

Consultation on Strategic Contracting in Health Systems

Synthesis of the meeting
Geneva, 9–11 January 2008

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This synthesis was written by Riku Elovainio, WHO and Jean Perrot, WHO based on the deliberations of the consultation meeting *Strategic Contracting in Health Systems* held in Geneva, 9-11 January 2008. This synthesis benefited from the suggestions and inputs of all those present at the meeting and from the members of the Information Sharing Group on Contracting.

Introduction

From 9th to 11th of January 2008, a meeting-consultation entitled *Strategic Contracting in Health Systems* was held at the WHO headquarters in Geneva, Switzerland. During this three day meeting a wide range of experiences on contracting in health systems were reviewed, the current evidence and lessons learned from these experiences were examined and, finally, policy options for the actors involved in this field were explored.

This meeting synthesis is based on the work done during the *Strategic Contracting* - consultation. This document is not a summary compendium of all the meeting's presentations and discussions; it is more of a guidance note that is based on the information gathered during the meeting.

The objective of this document is to:

- give a clear picture about the current situation and evidence on the major topics of contracting in health systems
- provide guidance for future activities in the field of contracting in health systems

Part I : The meeting rationale, objectives and proceedings

A. The rationale of the meeting - keeping up with recent evolutions in the field of contracting

Since a couple of years, we have been witnessing a paradigm shift in the approach to contracting in health systems: contracting has transformed from a technical tool, used on an exceptional basis, into a strategic policy approach for improving health system performance. In other words, contracting is no longer considered as a sum of disparate contracts passed between different actors, it has become a strategy used to (re)structure health systems by formalizing relations between the actors and (re)defining their mutual commitments.

The rationale of the January 2008 meeting-consultation was to keep up with these recent developments and to update our knowledge on contracting in health systems. The meeting wished to propose a forum for exchanging recent experiences and new ideas between different actors in order to gather up information and evidence concerning the current situation in this field.

B. The objective of the meeting - learning from experiences and exploring the ways forward

There is a general agreement on the fact that, in the short run, the poorer countries will not be able to significantly improve their health outcomes without strengthening their health systems. However, there is no simple formula for strengthening and developing a health system; we can only rely on several strategies and tools that have proved their effectiveness in this matter. As the WHA resolution of 2003¹ acknowledged, contracting should be considered as one of these strategies.

The objective of the meeting was to find empirically supported evidence that contracting is indeed a successful strategy for health system strengthening. And, of course, the main objective was to understand why, how and with which pre-requisites has the contracting strategy worked in the past and to explore how to make it work also in the future.

But it was clear from the beginning that the meeting should go beyond the advocacy level. Firstly, because contracting is now a well established phenomenon and the time of advocacy is more or less behind us. Secondly, because there is also a need to gather information on what has not worked in the past and what will not work in the future. It is indeed important to keep in mind that contracting is only one strategy of health system strengthening among many others and there should be also more evidence on when not to resort to contracting and when to prefer another strategy or tool to it.

Finally, the meeting had the objective to explore possible directions for future work. The goal was not to set any normative standards, but to discuss what are the needs and demands at the country level and how should different actors, internal and external, assure that their activities on contracting take into account the countries

¹ World Health Organization. The role of contractual arrangements in improving health systems' performance. World Health Assembly; 2003, WHA56.25.2003.

needs and the lessons learned from previous experiences.

C. Meeting proceedings

The meeting-consultation was held at the World Health Organization headquarters in Geneva Switzerland between the 9th and 11th of January 2008. The meeting was prepared by the Health Systems Financing (HSF) department at the WHO in collaboration with the Information Sharing Group on Contracting (ISGC), which gathers people from different WHO departments and from other organizations (ILO, GTZ UNAIDS)

More than sixty people coming from different areas and institutions attended the meeting. From the WHO there were representatives from headquarters (from different departments and programmes), from all of the 6 regional offices² and from some country offices. There were also attendants from ministries of health, from different multi- and bilateral cooperation and aid organizations, from international NGOs, and from the academic world.

During the three day meeting, 17 thematic and comprehensive presentations were given, three round tables were organized and numerous question and answer sessions took place. In addition, during the meeting's third day, many shorter presentations from countries and from different institutions were given. The objective of these presentations was to assess the needs and expectations of the countries and to learn more about the activities that the institutions involved with contracting in health systems have been, and will be, putting in place.

The meeting was bilingual, English-French, but there was also one presentation in Spanish. The presentations and the discussions were simultaneously translated during the sessions.

² Each Regional Office has a designated focal point-person for contracting issues

Part II : Four key topics - a framework for examining the recent developments in contracting

In February 1998, the first international meeting on contracting in health systems was held at the WHO headquarters in Geneva. This meeting was on the same subject as the 2008 meeting but the actual topics discussed during it were quite different.

In 1998, contracting in a health system context, especially in developing countries, was a new phenomenon and there were few concrete experiences of its implementation. The 1998 meeting focused mainly on some rare experiences on outsourcing previously publicly run health services. The goal of that meeting was to evaluate the contracting tool, understand its potential and discuss the methodology of contractual proceedings and contract management.

A lot has happened between 1998 and 2008. Contracting has now become a reality in almost all health systems, as well in developed, where it has expanded, as in developing countries, where the experiences have recently been rapidly proliferating. The generalization of contracting has widened the scope of experiences related to it. In other words, the concept of contracting is nowadays referring to a complex and diversified reality where contracting is used and approached in multiple ways.

