then renews that competition as often as possible. This approach is characterized by arm's-length relationships; frequent tendering, which is risky and costly; reliance on price; spot contracts or complex contingent claim contracting; multisourcing; lack of trust; reluctance to share information; and adversarial attitudes ("win–lose" outcomes).

Conversely, in adopting the "co-maker" (partnership) approach, the purchaser develops relations based on trust with providers, avoiding the unnecessary costs of excessive tendering and frequent competition. Such partnerships are characterized by fewer, dedicated suppliers; long-term contracts; coordinated strategies between buyers and suppliers; a sharing of risks and rewards; trust relationships; single sourcing; and resulting mutual benefit ("win–win" outcomes). The development of the English NHS demonstrates the transition from relationships based on competition to those based on trust.[44] Instead of "purchasing", we refer to "commissioning", i.e. the act through which an authority hands over responsibility and power for a limited period to an entity which 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 to satisfy the needs identified.[45,46]

Contractual relations based on cooperation

We have referred above to the "actors involved" rather than to "partners." The latter term may have two very different meanings: either the partner is a counterpart with whom one has relations or is someone with whom one is associated. Thus, being a partner means sharing the resources needed to work together towards a common goal while respecting one another's identity. The contractual relations described below are based on this second meaning.

Weak organizational interpenetration agreements

Weak organizational interpenetration agreements refer to situations in which the actors reach an understanding on the framework of cooperation (aims and means). However, putting these into practice affords each actor a high degree of autonomy. This arrangement may be illustrated through the following types of agreements.

Franchising

By contrast to the classic contractual agreement between two partners, the franchise may be distinguished by 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. Franchisees know that they all belong to the same network. In this way, the ministry of health can use franchising to further involve the private sector. In particular, the experiences of implementing the DOTS strategy for tuberculosis are noteworthy. Some countries have experimented with franchising for primary private health facilities, for example the PROSALUD network in Bolivia and the ZamHealth network in Zambia.[47] Experiments with family planning activities[48,49] and social marketing activities for adolescents have also been made.

Collaboration between health-care establishments and voluntary associations

An example of collaboration between health-care establishments and voluntary associations is provided by France, where since March 2002, French law has authorized public and private hospitals to sign agreements with non-profit associations to enable them to intervene in hospitals.[50]

Strategic planning at the level of the local health system and health networks

Negotiations among all the local actors may give rise to "contractual cooperation",[51] which determines the roles and responsibilities of each actor. In France, the concept of *communautés d'établissements* (community of establishments) exists. Since 1996, two hospitals may enter into a contract covering how they share their major equipment (technical facilities and operating theatre). In the Brussels region of Belgium, the Regional Inter-Hospital Network of Care Infrastructure is a network of five public hospitals. These hospitals retain their legal and budgetary autonomy, but coordination of their activities falls to a public law association-type umbrella entity charged inter alia with drawing up a strategic plan with a view to implementing a public health policy on a regional scale. Along the same lines, recognizing the plethora of health determinants opens the door to a multidisciplinary approach. The comprehensive care of patients requires better coordination of the chain of care delivered to them by health actors: the operational response is increasingly taking the form of a care network. The resulting contractual arrangements are therefore aimed at formalizing the role of each of these actors within a coherent mechanism.

Strong organizational interpenetration agreements

Strong organizational interpenetration agreements apply to situations in which actors reach an understanding on the framework of cooperation (aims and means) and conduct some if not all activities together with a view to achieving the objectives of the contract, as discussed below.

Joint management

Understood as a sharing of authority and responsibility, joint management can be seen on a macro-level; for example, the joint management of social security bodies by employers and trade unions. On a micro-level; it is used in managing health-care establishments by means of a joint management committee or a board of management composed both of members of the health staff and representatives of community institutions, such as town councils and associations. A balance is thereby struck between the health administration, which is responsible for ensuring that the health facilities fulfil

their public service commitments, and the population which — to the extent that it contributes towards their financing — has a say in and controls how its financial contribution is being used. This joint management takes various forms. These are evident in everyday management (for example shared management of cost-recovery revenues by members of the administrative committee and the director of the health centre) and also in the main trends of a health-care establishment's policy (e.g., users' associations sitting on a hospital's board of management). Thus the contract, in its broadest sense, consists of joint management procedures which are defined by the actors involved.

Alliances

Alliances lie at the heart of "working together". The success of agreements requires the active participation of the partners as well as complementarity between resources, technology and know-how. Much like what industry refers to as "strategic alliances," these are agreements in which partners define the terms of reference for their cooperation, i.e. how they pool their resources on a day-to-day basis to reach the targets they have set. The same applies to the setting up of a joint subsidiary. For example, two hospitals may decide to share some of their services (e.g., specific laboratory tests and specific accounting services) and health-care providers may decide to share drug-supply facilities. In some countries, public establishments 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.

