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**TRENDS IN MECHANISMS FOR ALLOCATING
FUNDING TO HEALTH-SERVICE PROVIDERS:
PERFORMANCE CONTRACTS**



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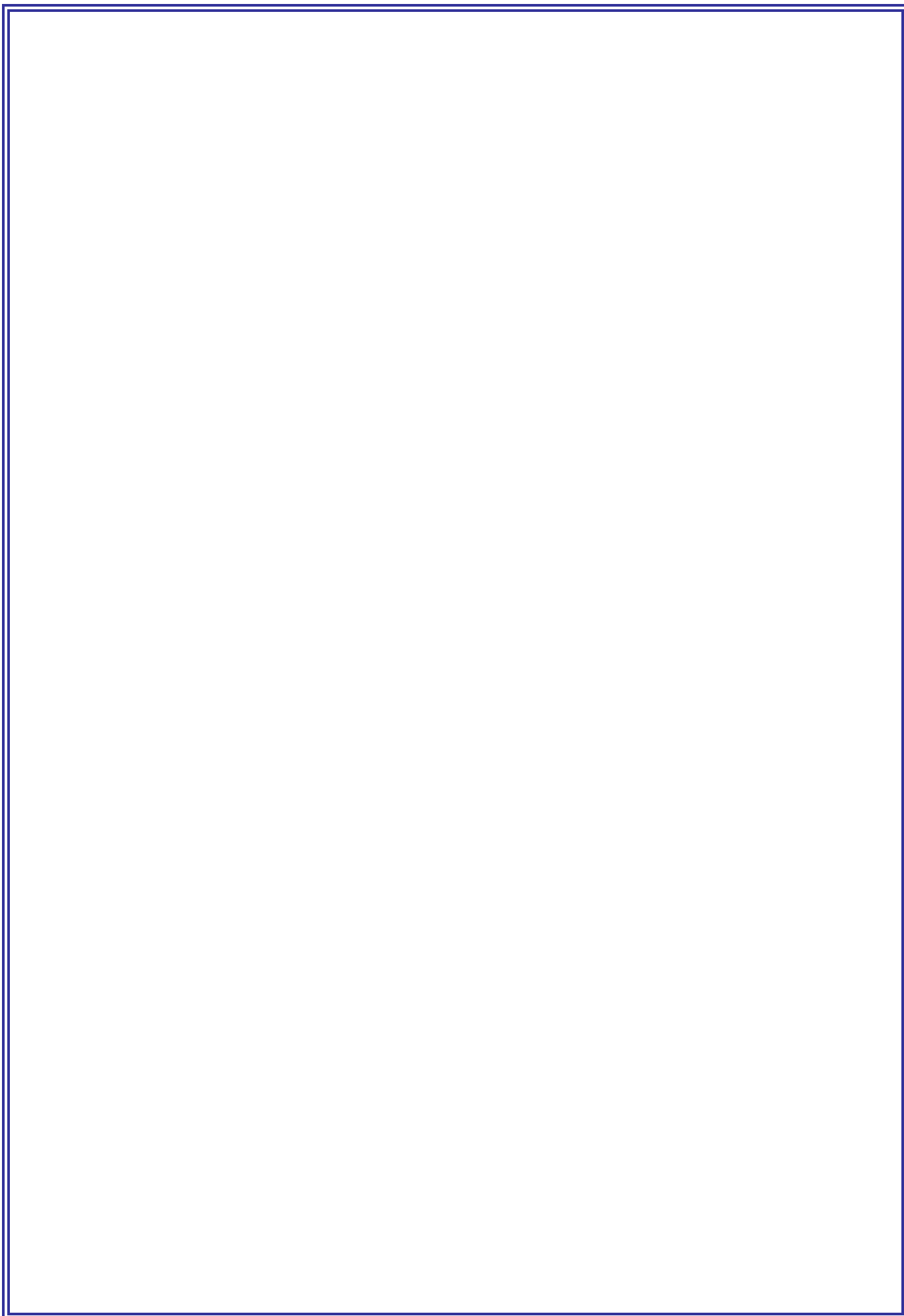
**TRENDS IN
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PERFORMANCE CONTRACTS**

by

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TRENDS IN MECHANISMS FOR ALLOCATING FUNDING TO HEALTH-SERVICE PROVIDERS: PERFORMANCE CONTRACTS

A health-service provider (such as a hospital or a health centre) is first of all defined by its remit. In the public sector, this is defined by the health administration, whereas the private sector defines it itself, or negotiates it with the health administration as part of a public service mission. In order to perform its remit, the provider introduces services and activities for which it requires resources.