Taking into account this general diversification in the use of contracting in a health system context, it is clear that a three day meeting can not cover the entire field. Therefore the meeting concentrated on some of the main topics that most clearly highlight the recent evolutions.

In this synthesis we examine four main aspects of contracting that were most discussed during the meeting:

- the nature of the contract
- performance based contracting
- the role of the private sector
- regulation and stewardship functions and contracting

These four topics do not of course cover the whole field of contracting in health systems, far from it. None the less, these topics offer an interesting matrix for analysis when studying the current evolutions and questions in this field.

A) The nature of the contract - varying and adjusting the "rigidity" of the contract

Key messages: A contract is a tool that formalizes the contracting process. The contract-tool varies in its degree of "rigidity" which can be measured by its enforceability and completeness. Sometimes a classical contract, which is bound to be as complete as possible and legally binding, is the right tool; sometimes a less detailed, relational contract is the instrument of choice. But in fact, there are rather few examples of "classical" or "relational" contracts; in a health system context, there is more of a continuum of contracts with different degrees of "rigidity". It is the context and the way the contracting process is designed that determine the type of contract that should be used.

Contract is a tool used in a contracting process

There is often a common sense question that arises when talking about contracting: what is the difference between contracting and a contract? The short answer to this question consist of defining contracting as a process and a strategy, where as a contract is a tool that is used to materialize, to formalize, the contracting process/strategy (there exists also contracting strategies that do not use contracts, for example when a partnership institution is created as a materialization of a contracting process).

When looking closely, one can find that the contract-tool actually comes in different forms and shapes, depending on how the contracting process will use this tool.

A classical contract is detailed and legally binding

The contracting processes in health systems can follow the rules and methods of the commercial sector - a detailed and legally binding classical contract is the corner stone of this approach. The commercial type approaches are used for example in many contracting out processes. The contracting out processes tends to need a commercial type classical contract because the agreement is negotiated generally between the private and the public sector between which you almost unavoidably have a certain degree of hesitance and mistrust. A classical contract is the tool of choice here because it offers, in theory at least, a clear and legally binding document which stipulates explicitly what the contracting parties expect from each other.

Box 1 : Outsourcing non clinical services in Morocco - an example of a contractual approach using classical contracts

Context: budgetary constraints hinder hiring of fixed civil service staff, resources are allocated in priority to clinical health care services

Decision: to contract out, at the health care unit level, some non-clinical services (cleaning, catering, equipment maintenance, reception)

Tool: classical commercial contracts with private sector providers

Results:

- quality improvements for services outsourced,
- relief in the human resources shortage,
- more efficient use of resources (for example, more efficient use of material → the health care unit does not bear the cost for the idle periods).

Problems:

- contracts created different status for personnel working side by side → frictions among the personnel,
- there were often hesitations to commit to long term contracts (especially the State),
- even though the contracts were designed following a classical approach, there were still uncertainties concerning the legal basis of the contracts → the general legal framework was not fully adapted to this type of approach.

Moving from classical contracts towards relational contracts

Beside classical, commercial type, contracts, contracting processes can also use other type of contract-tools. Relational contracts are one example.

A classical contract has the objective to be as complete as possible, a variety of different situations and outcomes are taken into account pre-emptively in it. A classical contract is also very detailed regarding the sanctions for a contract breach; in other words, there is a high degree of enforceability of the contract.

Relational contracts do not have the same degrees of enforceability or completeness as the classical contracts and they are not, in theory, enforceable by law. Instead relational contracts rely on cooperation and trust between the actors. A relational contract is less centred on measurable details and more focused on the management of the collaboration and the dialogue between the actors.

However, relational contracts are not to be seen as something totally "soft": every type of contract or agreement should assure that there are mutual benefits for each actor tied to it; so a relational contract, if well designed and implemented, should guarantee that it is not in the interest of the parties to breach the contract. This means that relational contracts, if well designed, are self-enforcing. In addition, the withdrawal of one of the parties from the contract or the non renewing of it can often be seen as a sanction that hinders opportunistic behaviour and strengthens the commitments of the parties.

Finally, one must keep in mind that contracts in a health system context can rarely be classified as pure "classical" or "relational" contracts. In the real life, the contracts that are used are somewhere between the two extremes and the main challenge lies in adjusting the "rigidity" of the contracts so that they will take into account the specificities of contracting in a health system context and the particularities of the socio-cultural environment of each country or community.

Technical capacities are different for relational contracts than for classical contracts

Relational contract, if compared to a classical contract, is less demanding in financial and legal expertise. The management of relational contracts is thus less influenced by the capacities, or the lack of capacities, that the contractors have on these aspects.

However, establishing and managing a relational contract does require other type of capacities. In fact, a relational contract requires quite specific capacities on managing and upholding good working relations between the contracting parties. In order to keep a relational contracting process going, there has to be constant negotiations and dialogue between the parties; this has to be conducted in a rigorous manner so that the parties honour their commitments and that opportunistic behaviour is avoided.

Relational contracts are flexible and they give more room for renegotiations. This is very important in many contexts where contracting is a new phenomenon and where a trial and error approach is well suited. The flexibility of a relational contract also allows establishing relationships in contexts where the uncertainties of the political and economical situation create an obstacle for more binding type of contracts.

