Application of Contracting in Health Systems: Key Messages
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 changes 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, it becomes impossible to rely on hierarchical authority. 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 purpose of contracting is to improve health systems' performance. The following diagram shows the rationale underlying contracting.
Contracting

As one tool to achieve

Better health system organization

Better health system performance

Improvement of the populations' health

Other determinants

Other determinants

With this diagram in mind, it is possible to summarize contracting in the following messages:

1. Contracting is a fact. Although for many years it was used only on an exceptional basis, its adoption has rapidly developed in recent years, first of all in the developed countries and even more recently in the developing ones. Nowadays it is possible to find some form of contractual relationship between health actors in almost every country in the world. As a result, we are beyond the period of mere advocacy, even if there are still some situations in which the attention of certain policy-makers needs to be drawn to the desirability of this tool.

2. Contracting applies in all countries, whether they belong to the developed or the developing world. Moreover, it is not a tool which is specific to the health sector; it is used in all spheres of economic and social activity. Consequently, a common approach to it must be adopted within each country.

3. Contracting cannot be reduced to a mere contract. It is a long-term process of which the contract is merely a stage. It introduces into relations between actors a form of relationship that is based neither on dialogue alone nor on hierarchical relations.

4. Contracting potentially concerns all actors involved in improving the health of populations: public-sector actors (the Ministry of Health and its autonomous agencies (decentralized agencies, hospitals), local authorities (municipal authorities, autonomous regions), private-sector actors (health-care institutions, private practitioners, local NGOs, communities, funding institutions, commercial firms) as well as donors. They are all, without exception, concerned by contracting. Their status, whether public or private, is important, but not essential.

5. Contracting also potentially concerns all the functions of the health system: obviously, provision of non-medical services comes first to mind (maintenance, upkeep, catering, caretaking, management and training) as well as provision of health services (whether through health facilities or otherwise). However, contracting may also concern the production of health-related goods (for example, insecticide-impregnated mosquito nets, oral rehydration salts etc.), health financing (through insurance agencies) and technical and financial support from external cooperation agencies.

6. Contracting is not to be confused with privatization. Under contracting, existing institutional arrangements form an established part of the system, whether they are the result of the status quo or of reforms. Consequently, the aim of contracting cannot be to increase the number of private players. On the other hand, as they move away from hierarchical relations to relations based on negotiation, actors accept rules which are more prevalent within the private sector; in this respect, and in this respect alone, contracting may be seen as an increase in privatization.
Analysis of the situation in countries shows not only that there is a wide variety of situations in which contracting is adopted but also that the objectives that form the basis for its adoption are themselves highly diverse. 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 the concession of public utility (B.O.T or lease contract) or association with the public service and links with the supervisory bodies, relations between the central level and the local level of the health administration (internal performance-based contracting);

- **Contractual relations based on an act of purchase** correspond to situations in which a fundholder 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 fundholders 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 long-term 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.

The decision to resort to one of these contractual relationships must first and foremost be taken on the basis of the prevailing situation, although national circumstances are also important; some countries prefer to resort to the different types of enforceable, i.e. legally binding contracts while others will more naturally prefer relational contracts.

Contracting allows close links to be established between actors. Experience has produced encouraging results. Adoption of contracting may also prove valuable in situations where the State has to deal with cumbersome administrative procedures that handicap its response and adjustment to change. Even though insufficient technical capacity of the tool is common, the dissemination of methods and of guidelines and the organization of training workshops are starting to bear fruit and allowing better use to be made of the tool.