These resources may be provided, either in full or in part, by payments from users or by their representatives, the health-insurance entities. However, as a matter of political choice, some countries do not practice direct payment by users; in these countries, there are certain activities, in particular preventive and health promotion activities, for which users cannot be charged. In this case, the resources allocated to health-service providers come from public financial institutions: the health administration, a parastatal agency or a development partner in the case of the developing countries.

Under the traditional approach, resources are assigned through a budgetary appropriation which is as a rule determined by the central government (mainly by the Ministries of Health and Finance) on the basis of criteria that remain in place from one year to the next. The provider waits for the resources to be assigned to it and will use them in compliance with public accounting principles, which are as a rule expenditure-based.

- The first modification to this pattern was the introduction of planning, which took into consideration the notions of objectives to be achieved and activities to be performed, together with the development of a medium-term vision. The Plan, which is drawn up by the different levels of the health pyramid, marks an understanding between the different operators. However, its translation into operational terms via the budget has not always followed, in particular because of the annual nature of budgets and of observance of the rules of public accounting. Especially during the 1990s, there was a strong dichotomy between, on the one hand, efforts to ensure consistency involving the use of planning, and on the other the persistence of an annual budget tool based on resources.
- The second and far more recent development has been the introduction of the notion of "*results-based management*". This has been the case in France, with the Finance Organization Act of 1 August 2001 (LOLF), in New-Zealand with the Public Finance Act, in Sweden with the Accrual Accounting and Budgeting System and in the United Kingdom with the Modernising Government and the Public Service Agreements, etc. As far as financial management and its tool, public accounting, are concerned, this has been nothing less than a revolution. Results-based management is a management strategy that directs operators' efforts towards achieving precise results with direct effects for which they will be accountable, rather than towards achievement of specific activities. This

approach means that operators have reached an understanding about the aims of the action, on the nature of the results to be achieved and on measurement of the results by means of relevant indicators. Under this approach, managers are accountable for the results of their actions: in exchange, they have greater freedom to take decisions (budgetary provisions are treated as being fungible). The level of performance depends on the extent to which the objectives have been achieved.

Question 1: *How are operators persuaded to achieve the jointly agreed results?* Within the conventional public-sector rationale, the hierarchical leader is responsible for ensuring the objective is attained. Orders are passed down from the top and those receiving them are expected to achieve the best possible result (taking into account the means made available). The leadership may use sanctions to make sure its orders are obeyed. However, this is less and less what happens in reality; the higher level increasingly uses contracting to assign responsibility to and ensure the commitment of the subordinate level. Here, a contract is the tool which makes it possible to formalize the agreement between and responsibility borne by operators by defining their mutual commitments. Contracting thus permits the transition from a non-binding constraint, as in the case of conventional planning, to an obligation to which operators may be held. Consequently, there is no question of results-based management without contracting that sets out the responsibilities of the operators.

Question 2: *is the mere existence of a contract sufficient for actors fully to assume their responsibilities?* It will all depend on the position of the operators in relation to one another and the extent to which the contract is enforceable:

- If the contract actually is enforceable, in principle there is no problem. For example, if a ministry of health signs a services contract with an NGO and the activities are not carried out as intended, the ministry has the means of ensuring the contract is enforced. However, it also has to be borne in mind that an NGO is not a commercial enterprise and that it represents a power with which a conflict may not be desirable;