As the legal and the financial details are less important in relational contracts, the transactional costs for relational contracts will, in most cases, be lower, notably because the need for monitoring will decrease.

Limits to relational contracts - need to increase the "rigidity" of the contracts when scaling up

Relational contracts do however have their limits. There is for example a doubt on whether a contractual approach relying on relational contracts can be scaled up to larger scale policies for health interventions. Relational contracts can also be less viable options when there are large institutions involved in contracting processes; for example if a country wants to create or widen its social security system, it is quite likely that the social security body can not operate with relational contracts when dealing with the providers.

Box 2: Relational contracting in TB control - drugs for performance contracts

In the field of TB control, there has been recently a strong evolution of initiatives that involve the private sector providers. In most cases these initiatives have taken the form of drugs for performance contracts. Drugs for performance (DFP) contracts are agreements between the public authorities (the National Tuberculosis Programme (NTP)) and private providers (individual physicians or private health care structures). These contracts are neither legally binding nor detailed, but they lay out a general agreement on the mutual obligations of the parties.

The obligations of the public authorities in DFP contracts:

- to distribute free drugs, equipments and stationeries to the private sector providers
- to assure training of the private providers
- to assure the general management and coordination of the programme

The obligations of the private providers:

- provide for free the drugs that they receive from the NTP
- to follow basic diagnostic and case management principles in line with the national and international guidelines
- provide services at low cost
- accept supervision by the NTP

The drugs for performance contracts do not have any monetary incentives for the providers. In other terms, the providers are not directly paid for the time and effort that they have to consecrate to the obligations laid down by the contract. But there is a large variety of non monetary incentives: inputs, training, etc. The absence of monetary incentives has sometimes been seen as a problem because some providers are not motivated if only non monetary incentives are offered. There is in fact evidence that monetary incentives, in some context, work better than non-monetary ones and introducing monetary incentives could thus be one option for future development of the DFP programmes.

For the public authorities the drugs for performance contracts serve as tools for effectively integrating the private providers to the national health system. Through these contracts, the public authorities can have a better oversight of the private sector and influence on the quality of care provided by it.

B) The notion of performance and performance based contracting

Key messages: Performance based contracting is a technique that structures the contracting arrangement around the outputs (as opposed to the inputs or the working processes). Performance contracts set target outputs for individuals or organizations, if the targets are met monetary or non-monetary rewards will be distributed. Thus, performance based contracting is a way to motivate individuals or organizations to "do more than the minimum required"

Performance based contracting - motivating workers and organizations

Health system performance is still considered to be unsatisfactory in most low-income countries. The multiple health system reforms of the last decades have tried to solve this problem by different types of institutional reorganizations. But these reforms have often failed to profoundly change the way individuals and organizations work. One of the main problems is that there are too few and badly designed incentives incorporated in health systems at different levels. In other words, health systems and the organizations that constitute them are still working with ancient hierarchical management models where the main focus is on the processes and where there are little or no compensations related to achieving results. This leads to a situation where the individuals and the organizations are not motivated to change their behaviour, to do "more than the minimum required".

Performance based contracting is a strategy that is getting increasing attention since a couple of years. It allows introducing incentives that should motivate the individuals and organizations to improve their performance.

Performance based financing, performance based contracting, etc.

Before going further a terminological issue has to be cleared out of the way. Performance based contracting, performance based financing, output based payments - there seems to exist a lot of different variations on a theme. The differences between these concepts are relatively small and they depend mainly on the adopted point of view. For the sake of clarity, the term performance based contracting shall be used here as a generic term.

Shifting the focus from working processes to the outputs at the human resources level

Incentives and performance based contracting can be examined at different levels. At the human resources level, the health worker level, performance contracts are additional to the basic work contracts. A basic work contract is focused on the way individuals work; in other words, the employer wants to know if the employees respect the predetermined procedures of work. A performance based contract between the employer and the employee shifts the focus from the work processes to the actual production of outputs. As these outputs can be evaluated rather easily by a set of predefined indicators, the monitoring cost for the employer will be lower.

Motivating workers to improve their performance with incentives

But the monitoring aspect is only one part of the equation; the positive incentives that come with a performance based contract are even more important. The positive incentives included in a performance based contract should motivate the personnel to improve their performance. This means that the employees will get financial or non-financial bonuses, top ups, if they can produce the results that were expected from them. In this sense performance based contracting can be seen also as a strategy to articulate individual incentives with the objectives and priorities of the organization.

Measuring performance

In order to measure performances, indicators have to be used. There has to be several indicators so that the complexity of the individual tasks is taken into account. One way of assessing the overall performance is to use performance scores that are calculated for each indicator - this allows to aggregate differently build indicators. The aggregation (with the possibility of using coefficients) of the scores will give the total score which indicates if the individual has met the performance targets or not. The individual will then be rewarded based on this calculated score.

The indicators that could be used at the human resources are for example:

- Quantity indicators: ex., how many consultations has a doctor performed in a day/week/month
- Quality indicators: ex., how many consultations have respected a certain protocol

Performance based contracting at the organizational level

When moving to the organizational level we find more or less the same elements as on the individual level. The structure of the incentives is similar and the objective is the same: to encourage better performance. The major difference is that the indicators will be more complex at this level, because an institution has diverse and complex outputs. The Malian example below, shows how performance based contracting can be implemented between the Ministry of Health and public hospitals.

