

Round Table Discussion

Contracting is not an end in itself

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Jean Perrot sheds valuable light on the conceptual relationships between contracting and privatization. This stimulating methodical clarification is welcome on questions where semantic confusion runs rife, undermining the quality of cooperation between different actors (ministry of health, donors, service providers, nongovernmental organizations, civil society, etc.) and, ultimately, the reform of health systems.

Clearly, contracting with private providers may increase the volume and *share* of health services provided by the private sector. Similarly, depending on the provisions of the contracts entered into with public or semi-public operators, contracting may increase the volume and *share* of services produced through processes that resort to market mechanisms. If that is the case, should we be worried or pleased? Neither one nor the other, because the crux of the matter lies elsewhere. As Deng Xiaoping said: “What does it matter if the cat is black or white, the main thing is that it catches the mouse”. Obviously, contracting is not an end in itself; it is but a tool. Here, the questions are whether or not, on a case-by-case basis, the use via contracting of mechanisms related to privatization (as cited by Perrot) constitutes a relevant response to the challenges facing health systems in developing countries and, beyond that, whether these are suitable tools for *efficiently* enhancing the public’s health in keeping with the objectives the country has set itself.

The literature on ex post evaluation of contracting experiences with private providers for the delivery of basic health services (of which Cambodia is the best-known example¹ and also from Bangladesh, Guatemala, Haiti, India, Lesotho, Senegal, South Africa and Zimbabwe) is not as extensive as we would like. It nevertheless highlights several elements that explain the attractiveness of private delivery compared with delivery of the same services by public operators. This is particularly true for broadening access to care and health coverage, which are often rapidly achieved. The studies available also show that this type of contracting may achieve large-scale delivery of care — to several million people, as in Bangladesh — even in very remote areas: for this last point, the preliminary results of contracting with nongovernmental organizations in Afghanistan are highly encouraging. As regards enhancing equity and quality (perceived or real), however, the results appear to be less homogenous and somewhat inconclusive. The same goes for the comparative impact of contracting initiatives on efficiency, which is often neglected in evaluations even though one of the theoretical arguments in favour of contracting with the private sector — and other forms of privatization cited by Perrot — is its potential for enhancing efficiency.

This brief outline points to the imperative need for rigorous evaluations of the comparative impact of contracting with private operators, particularly as regards equity, quality and

efficiency. However, other issues related to contracting/privatization are crucial for reforming policy and health systems against a backdrop of scarce resources:

- Studies suggest that individual factors play a significant role in determining the relative performance of service providers operating with the same structures and the same organizational incentives.^{2,3} This is reason enough to conduct more case-study-based research into the factors that might account for variations in performance and to identify their implications for the substance of the contracts. Looking wider, it questions the link between the features of the contract and the performance of the provider in a given environment.
- In low- and middle-income countries, we know little about the comparative effects of contracting/privatization on the delivery of complex specialized care that is very expensive for the system, the insurance scheme and the patient. In addition, the efforts made by the provider and the quality of care are generally not very well known, either to the patient or to the caretaker entity.
- As things stand, it is impossible to state whether contracting with private operators reduces the *total* cost of providing the service if one considers the transaction costs in their entirety, a non-negligible part of which is often covered directly by the donors. Transaction costs are those linked to the definition of contracts (acquisition of necessary information), selection of partners, application of contracts, follow-up operations, monitoring and evaluation as well as prevention and settlement of conflicts.
- Several authors have underscored the methodological failings of certain studies, which detract from the robustness of the results and limit the wider conclusions to be drawn from them.

Given the vital importance of evaluation in view of the stakes involved and the grey areas that still remain, an “international evaluation programme” could be envisaged. This could be funded mainly by the international community, as its results would constitute a public good with potentially far-reaching positive externalities. Numerous organizational and financing scenarios are possible. The assessments should be conducted by totally independent agents so as to avoid any possible conflicts of interest. It is crucial for the evaluation methods to be scientifically rigorous, with information gathering before the intervention and the use of control groups, etc.

Three fundamental points are made by Perrot to which the state and its partners still do not give due attention: (i) contracting/privatization should be used by the state as a tool for regulating the health system; in that sense it has to be highly articulated with other health policy instruments; (ii) contracting/privatization allows a “reasoned withdrawal” of the state which should make the most of this to refocus on the essential functions that derive from its primary responsibility (such as stewardship^{4,5}) and better discharge them; and (iii) the use of contractual mechanisms that borrow from privatization requires appropriate governance^{6,7} as well as a strong state, in the sense that Gunnar Myrdal understood it, especially when contracting involves large-scale operations. Failing observance

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of these points by the state and its partners, the mechanisms run the risk of being side tracked with unexpected results. A parallel may be drawn here with certain experiences of decentralization. ■

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Contracting in practice: a low- and middle-income perspective

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The above paper by Perrot is opportune. Many low-income and middle-income countries promote the use of contract, as opposed to direct provision by the public sector, as one of their health reform approaches — part of the “purchaser–provider split.” Palmer found that the expected goals of contracting in terms of improved accountability, transparency and efficiency were often not achievable, because of limited government management capacity and a weaker competitive market.¹ Evidence from cross-country studies indicates that nonclinical service contracts such as those for cleaning and catering present fewer difficulties than clinical service contracts, owing to the nature of private markets,² and both in-house service provision and outsourcing require better government systems and skills. Though evidence is scarce, comparative studies reveal that contracts to nongovernmental agencies for primary care and immunization services in Cambodia resulted in better performance than traditional government services in terms of higher immunization coverage among poor children.³

Macneil asserts that, in practice, the contract has moved from a classic rigid, nonflexible instrument to a slightly flexible

neoclassical approach, and to a relational contract where specific content in the contract becomes subordinate to the need to harmonize conflicts, preserve the relation and build up trust.⁴ This is confirmed by the United Kingdom's National Health Service contracts to primary care general practitioners, which were often vague about risks and responsibilities and ignored sanctions for failure to perform.

In Thailand's Social Health Insurance, more than a decade of practice with the contract model in public and private hospitals confirmed Macneil's assertion, as both contractual parties relied on trust and long-term collaboration. The Social Security Office did not terminate contracts with poorly performing contractors, though indirect sanctions were applied through the beneficiary's decision not to register, in a subsequent year, with a contractor not meeting its needs.

The recent contract of the Universal Coverage Scheme to the district health system (DHS), a network of district hospital and health centres, confirms the relational contract. The DHS is the only service provider for the whole population in a given district and thus has a geographical monopoly. Though private clinics exist, they do not provide a comprehensive range of prevention and health promotion services. The purchaser had no choice but to contract the DHS; a constructive engagement and partnership building between the two parties were major instruments to improve the contractor's performance. Trust among contractual partners plays an increasing role, especially where a competitive market is not possible.

In conclusion, in the context of limited government capacity and provider markets, the nature of services under contract and the role of beneficiaries, contracting — even when the roles and responsibilities between purchasers and providers are clearly stipulated — is not a panacea to strengthen health systems performance. A proper analysis of the contextual environment is required, together with increased government capacity to monitor and improve the performance of contracts. ■

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