- In some cases, the contract is enforceable only in theory. Consider the example of a public hospital that has the status of a public establishment and thus exists as a legal entity in its own right, and which has a contract with the health administration concerning the payment of a subsidy enabling the hospital to function. This contract is legally enforceable; but, it would be difficult for the administration to enter into litigation if the expected results fail to be achieved. It would also be politically difficult for the Minister of Health to sustain such enforceability. In fact, sanctions are not really applicable. Here, we are close to the notion of a "relational contract"¹. The adoption of a contract will not have strengthened the possibility of penalizing the deficient party. The constraint introduced by the contract proves to be no more powerful than resorting to control and penalties as in the framework of management based on hierarchical authority;

- There are also some contracts which are by definition unenforceable. Consider the case of internal contracts between the top echelon of a ministry of health and a deconcentrated entity. There is only a single legal entity and consequently no possibility of legal enforceability;

It therefore follows that if a contract is not enforceable (either *de jure* or *de facto*), it is impossible to resort to penalties. The mere existence of the contract will in all likelihood be insufficient to guarantee the commitment of the operators. In this case, instruments other than penalties may be used:

¹ A relational contract is based on the trust that leads parties to act in pursuit of a common interest, rather than, as with a conventional contract, its enforceability.

- Respect for commitments may rest on the parties' credibility, and on their notoriety or reputation, as well as on trust and good faith. Contracts of this type are "self-enforcing": each party has an interest in respecting the contract if it wishes to preserve its reputation and credibility. For a relational contract to achieve the expected results, it needs to be set in a framework of continuous management of relations, dialogue and negotiation. These are the elements that compel actors to respect their commitments, maintain their cooperation and eschew opportunistic behaviour: the theory of "relational signals" is based on this logic, in that the contracting parties must permanently refer to mutual signs through which each seeks to assure the other of their cooperative intentions. For example, if similar contracts are signed by all hospitals throughout the country, it is plausible that a degree of emulation will be created and it will be viewed badly if one of the hospitals fails to meet its commitments. The same is true on the side of the health administration: its credibility will be lost if it fails to honour its commitments. This type of contract is particularly useful when the results are very hard to verify;

- Another route makes use of positive incentives. The contract will now aim to give performance incentives but no longer allow penalties. Technically, this involves paying a premium, bonus, or reward; or, in administrative terms, a special subsidy or profit-sharing scheme, based on the results achieved. In order to persuade the person or their institution to do more and/or to perform better, in other words to maximize their effort, it must be in their interest, i.e. there must be a reward for their effort. The strength of the contract no longer lies in the use of **penalties** but on the possibility of awarding **incentives** based on the results achieved. In practice, there are many ways of introducing this: the bonus may be included in an initial contract or made the subject of a specific contract.

At the present time, contracts that give performance incentives are based on two quite different rationales:

- In the first case, the aim is to act on the production of certain health services. For example, a health centre might have to immunize 1000 children, and will be paid US\$ 2000 for doing so. US\$ 1800 will be paid at the start of the contract to enable it to carry out the activities. The remaining US\$ 200 will be paid only if it achieves the expected result; and a decision can also be made to pay a further US\$ 200 if it exceeds the result. The performance incentive is thus included in the initial contract. The object of the contract therefore concerns the direct purchase of health care activities;

- In a second case, the aim is not to act directly on the production of health services or on the respective results, but to encourage suppliers to change their behaviour. The contract acts on the contextual factors that are thought to affect the results. Possible indicators might be the number of days for which medicines are out of stock, user satisfaction, the degree of conformity with hospital-waste management, etc. In general, there will firstly be mechanisms, including contractual ones, for the allocation of resources for current operations; and, secondly, a specific contract concerning changes in providers' behaviour that are considered important for improving the provision of services.

The choice of the indicators whereby it is possible to measure performance, and the manner in which they are put together will be of vital importance. For providers, these indicators are signals marking out areas in which it is important to make efforts; however, these indicators should not distract providers from the remit that has been defined for the health facility.

Performance contracts are valuable tools that are capable of improving health systems' performance. However, their use calls for considerable technical skill and consensus among all the operators concerned in order to avert adverse behaviour.