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APPLICATION OF CONTRACTING IN DEVELOPED COUNTRIES

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APPLICATION
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IN
DEVELOPED COUNTIRES
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In recent years, health systems’ organization has undergone a considerable evolution. One factor which has unquestionably contributed to these changes has been the mitigation of rivalry between the public and private areas in all spheres of economic, social and political life. In an effort to make up for the inadequate performance of their health systems, most countries have undertaken reforms. Policy-makers have several choices: devolution allows more responsibility to be vested in local Ministry of Health officials; administrative decentralization is a means of transferring responsibility for health to a local authority; autonomy for public providers is designed to endow health facilities with autonomy, within the public sector, based on legal status; separation of funding bodies from service providers allows competition between providers, whether public or private to be introduced; the broadening of the range of possibilities for funding health, through risk-sharing arrangements, makes possible the emergence of an actor charged by its members with negotiating access to care; privatization, at least in the conventional sense, involves transfer of ownership from the public to the private sector; deeper involvement of the private sector in public service missions is a means of enhancing the ability of the health system to meet the needs of populations; laissez-faire practices are more and more regulated by both health administrations and by funding bodies.

These institutional reshufflings have led to diversification and multiplication of the actors involved in health and to greater specialization in the roles performed by each of them. The isolation that often characterized traditional health actors has become more difficult to sustain. In addition, as new independent or autonomous actors come on stage, relying on hierarchical authority becomes impossible. This compels health actors to reconsider their relations.

The relationships they develop may be based on dialogue; exchange of information and the development of joint principles for intervention are some of the forms this may take. However, there are limits to this moral commitment. It is increasingly common for such relations to be based on contractual arrangements, which formalize agreements between actors, who accept mutual commitments. In most countries, such contractual arrangements have been in place for many years; however, in recent years even greater use has been made of this tool in both the developed and the developing countries.

**The diversity of the contracting**

An analysis of the situation in countries shows the great diversity of situations in which contracting is adopted and of the wide diversity of objectives that justify resorting to this tool. We may propose a typology made up of three categories:
- Contractual relations based on delegation of responsibility correspond to situations in which an actor prefers to delegate, through a contract, its responsibility to another actor who will act in its stead: the main forms this takes are concession of public utility (B.O.T or lease contract) or association with the public service and links with the supervisory bodies.

- Contractual relations based on an act of purchase correspond to situations in which a fund holder prefers to purchase the provision of services rather than itself producing them. In this case, the rationale is based on a simple principle: rather than "doing", in other words providing the service itself, a health actor will entrust a partner with providing it, in exchange for remuneration. This purchasing strategy applies at two levels, depending on the object of the purchase: i) it concerns how fund holders use their funds to procure health services from health service providers (in this case, the purchase concerns a finished product – the health service provided by the provider); ii) it concerns the mode of production chosen by the health service providers (in this case, the purchase concerns production factors);

- Contractual relations based on cooperation correspond to agreements involving interaction between members of independent organizations that combine or pool their forces. We shall distinguish between them on the basis of the degree of organizational interpenetration. In weak organizational interpenetration agreements actors reach an understanding on the framework of cooperation; however, the implementation of activities affords each actor a high degree of autonomy: franchising, care networks, partnership agreements etc. Under strong organizational interpenetration agreements, actors reach an understanding on the framework of cooperation but also carry out some activities together: joint management, strategic alliances and joint subsidiaries are some of the most common forms.

The decision to resort to one of these contractual approaches must first and foremost be taken on the basis of the situation, although national circumstances are also important; some countries prefer to resort to the different types of enforceable, i.e. legally binding contracts, either drawn up on the basis of competition (call for tenders) or negotiation (mutual agreement). Others will more naturally prefer relational contracts.

We also need to take into account the degree of enforceability. Generally speaking, a contract is a binding commitment – enforceable is the legal term – which means that non-fulfilment of the clauses by one of the parties can lead to penalties, and above all the parties can invoke the commitments before entities not party to the contract (the courts). The contract will contain provisions for these penalties and for the means of enforcing them. Some contractual arrangements, however, cannot be placed in this category; we shall refer to them as "relational contracts". This is a negotiated agreement between actors, generally belonging to the public sector, which sets out each actor's role in the joint venture or action. The underlying 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. 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, leaving a certain leeway for unexpected incidents (this is referred to as the incompleteness of the contract). Relational contracts call principally 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, his credibility and reputation deriving from his respect for commitments, but also social control. If a relational contract is to produce the expected results, it must form part of a framework of permanent adjustment of relationships, dialogue and negotiation. These are the elements that ensure actors respect their commitment to continue their cooperation and avoid opportunistic behaviour. The theory of "signalling" is based on the idea that contracting parties should permanently send each other signals, whereby they each seek to reassure the other of their intention to cooperate. In some cases, too detailed a contract, which forcefully outlines the dispute settlement procedure, can be a sign that the contracting parties have no confidence in each other.

The situation in the OECD countries

In recent years, it has been possible to observe two almost diametrically opposed trends in the OECD countries:

- Adoption of contracting in the health sector is based on the market principle, in other words competition as a means of finding the best solution for the actors who enter a relationship. Competition is expressed by means of the tools conventionally used by the market, such as competitive bidding.