Box 3: *Performance based contracts for hospitals in Mali*

The 12 national and regional hospitals in Mali have been structured recently into autonomous public health establishments giving them a large independence. In order to improve the performances of these hospitals, the Ministry of Health has put in place a system of performance based incentives aiming to change behaviours and practices in the hospitals.

The MoH adopted a special budget that was destined to extra-payments to hospitals. This extra budgetary payment could not substitute to regular budget or to other investments. The extra payment is attributed to hospitals according to their performance which is calculated by using several indicators:

- number of days of out-of-stock conditions for drugs,
- level of customer satisfaction,
- level of compliance to the norms regarding medical records, etc.

Scores for each hospital are then calculated based on the selected indicators. And finally, the calculated scores will determine if the hospital should receive an extra-payment and if yes, what is the amount of this payment (better the score, higher the payment).

The performance based contracts in Mali have been implemented in a defined contracting framework. This means for example that there have been negotiations between the stakeholders on the indicators, on the modalities of the payments, etc. The contracting process also includes a distribution of roles; for example, for the purpose of this contracting arrangement, a national evaluation committee was established. The committee's role is to supervise the contracting process, to negotiate solutions in case of disagreements and to take action when there are contract breaches. The committee is composed of MOH representatives, of the directors of all the hospitals that have signed the contract and of some external members (for example development partners).

As the Malian initiative of performance based contracting is still in its early stages it is difficult to draw any definitive conclusions. But the contracting strategy has already produced indirect results; it has for example clarified the stewardship role of the state regarding its relationship with hospitals and it has motivated the hospitals to look into their management methods and improve them.

Importance of contracting simultaneously at the individual level and the organizational level

Performance based contracting should address the individual and the organizational levels simultaneously, it is quite evident that the performance of an organization is strongly linked with the performance of the people working in it (but the performance of an organization is not a simple sum of the performance of its workers). For example, if a central government passes a performance based contract with a district hospital, it is strongly recommended that the district hospital then passes contracts with its employees so that it assures that everybody is working towards the same objectives and that the incentive flow does not stop at the organizational level.

Performance based contracting - using funds more efficiently in larger scale projects

When looking at performance based contracting from a wider angle, one should examine its linkage with the different health financing mechanisms.

In most low-income countries, public health care resources are essentially collected by taxation and used in public health care provision. There are some countries that are expanding social health insurances, but these systems still tend to be destined only to people who work in the formal sector. There are also initiatives that try to reach the informal sector: the community based health insurances for example. But they also have their limits

So as things stand at the moment, the health systems based on taxes (and external resources) and public provision are still the ones that prevail in low-income countries. This then leads us to the following question: how can we make the current funding system more efficient? The follow-up question being: can performance based contracting be of a solution? The Rwandan experience described below, will give some answers to this question.

Box 4: An example of performance based contracting for funding health care providers at provincial level - the example of Rwanda

Several performance based contracting initiatives were implemented in Rwanda at the beginning of this decade. These projects were based on a regional approach where all, or a major part, of the health centres and district hospitals, private and public, of a given region were involved in the project. These health facilities received a part of their funding through a performance based mechanism, where the facilities were paid according to their performances.

A household survey study has been tracking the changes in one of the regions that implemented the performance based mechanisms (Cyangugu - province). Here are some of the measured changes after two years into the programme:

- per capita out-of-pocket health expenditure: \$ 9.05 → \$ 3.43 = -62% (change in two years)
- average cost per OPD consultancy: \$ 2.43 → \$ 1.56 = -32%
- family planning coverage for women 15-49 years: 5.4% → 11.6% = +115%
- insecticide treated bed net coverage: 5.6% → 15.3% = +173%

Some lessons learned from the Rwandan experience:

- The health facilities that had performance contracts have produced more and better services with less expenditure
- Performance based contracting should be coupled with autonomous health facility management = the facilities should be able to use the funds as they see fit
- Subsidies should be paid in cash (studies indicate that 1\$ paid in cash has the same impact that 4\$ given in non monetary forms (inputs))

Choosing the right indicators

There are still a lot of questions remaining concerning performance based contracting. The question of performance measurement is one of them. In order to measure performance you need indicators, but there are no simple formulae for choosing these indicators. When choosing indicators one is often confronted to a dilemma: choose too many indicators and the monitoring costs will become too high, choose too few indicators and the reliability of the performance measurement will suffer. In top of this, the choice of indicators should be done in a way that it takes into account a variety of activities. For example, if the indicators chosen only cover some activities of a hospital, there is a real risk that the hospital will shift all its efforts to these activities and there will be less resources allocated to activities that are not taken into account by the indicators.

Introducing quality indicators

In the early days of performance based contracting, indicators were designed to measure quantitative outputs. These indicators measured for example the number of patients treated during a period. Recently the focus has been turned to different types of quality indicators. The quality indicators are much more complex because quality is hard to measure. The quality indicators can be based for example on customer satisfaction or on the compliance of the processes on a set of norms. It is important that the quality aspects are taken into account in the performance based approach because if the focus is only on quantitative outputs there is a high risk that there is a "overproduction" of some interventions based on "false positives".