Contracting is thus actually much broader and richer than the notion of "contract" in the legal sense of the word. It covers all kinds of arrangements between actors, whether they take the concrete shape of a contract or are realized in other ways.[52]

Modalities for establishing contractual arrangements

The different approaches to contracting can also be demonstrated by the modalities for establishing contractual arrangements.

The examples presented above differ considerably in the manner in which the contractual relationship is established. Some are based on the assumption that competition between actors is an essential condition for contracting to achieve its objectives, which implies that the absence of competition is an impediment to using the contracting tool. An alternative approach sets the presence of credible actors as a prerequisite and seeks to optimize their synergy. Contractual relationships may be established without any negotiation or, conversely, following very long-drawn-out and open negotiations. In the first case, negotiation is not allowed; one actor prepares the terms of reference and the actors who agree to enter into the contractual relationship need only to sign the contract proposal. At the other extreme, nothing is predetermined and everything must be negotiated; the actors jointly determine, without preliminaries, the terms of the contract. This diversity of approach must be recognized and no doubt constitutes one of the strong points of this tool. However, the decision to use one or the other of these methods should be based on an in-depth study to determine which strategy is the most suitable. This is where the importance of national context comes into play.

Moreover, it is important to consider the degree of *enforceability*. Generally speaking, a contract is a binding commitment — "enforceable" in the legal sense. That means that non-fulfilment of the clauses by one of the parties can lead to penalties, and ultimately the parties can invoke the commitments before the courts. The contract usually contains provisions for these penalties and for the means of enforcing them.[53] Some contractual arrangements, however, do not follow this rule; for example, it would be difficult to force parties to a sector-wide approach (SWAp) to honour their commitments. In that case, we refer to a "relational contract".[54] This is a negotiated agreement between actors generally belonging to the public sector[55] which sets out each actor's role in the joint venture or activity. The 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.[56] 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 (referred to as the "incompleteness of the contract").[57] Relational contracts rely primarily 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 from some measure of social control. If a relational contract is to produce the expected results, it must form part of a framework of continuous management of relations, dialogue and negotiation. These are the elements that ensure actors honour their commitments, continue their cooperation[58] and avoid opportunistic behaviour. The theory of "signalling" is based on the idea that contracting parties should continuously send each other signals whereby each seeks to reassure the other of their intention to cooperate.[59] In some cases, too detailed a contract can be a sign that the contracting parties do not trust each other.[60,61]

Conclusion

Contracting in health systems is extremely diverse in terms of the types of actors that use it, the types of contractual relationships that are established and the purposes thereof. However, one must never lose sight of the fact that contracting is a tool that should be evaluated on the basis of its impact on the performance of a health system and, ultimately, on people's health. Contracting should not be reduced to a mere management tool used to cut health costs. It is an approach that should lead the various actors to offer to the public health services that are increasingly efficient, effective, superior and fair. ■

Competing interests: none declared.

Résumé

La diversité du recours à la contractualisation dans les systèmes de santé

La contractualisation est un des outils permettant d'améliorer la performance des systèmes de santé auquel on recourt de plus en plus souvent, tant dans les pays développés qu'en développement. Elle prend des formes très diverses ne se limitant pas au simple achat de services. Les acteurs y font appel pour formaliser toute forme de relation qu'ils établissent entre eux. Etablir une typologie permet de rendre compte de cette diversité et de mieux comprendre les différents enjeux de la contractualisation.

Au cours des dernières années, l'organisation des systèmes de santé a considérablement évolué. Pour faire face à l'insuffisance des performances de leur système de santé, la plupart des pays ont mis en place des réformes qui aboutissent à des recompositions institutionnelles importantes : la déconcentration, la décentralisation administrative, l'autonomie des prestateurs publics, la séparation entre les instances de financement et les prestateurs de services, la diversification des options de financement de la santé, le développement du secteur privé avec ou sans but lucratif.

Ces recompositions institutionnelles entraînent une multiplication et une diversification des acteurs, mais aussi une plus grande séparation des fonctions de prestation et d'administration. Les systèmes de santé se complexifient et fonctionner de manière isolée n'est plus possible. Progressivement, les acteurs prennent conscience de la nécessité de construire leurs relations. La voie la plus simple est celle de la concertation. Mais certains acteurs souhaitent un engagement plus formel.

Les interactions entre les acteurs diffèrent tant par leur nature que par leur ampleur. Il existe de nombreuses typologies de relations contractuelles : certaines sont basées sur la nature du contrat (public - privé), d'autres sur les acteurs en présence, d'autres encore sur le champ d'application du contrat. Elles sont ici regroupées en trois catégories selon l'objet du contrat : délégation de responsabilité, achat de services, coopération.