The British National Health Service (NHS)

The national health service reforms introduced by the former Prime Minister Mrs Thatcher were based on a clear distinction between providers and fund holders or purchasers and on the introduction of competition among the actors through "quasi-markets" or the internal market. The purchasers are either district health authorities or groups of general practitioners who purchase hospital services for their community from providers whom they pit against one another. Contracts are then signed by the actors. The general framework and principles of this reform were laid down by a 1990 act.

Several OECD countries introduced reforms in line with this rationale: the United States, Australia and New Zealand between 1993 and 2000 (Health and Disability Services Act, 1993); Sweden (which in the early 1990s introduced internal contracting in the public sector); the Netherlands; Spain, where competition was gradually introduced into the health system during the 1990s, especially in Catalonia; Portugal where, despite the 1996 Pacto de Concertação Social, competition is still experimental and more recently Italy.

- Contracting is a tool that makes it possible to formalize collaboration between actors who share common objectives and who jointly define the means of attaining them.
The 1996 reform in France

The order of 24 April 1996 reformed public and private hospitals and instituted Regional Hospital Agencies (ARH) which are public interest groups, legal entities under public law with administrative and financial autonomy, set up by the State and the health insurance bodies. The agencies are under the direct authority of the Ministry of Health. Their tasks include ensuring that public and private hospitals have drawn up contracts specifying objectives and means. This contract documents each actor's commitments: it is generally based on an institutional project and sets out the institution's strategic orientations and conditions for their implementation, objectives in terms of quality and safety of care, provisions relating to human resources management, the objectives of implementation of the orientations adopted by the regional health conference, the deadlines for applying accreditation procedures, participation in care networks, the institutions pooling their resources and financial considerations – in particular the State and local government contributions.

In Quebec, the 2001 reform provides for agreements between the regional régie and the Ministry on the one hand and between the regional régie and public facilities on the other, based on the notion of performance contracts.

Recent trends

In recent years there have been a certain number of developments:

- Adoption of pure competition has proved problematic. In England, evaluations have emphasized the difficulty of introducing genuine competition and the possible negative effects (collusion between providers, selection of low-risk patients, etc.). In most cases, this does not call into question contracting itself, but involves adjustments to market mechanisms. In 1997, Tony Blair's Government established the "new NHS" based on the quest for a third way. The principle of the internal market was abandoned; competition was replaced by cooperation and trust between partners. In New Zealand, in 2001 the new Government abolished the separation between the purchaser and the provider along with competition. Since the middle of the 1990s, Sweden has abandoned the internal public-sector market. In the United States, the large firms that purchase packages of health services for their employees from health-service providers increasingly resort to "partnering" arrangements rather than conventional competition.

It has also been observed that transaction costs are high and may offset the benefits of contracting. Thus, in 1996, the Audit Commission on GP Fund holders estimated that while the reform had made it possible to save 206 million pounds, the cost of computers and of the staff required to implement "fund holding" amounted to 232 million pounds. Moreover, these transaction costs were all the higher because they concerned conventional contracts based on the introduction of
competition into the public sector.

- In many countries, health financing systems are experiencing difficulties in dealing with the upward trend in expenditure. Those systems that might once have been described as passive (France, Germany, the Netherlands) are increasingly adopting the notion of active payers or, or more exactly "informed" purchasers of health care. The notion of purchasing services on the basis of contracts with providers is introduced in two ways. Straightforward competition: the insurer stands in for the insured person to negotiate contracts for the supply of care with providers who compete with one another: the Preferred Provider Organizations in the United States. Dual competition in which insurers too compete against one another, thereby reintroducing a true contractual relationship with members: the earlier Dekker plan in the Netherlands.

A degree of convergence

After having spectacularly embraced economic liberalism and the market economy, the systems inspired by Lord Beveridge in northern Europe, and to a lesser extent in southern Europe, are returning to relations between providers, fundholders, patients and the State which place greater reliance on negotiation. In contrast, those systems inspired by Bismarck and systems akin to them are gradually introducing the notion of health-care purchaser into the relationship between providers and fundholders, although within the framework of State regulation. However, the most striking phenomenon in this trend is perhaps the realization that the necessary development of relations between actors increasingly relies on contracting. The days of administrative and hierarchical relations seem to be increasingly a thing of the past, and are giving way to a health system organized as a node of contracts.

Moreover, the occasionally decried State is returning to the stage in a new role as regulator of contractual arrangements in all health systems, whichever form of contracting they adopt. Contracting is a tool that needs to be supervised; otherwise, it may prove destructive of a systemic approach. The State is thus the actor responsible for defining contractual polices. However, it does not always know how to play its role properly: providing encouragement, facilitating while providing guidance and supervising are tasks that are not always mastered by Ministries of Health, accustomed as they are either to letting things alone or directing everything.

Middle-income and developing countries too, increasingly resort to contracting. Their objectives are often different from those of the developed countries and include, in particular, an emphasis on public-private partnership. However, the question of the role played by the State remains crucial and largely determines the success of the use of contracting as a tool for improving health-system performance.