However, the multiplication of specific contractual arrangements may have harmful consequences. For example, the juxtaposition of uncoordinated ad hoc contractual arrangements may result in disparities and inequities that are hard to justify. The surge in the number of such contractual arrangements may also make it impossible
for the public authorities to regulate and supervise the dynamic, as a result of which they may drift off course in various ways with harmful consequences for the population. Last, and perhaps most important, such ad hoc contractual arrangements are designed above all to resolve the specific problems of the contracting parties, without necessarily taking into account the common interest. This makes it important for ad hoc contractual arrangements to be a part of the health system and to be integrated within a global political strategy. In order clearly to link each contractual arrangement with national health policy, it is important to lay down contractual policies, which may be defined at the level of a country's entire health system or at that of each of its elements: a health measure assigned priority (such as integrated management of childhood illness), a health issue (malaria or TB control), a particular population (AIDS victims), a different function of the health system (risk-sharing systems, drug distribution), a geographical area (the organization of a health district). The different contractual arrangements agreed between actors are the practical expression of a collective and concerted strategy (which may itself be more or less formal (for example a framework agreement or aims-based contract)).

It is the responsibility of the State, or more precisely of the Ministry of Health, to implement and evaluate this contractual policy. However, it is impossible for it to perform its stewardship function without the participation of all the actors responsible for its implementation through specific contractual arrangements. Thus firmly encompassed by a contractual policy, contracting represents a strategic means of improving health system performance. What is at stake is not merely a relationship between contracting parties; it is the search for and development of genuine and lasting partnerships.

11. In order to regulate an uncoordinated trend towards ad hoc contractual arrangements, the State may also resort to framework agreements, which represent an agreement with a group of actors operating in the sphere of health.

12. The State plays an essential role in this approach: it appreciates the risks of uncontrolled development of ad hoc contractual arrangements and acts as the guarantor of a systemic approach which alone is capable of bringing about a lasting improvement in health system performance. This role breaks down as follows:

- after having analysed both the potential and the risks of contracting and considered whether its adoption fits into the State's management methods, the public authorities responsible for health may implement measures to encourage the controlled development of the tool;
- given that the success of contracting also depends on how it is used, the public authorities must ensure that the protagonists (themselves included) possess the requisite technical skills;
- the State must encourage a constructive dialogue between all actors involved in the field of health in order to seek the synergy capable of improving the performance of the health system;
- it is the duty of the State to regulate contractual relations in a way that ensures they benefit the general interest and help to improve the performance of the health system. This regulatory function may take various forms: definition of a legal framework, regulation of competition, upstream (for example, through a system of accreditation) and downstream control of the system and the use, in particular, of various forms of, financial incentive.
- the development of contractual policies, in which all actors are necessarily involved, is a powerful lever with which to regulate contractual practices by limiting the cost of supervising each individual contractual arrangement and limiting departures from the norm.
- finally, the State is responsible for directing the evaluation not only of contractual practices but also of contractual policies in order to assess their impact on health system performance and draw from it the lessons that will serve to strengthen action.

It is the duty of the State to ensure, without undermining the dynamics of contractual relations based on the practical sense of health actors, that this tool is used for the benefit of the populations rather than to solve the particular problems of certain actors.

13. In order for it to be efficient, contracting requires actors who are familiar with its manifold technical aspects: legal issues (private, commercial, public and administrative law), economic analysis, the negotiation process and public health. In the developed countries, but even more so in the developing ones, this contractual culture is still at an embryonic stage. Consequently, in order successfully to implement contracting, the technical skills of all those actors who wish to make use of it need to be considerably improved.

14. If contractual relations are to be sound and to have an impact on the organization of the health system, their creation and implementation demands time. Similarly, the implementation of a contractual relationship involves transaction costs which should not be underestimated, as they may cancel out the direct benefits of the contractual relationship.

15. Evaluation is essential. External evaluation must make it possible to draw the lessons from both contractual relations and contractual policies and to go beyond mere analysis of the contractual process to focus on its impact on the organization of the health system. However, evaluation must also be internal and permanent so as to enable those involved to keep track of the implementation of their contractual relationship.

To conclude, it is important to draw the attention of countries to the risks of rapid but uncontrolled development of specific contractual arrangements whose explicit purpose is not always to help improve the performance of health systems. The authorities must both encourage initiatives by all health actors and simultaneously perform their role as regulators of contractual practices.