C) Contracting and the role of the private sector

Key messages: Private sector actors, be they for profit or not-for profit, are nowadays recognized elements of health systems. When public authorities deal with the private sector, this happens often by using contractual arrangements. Sometimes these contractual arrangements increase the private sector involvement, sometimes they "pull" the private sector more close to the public sector, and sometimes a true partnership is established. Whatever the situation, the main objective should always be the search of efficiency gains by mixing and interrelating the different sectors. The complexity of the relationships between the private and the public sector, modelled and established by contracting, implies that the connection between contracting and privatization is a complex one too.

Contracting with the private sector for infrastructures

There are several ways that contracting involves the private sector. Delivering and/or maintaining infrastructures is one clear example. In these types of Public-Private Partnerships (PPP) arrangements, the MoH (or other governmental body) passes a contract with private sector enterprises for building and/or maintaining facilities such as hospitals. Contracting with the private sector for infrastructure building is often unavoidable, because the MoH does not have the expertise or the investment capacities of the private sector.

These PPP arrangements also allow a transfer of risk from the MoH to the

constructor. The risk transfer is due to the fact that the contract sets a certain price for the hospital and if there is a change in the context, for example a rise in the building costs, the builder can not transfer this rise to the MOH since the price for the hospital has already been set.

The existence of a competitive market and the possibility of organizing a transparent and meaningful bid process are important prerequisites for the infrastructure contracting to succeed. In addition, the Public-Private Partnership model requires a high level of contracting capacities. When all these prerequisites are put together, it becomes quite obvious that implementing infrastructure contracting in the low-income countries does not go without problems and so far this type of approach is mainly used in developed countries.

Contracting with the private sector for health service provision

We have already seen with the Moroccan experience that the private sector can be involved in non clinical activities at the health centre level. But the private sector can also be involved in clinical activities and in a larger scale.

The Afghanistan example below is an example of a contractual approach where a geographical area is contracted out to a non-profit private health service provider.

Box 5: Afghanistan – contracting with NGOs

After the decades of war, Afghanistan's public health care delivery network was almost inexistent. During the years of war, the health care delivery was mainly operated by NGOs. These non-profit private sector actors had contracts with donor agencies who financed their activities. In 2002 the newly established Afghan government choose to continue the contracting strategy with the NGOs. The international donor agencies, with supportive capacity building programmes, transferred the management of the contracts to the ministry of health where a special unit now handles the contracting processes and channels the resources coming from donor agencies.

The contracts with the NGOs cover a basic package of health services which includes: maternal and newborn health, communicable diseases, nutrition, essential drugs delivery, etc.

Household surveys have shown that during the period when the contracting strategy with the NGOs has been in place, improvements in the health indicators has occurred. For example from 2003 to 2006:

- the percentage of women getting antenatal care in rural areas rose from 4,6 to 32,2
- the percentage of children in rural areas vaccinated for TB rose from 56,5 to 70,2
- the percentage of women in rural areas delivering in the presence of skilled personnel rose from 6,0 to 18,9

Looking at the indicators it is quite evident that there has been significant progress during the last years. But there are questions arising about the sustainability of the contracting out strategy.

The current situation is a result of a very particular context and as the situation in Afghanistan evolves there may be a need to reassess the situation. Should contracting with NGOs be pursued and if yes, in which conditions? Should there be a return to public health care provision? Or could there be some other possible ways forward? Knowing that the donor agencies' firm commitments to finance the current projects will end in 2013, it becomes clear that some basic decisions have to be made.

Formalizing relations and associating the private sector in public service provision

Contracting does not necessarily increase or decrease the level of private sector involvement in a health system. Very often contracting is a strategy that is used to formalize a situation that existed already. Indeed, in many contexts a certain cohabitation between the private and the public sector has prevailed with each sector minding their own businesses. In these situations, the contracting strategy can be used to create or to formalize relationships between the two sectors. This means that there are agreements on the distribution of the roles and on the ways that these two sectors will work together.

Box 6: Contracting with the confessional, non profit, private sector in Ghana

Churches have been major health care actors for years in Ghana. The faith based health care institutions provide 35% of total health care and 45% of the health care in rural areas.

For a long time the work of faith based providers was not integrated or recognized by the state. During the 1990's a formal partnership was developed between the public sector and the faith based organizations. The partnership is organized at the national level and it is materialised by two major documents: Memorandum of Understanding and Administrative Instructions. These framework agreements define the mandates and the responsibilities of each sector and the areas where closer collaboration will be put in place. For example, the agreements define catchment areas for mission hospitals and public hospitals. The objective of this contracting partnership is to achieve an integrated health system where the two sectors work towards the same goal with their respective functions and roles defined.

Box 7: Social Franchises in health systems

The social franchise model is a good example of cooperation between the public and the private sectors.

Social franchises are distinguished by the concept of network; in a health system context the franchise network is usually made up of private health care providers (the franchisees) who enter in a contractual relationship with the government (the franchisor).

One of the main goal of a franchise approach is to harmonize the practices of a group of private providers. In a way, the franchising approach is a form of accreditation: in order to enter in a franchising network and to become "accredited", private providers have to accept certain standards of service that are enumerated in the franchising contract.

For the providers, being part of franchise networks means that they will have access to different types of support from the franchisor (inputs, training, etc.), and they can also use the franchise as a "marketing tool".

From the government point of view, franchising is a tool to further involve the private sector actors with the public policy goals. In addition, the franchise model and its accreditation aspect allow the government to act on the quality of care of the private providers.