Resumen

Diferentes sistemas de contratación en los sistemas de salud

La contratación es una herramienta cada vez más utilizada para mejorar el desempeño de los sistemas de salud tanto en los países desarrollados como en los países en desarrollo. Adopta diferentes formas, y no puede limitarse a la mera compra de servicios. Los agentes interesados conciertan contratos para formalizar todo tipo de relaciones entre ellos. Una tipología de este sistema demostrará su diversidad y permitirá comprender mejor los diversos aspectos de la contratación.

En los últimos años la organización de los sistemas de salud ha sufrido importantes transformaciones. A fin de corregir la escasa eficacia de sus sistemas de salud, la mayoría de los países han emprendido reformas que han desembocado en grandes cambios institucionales, entre ellos la descentralización de los servicios de salud y administrativos, la autonomía de los proveedores de servicios públicos, la separación de los órganos de financiación y los proveedores de servicios, la ampliación de las opciones de financiación sanitaria, y el desarrollo del sector privado con o sin fines de lucro.

Estas reorganizaciones institucionales conducen no sólo a la multiplicación y la diversificación de los agentes interesados, sino también a una mayor separación de la prestación de servicios y las funciones administrativas. Los sistemas de salud son cada vez más complejos y ya no pueden operar aisladamente. Los agentes implicados se percatan progresivamente de que necesitan forjar relaciones, y la manera más sencilla de lograrlo es la acción concertada, aunque algunos prefieren un compromiso más formal.

La interacción entre los agentes puede adoptar diversas formas y realizarse a distintos niveles. Hay varios tipos de relaciones contractuales: algunas están basadas en la naturaleza del contrato (público o privado), otras en las partes involucradas, y otras aún en el alcance del contrato. Aquí se clasifican en tres categorías según el objeto del contrato: delegación de responsabilidad, acto de compra de servicios, o cooperación.

ملخص

الأساليب المختلفة للتعاقدات في النظم الصحية

تعد التعاقدات من الأدوات التي يتزايد استخدامها باضطراد لتعزيز أداء النظم الصحية في كل من البلدان النامية والمتقدمة على حد سواء. وتأخذ التعاقدات أشكالاً عديدة، فلا يمكن حصرها بالشراء أو بالخدمات. ويتخذ الفاعلون في النظم الصحية من التعاقدات مطية لاستكمال جميع أشكال العلاقات التي تربط بينهم. وستوضح دراسة ملامح هذا الأسلوب مدى تنوع التعاقدات، وستقدم فهماً أفضل لمختلف القضايا التي تثيرها التعاقدات.

وقد تغيرت في أيامنا هذه طريقة تنظيم النظم الصحية عما كانت عليه من قبل، فقد سارعت معظم البلدان للإصلاح لتلافي ما تعانيه النظم الصحية فيها من تدني الأداء، وقد أدى ذلك إلى دراسات متعمقة قامت بها المؤسسات، وشملت لامركزية الخدمات الإدارية والصحية، واستقلالية القائمين على إيتاء الخدمات الصحية في القطاع العام، والفصل بين الهيئات المسؤولة عن التمويل وتلك المسؤولة عن إيتاء الخدمات، وتوسيع الخيارات المتاحة للتمويل، وتنمية القطاع الخاص سواء كان يستهدف الربح أم لا يستهدفه.

ولم يقتصر تأثير هذه التغييرات الجذرية على مضاعفة أعداد الفاعلين وتوسع اختصاصاتهم، بل امتدت لتشمل إحداث المزيد من الفصل بين وظائف تقديم الخدمات والوظائف الإدارية. وهكذا أصبحت النظم الصحية أكثر تعقيداً، وأصبح من المتعذر إدارتها في معزل عما يحيط بها. وسرعان ما أدرك الفاعلون فيها أن عليهم أن يوطدوا العلاقات بينهم. وكان أبسط سبيل لتحقيق ذلك أن ينسقوا العمل فيما بينهم، وذلك رغم أن بعضهم لا يزال يفضل الالتزام الرسمي.

ويمكن للتأثير المتبادل بين الفاعلين أن يأخذ أشكالاً عديدة، وأن يكون على مستويات عديدة، فهناك أشكال متعددة من العلاقات التعاقدية؛ فبعضها يرتكز على طبيعة العقود (من القطاع العام أم من الخاص)، وبعضها يرتكز على الأطراف المتعاقدة، وبعضها الآخر يرتكز على مجال التعاقد. ومن هنا فقد صُنِّفَت إلى ثلاث فئات وفقاً للغرض المتوخى منها: التفويض بتحمل مسؤولية ما، والعمل لشراء الخدمات، والتعاون.

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