There exist several initiatives in the field of reproductive health that have used the franchising model to engage private provider networks. Even though these initiatives are quite recent, there have been already positive signals coming from them: the franchise initiatives have been able to improve the access to care as well as the quality of care.

NGOs and other non-state actors as intermediaries in contracting process

There is one form of private sector implication that is still worth mentioning. This is the intermediary role that many NGOs or other non-state actors have in contracting activities.

An NGO often has the role of a facilitator between the contracting parties. In this type of situation the NGO is not a contracting party, its role is to offer technical support to the project.

In some cases the NGO can be an intermediary contracting party. For example, the TB Drug for Performance contracting projects often use intermediary NGOs in order to establish relations with the for-profit actors. In these situations it is the NGO who passes a contract with the National TB Programme and it is then the role of that NGO to involve private (for-profit) providers in the process.

Is contracting a form of privatization?

Considering the previous examples of contracting with the private sector, the question of privatization has to be addressed.

There seems to be different answers at different levels to the privatization question.

The first element of answer concerns the political level: resorting to contracting is always a choice, a political/policy choice. It could be argued that contracting is a tool for political strategies in the same way as a contract is a tool for contracting strategies. So if there is a political decision of privatization, then contracting could be possibly used as a tool in order to implement this decision. In this type of circumstances contracting can be associated with privatization, but the fact remains that it is the political/policy decision that is behind the privatization, not contracting itself.

The second element of the answer depends on the way privatization is defined. Actually there is no simple way of defining privatization. For example, contracting out health care services to a private provider could be seen as a form of privatization because it increases the private sectors involvement in the health system. But on the other hand, it could be argued that a contracting out strategy is just a way to implement a purchaser-provider split that leaves the States control and financing functions intact – hence there is no real privatization.

The third element of the answer is linked with the fact that in several cases contracting is a strategy which formalizes an existing situation; for example when mission based health care organizations contract with the Ministry of Health. In these

cases the objective of the contract is not to increase nor decrease the private sector involvement, but to clarify the relationship between the two sectors and define the rules and methods of cooperation. In these cases the privatization question becomes more or less irrelevant.

D) The State regulation and stewardship

Key messages: The rise in the number and the increasing complexity of contracting initiatives have made the regulation and stewardship question even more important. There is large consensus that the State is the actor that should regulate contracting at the national level. It is the State that should guarantee that the contracting activities are compatible with the public interest. In order to regulate contracting the State can use several tools, a National Policy of Contracting is one of them.

The State regulation and stewardship - coordinating efforts, harmonizing and setting goals

The state has multiple roles regarding contracting. The state can be one of the contracting parties and in these cases it is directly implicated in specific contracting processes. But the state has also a more general role that consists of ensuring the regulating and the stewardship of all the different contracting activities.

Regulation and stewardship have become questions with growing importance as the contracting initiatives have multiplied and become more complex. The main problem is that without some sort of central regulation or stewardship, the multiple contracting activities will not necessarily follow the same objectives and the impact of these uncoordinated efforts on the global health system will be limited. This is why contracting should be seen as a strategy: a coordinated effort that has well defined objectives. And when there is strategy there has to be a strategist and it seems that the only actor who can take this role is the State.

The Colombian case can be taken as an example of a complex health financing system where the regulation and stewardship question concerning contracting practices becomes relevant. The Colombian Social Health Insurance system makes use of contracting at different levels: the formal sector workers, who belong to the *Régimen Contributivo* (RC) branch of the system, contract with intermediary organizations *Entidades Promotoras de Salud* (EPS) who then contract with the service providers. In the *Régimen Subsidiado* (RS), the branch that covers the informal sector and the indigent population, the municipalities are charged with the contracting process with the EPS on the behalf of the individuals (and the EPS then contracts with providers - as for RC). One observation that can be made when examining the Colombian case is that contracting has been spread between different actors who do not necessarily have the technical capacities to conduct contractual arrangements - the municipalities in particular. So there seems to be a need for some sort of stewardship that could reorganize and clarify the system so that the contractual arrangements can be conducted in an efficient and harmonized way.

The scope of the regulation - finding a balance between "*laissez faire*" and hindering initiatives

How should the State stewardship and regulation be implemented? There are some divergences in the points of view concerning the scope of the State regulation. While there is a large consensus on the fact that there should be some sort of State regulation, there is also a case made against an active and "commanding" State which would be a nuisance and an obstacle for spontaneous initiatives. It seems that there is no clear-cut objective way to find a right dosage of State regulation, it is indeed almost impossible to conceive a way to gather hard evidence on this matter. So, at the moment, it seems that a trial and error approach is the rule.

National Policy on Contracting as a tool of regulation

A National Policy on Contracting (NPC) is an element that can be used in the implementation of the state stewardship. This document should make sure that there is a systemic approach to contracting and that the contracting strategy and its objectives are in harmony with the National Health Policy. But the NPC is much more than just a document, it should also be regarded as a strategy that introduces a negotiation process between all the stakeholders with the objective to find collective understanding on the objectives and the means of the national contracting policies. The main problem when establishing a NPC is to find a balance between the need to fix common rules and the necessity to give elbow room for the diverse contracting initiatives that different actors want to put in place. So, there is no unique model for a National Policy on Contracting, each country has to find its own way of defining what it should consist of and how it should be implemented.

Box 8 : Burundi's National Policy on Contracting

Burundi has defined its National Policy on Contracting (NPC) as a reference framework which allows the Ministry of Health to effectively fulfil its stewardship role in contracting matters.

The objective of Burundi's NPC is to:

- officially recognize contracting as a strategy for health system strengthening,
- make sure that the contractual arrangements are in line with the National Health Policy ,
- harmonize the contracting activities in a way that there are now contradictory evolutions and that these activities do not create inequalities between different segments of population,
- strengthen the public-private mix approach.

Following the validation of the NPC, Burundi has put in place institutional structures that facilitate the coordination of the contractual activities in the country. The National Office of Public Health has for example a unit that offers technical support to all the actors that are willing to resort to contracting. This unit also produces guide lines and toolkits for contracting in the Burundian context.

Part III : Ways forward

The January meeting's purpose was neither to define any specific guidelines nor to formulate an action plan. However, the exchange of experience and ideas during the meeting helped to formulate some paths for further developing the discussion around contracting in health systems.

An "e-mail discussion" was initiated after the meeting. The rationale behind this was to offer a follow up tool to further develop discussions. This discussion has already created interesting results and the inputs of this discussion are taken into account hereafter in this section.

Considering what was brought up during the meeting and in the e-mail discussion, there seems to be at least three different series of issues which should be further emphasized in the future.

A) How to gather solid evidence on contracting - directions for further investigations

Sharing experiences

There seems to be still a wide gap in the evidence concerning numerous aspects of contracting. The January meeting was a platform for exchanging experiences and this experience sharing should be continued in the future at different levels. Several meeting participants, from different horizons, underlined the fact that the different actors and institutions should tighten their collaboration in this matter.

Analytical framework for "hard" evidence

Exchanging experiences is only the first step in the search for evidence, there should also be an emphasis on building an analytical framework which would guide the future discussions and which would make it easier to end up with pertinent lessons from the experiences. This framework should be build as a two dimensional matrix which on the one hand takes into account the large number and the diversity of the existing contracting experiences and on the other hand takes also into account the different dimensions regarding the effects that contracting is expected to produce (in terms of efficiency gains, output increase, quality improvement, impact on equity and accessibility, cost of the programme, etc.)

Framing contracting in the general discussion on health systems

In addition, one of the major purposes of such a framework would be to integrate the research on contracting with a wider health system analysis. The main purpose of such an approach is to find the veritable added value that contracting can bring to health systems. This involves a comparative study between contracting strategies and other health system strengthening strategies with the objective to find where and when contracting is the strategy to choose and when not. Some specific attention should be given to studies on contracting for health services in fragile contexts (can contracting be an effective strategy in these context and if yes, how?). In short, the main objective would be to find the right place and scope for the contracting strategy in health systems.

The importance of studying the contextual, external, factors

A more specific line of studies on the contextual factors affecting contracting should be considered. There is of course an immense variety of factors that could be taken into account here, but it seems that there are some identifiable groups of issues. For example, there should be more investigations on the general legal aspects of contracting: how does contracting comply with the existing legal frameworks? is there a legal coherence between the contracting activities and the overall legal context in a given state? is there a relevant legal base for sanctions in case of contract breach? Also, the general political context and its influence on contracting should be more studied. The focus here should be on the way that contracting fits in the political landscape of a given country and on the general acceptance of contracting by the political leaders (at national, regional and community level). Finally, contracting should be studied from a socio-cultural perspective: how do contracting and contracts relate to the customs and manners of a given culture? In which ways can and should the contracting process be modified to a given socio-cultural context (ex. how to balance the "rigidity" of the contract in a given context?)

New domains, new theories and new methods = new needs for knowledge and evidence

The contracting field is getting increasingly complex with the adoption of new initiatives, methods and approaches. To keep up with this evolution, basic research has to be carried out in order to identify these new domains and to understand the methodological and theoretical issues that are related to them.

For example, performance based contracting is rapidly growing in many geographical areas and at many different levels (HR, health facility and district). The recent experiences have produced encouraging results and there has already been valuable work done in evaluating these experiences. But there are still several questions that should be looked at more closely. For example the measurement issues: which indicators should be used, how to design indicators that will optimize the benefits?

There is also a wide variety of contractual approaches that are already in place in developed countries - for example the private-public partnerships for infrastructures. But we lack clear evidence on how to transpose these approaches in low-income contexts.

B) Capacities and capacity building

Capacities - a key to the correct implementation of contracting

The effectiveness of a contracting strategy depends highly on the capacities of the different actors involved in the processes. One of the critical challenges concerning the capacities is how to have a critical mass of knowledge and competences for different actors at different levels so that contracting can be implemented correctly.

Capacity building - answering to country demands and needs

During the meeting, the participating countries often expressed a need for an external support for contracting. Capacity building was also underlined by several presentations coming from different development partners who had already integrated or will integrate capacity building as one of the approaches in their activities

concerning contracting.

Capacity building can be done in different ways. One method is to start a donor driven project and then gradually, during the project, transfer the necessary capacities to the national actors. This is what happened for example in Afghanistan where at the beginning of the contracting out project the World Bank was giving considerable technical support for the contracting process, but gradually the local authorities have been taking over this technical work.

Capacity building does not however need to be directly connected with an ongoing project. General training sessions are also an option. The international NGO CORDAID has for example been working on a training session that targets actors involved in performance based contracting. The WHO in collaboration with the World Bank Institute has also organized several training sessions.

As there seems to be a clear demand from the countries, it would be profitable to further develop the different capacity building activities. However, there is no simple way of defining in which way this should be done. Some capacity building activities have already proven their utility but as every country and every situation is different and as the contracting activities become more complex, there seems to be a lot of room for further developments concerning capacity building.

Building individual and institutional capacities

When addressing the capacity building issue, a distinction between individual capacities and organizational capacities has to be made.

Individual capacities refer to the competencies, knowledge, skill and attitude that a person possesses. Institutional capacities are related to the functions of institutions. Both of these dimensions are important, but it seems that there is some priority given to institutional capacities. The benefit of the institutional approach is that capacity building can be directly linked to crucial problems like management tools and methods. The objective being the rooting of the capacities in the ways of working of the institutions. Such an approach should pay off in the medium and long term.

There is also another institutional approach to capacity building which consists of using local training institutions as “first level” capacity building targets. The objective of this approach is to develop and strengthen the training capacities of the local institutes to whom the capacity building on contracting can then be handed over to.

New challenges for capacity building

A decade ago, the main focus was on the technical capacities concerning contracts: how to negotiate, how to draw up and how to execute a contract. These questions still remain highly important, but since a couple of years now, new types of capacities are also needed. The fact that contracting is more and more used and clearly becoming a main stream strategy of health system organization, increases the importance of capacities that allow the strategic utilization of contracting. This means that different actors have to gather more capacities on identifying how contracting, in its different forms, relates to the strategic (policy) choices in health system organization. These capacities are needed at different levels, a hospital manager for example needs knowledge and skills for pondering the outcomes of different strategic choices (to contract out or not some activities). Another example could be found in medicine supply: what capacities are needed at different levels for actors who are organizing pharmaceutical procurement networks?

C) The question of regulation

Defining the methods and objectives of the regulation

The generalization of contracting and its diversification has even further underlined the importance of regulation. As mentioned earlier, there is still some debate on the scope and shape of the regulation of contracting, but none the less, there is a clear need to define the tools and the methods that will guide the regulation and stewardship. Regulation should be implemented in a way that it provides a harmonizing framework for the different contracting activities by linking them with the overall health system goals and strategies.

Regulatory capacities

In the future there should be more emphasis put on the new type of regulatory capacities that are needed. Investing in these regulatory capacities was seen as a priority by a lot of the actors present during the meeting. But there is no one correct way of capacity building for regulation, it has to be done in a country specific way, since the regulation question depends very much on the contextual factors (general political situation, general legal framework, the place given to contracting by the policy makers).

Should there be an independent non- or para-governmental body which regulates contracting?

The fact that the State is involved in specific contracting arrangements as a stakeholder and at the same time it holds the regulatory function/role can be seen as a problem of conflict of interests. This question has inspired a debate on the definition of the regulatory role of the State and on the ways that this function should be fulfilled. It has been argued for example that there is a need to "de-politicise" the regulatory role by handing it to technical agencies. This would create a new third party actor which would not have direct self-interests regarding the contracting arrangements and thus this body should be able to have a technical, objective view on them.

In order to clarify the regulatory problematic, it would be useful to look more closely into the possibility of creating regulatory agencies, which would not be directly related to ministries of health.

Conclusion

The meeting-consultation *Strategic Contracting in Health Systems* proposed a platform for exchanging ideas and experiences. The meeting involved a large variety of stakeholders who have often approached contracting from diverse angles.

The multiplicity of the contracting approaches and methods that were discussed during the meeting clearly demonstrates that there has been, and there surely will be, considerable evolutions in this field. New ideas and methods have been developed and new initiatives are taking place all over the globe.

It also seems that as contracting diversifies and becomes more complex, there should be a shift of focus from purely technical issues to broader questions. In other words, it has become clear that contracting should be viewed from a point of view that links it with other health system financing and organizing strategies.

This new "paradigm", translates into new type of questions:

- Can a health facility increase its performance by outsourcing some of its non-clinical activities?
→ The Moroccan example seems to indicate that this strategy could offer some gains (more efficient use of equipment, better and more flexible human resource management, etc.); but at the same time there are also problems linked to this choice (frictions between employees, limited willingness to commit to agreements).

- Could performance based contracting and the introduction of incentives be of a solution for improving the individual or institutional outputs?
→ The Rwandan experience seems to indicate that this strategy produces tangible results; but it is still too early to tell if this type of approach will work in every context.

- Is a large scale project of contracting out health services the right option for expanding and consolidating a health system in a fragile context?
→ The contracting out initiatives in Afghanistan have shown that this strategy can effectively increase the coverage of basic health services; but is this a good strategy in the long term and/or should there be also some focus on a strategy for strengthening the public health service provision?

- And what about the stewardship and regulation of contracting? Who should take the charge of these functions and how and with what methods should this be done.
→ National Contracting Policies (NCP) which have been put in place in several countries, for example in Burundi, are important tools that have been used in order to strengthen the public stewardship and to clarify the role distribution between actors; but there is no simple template that could be used everywhere, each country has to adapt its NCP to the local context.

As one can see, the meeting proposed some answers to these strategic questions; but at the same time, there are still numerous aspects that need clarification.

As contracting in health system contexts diversifies and becomes more

complex and as the questions related to it become more "strategic", the needs and demands of the countries will grow. This means that there is still lot of work to be done in the future and that there is clearly a solid case for scaling up the activities relating to contracting.