

Round Table

Is contracting a form of privatization?

Jean Perrot^a

Abstract Contracting is often seen as a form of privatization, with contracts functioning as the tool that makes privatization possible. But contracting is also viewed by some as a means for the private sector to expand in a covert way its presence within the health sector.

This article discusses the wider meaning of the term privatization in the health sector and the ways in which it is achieved. Privatization is seen here not simply as an action that leads to a new situation but also as one that leads to a change in behaviour. It is proposed that privatization may be assessed by looking at the ownership, management, and mission or objectives of the entity being privatized. Discussed also is the use of contracting by the state as a tool for state interventionism that is not based on authoritarian regulation.

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يمكن الاطلاع على الملخص بالعربية في صفحة 911.

It is common for contracting to be seen as a form of privatization. When it ceases to provide health services, the state contributes instead to the privatization of the health sector. Contracts are generally seen as the tool that makes privatization possible. Others take the more subtle view that unwillingness to declare the objective of direct privatization accounts for the use, at least initially, of contracting, which enables the private sector to expand its presence within the health sector. By these means (like the Trojan horse), after some time has passed, the private sector will end up occupying the field.

But what is privatization? In its accepted meaning, privatization involves a transfer of legal ownership from a public-sector entity to the private sector. Privatization is thus an institutional arrangement rather than a contractual one. However, in the specialized literature on the reform of the state, the concept of privatization has taken on a wider meaning: privatization also encompasses the adoption of a management model that draws on the rules of the market. If we apply the rationale developed by Rondinelli & Iacono,¹ privatization of this sort may be achieved in several ways, as described below.

- *By transferring ownership:* this involves transfer of the ownership of certain public entities (such as hospitals, health centres, laboratories and drug distribution services) to the private sector. This is described by some authors as state “disinvestment.”²
- *While preserving public ownership, ensuring that public entities adopt the managerial practices of the private sector:* this involves suppression of arbitrary subsidies and public monopoly status, adoption of a status granting autonomy to the entity, the possibility of outsourcing certain non-essential tasks and the use of non-public-sector work contracts. The basis for this approach is the assertion that the administration may no longer be considered as a whole, but that it comprises specific entities which must be able to act independently.
- *While preserving public-sector ownership, entrusting the management of public entities to the private sector:* this is known as delegated management. In such cases it is necessary to address the question of the preservation of the public service mission.
- *While preserving control over public funding, purchasing services from private providers, regardless of whether they operate from health facilities:* the private provider becomes a service

provider and is paid for acting as such and for providing the product defined in the contract.

- *Persuading the private sector to take the place of the public sector:* in this case, ownership is and remains private, but the private entity takes the place of the public actor which previously performed the activity.

We can thus say that in each of the above situations, the health system will be increasingly privatized because it will operate more in line with the rules of the market. However, the concept of privatization is clearly far more complex than its commonly accepted meaning would imply. It is not simply an action that leads to a new situation, but also an action that leads to a change in behaviour.

There are thus three factors that allow us to assess privatization:

- *Ownership of the entity:* this is generally understood to involve transfer of the ownership of the entity from the public to the private sector.
- *Management of the entity:* the entity is managed in accordance with the rules of the market and of the private sector. In other words: users are considered as clients; services are defined on the basis of demand from clients; the production process is determined by

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this demand; and production costs must be controlled.

- *The entity's mission or objectives*: this involves determining whether there are no constraints affecting the providers' mission (*laissez-faire*) or whether the state intervenes to define their mission (through contractual arrangements or regulation), and consequently influences the definition of the products.

If privatization of a health system is more advanced, responsibility for the effects of privatization should not be ascribed to contracting, but rather to the reforms undertaken. At the most, we may acknowledge that contracting has proved to be a valuable tool for implementing those reforms and has thus helped to attain a greater degree of privatization.

However, contracting may also be understood as a tool for regulation by the state. By making judicious use of this tool, the state is able better to regulate the health system through interventionism that is flexible, reflective and responsive, and no longer based on authoritarian regulation. The modern state is one that no longer issues orders from on high, but agrees to negotiate with its societal environment; contracting is one tool used by states that take this approach.

Without departing from its role as guarantor of the general interest, the state must define public-service missions, organize the operators who will then be responsible for performing those missions and then monitor and evaluate their practices. In this case, the state itself need not be an operator to achieve its ends. The state may withdraw from

management without withdrawing from what is essential; in other words it may preserve the possibility of directing the missions of health facilities or of operators. However, this calls for a strong state fully capable of performing these roles. It will require appropriate technical skills; and, to be realistic, it will also need to possess adequate financial resources to tip the scales in favour of its views.

Similarly, contracting calls for an honest state. If the state is beset by corruption, contracting will provide a means of rewarding private interests and will have been the means of privatizing financial resources and power. ■

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Résumé

La contractualisation est-elle une forme de privatisation ?

La contractualisation est souvent considérée comme une forme de privatisation, les contrats fonctionnant comme des outils qui la rendent possible. Certaines personnes la voient également comme un moyen pour le secteur privé d'étendre discrètement sa présence dans le secteur de la santé.

Le présent article analyse dans un sens plus large la notion de privatisation du secteur de la santé et les modalités selon lesquelles elle s'effectue. La privatisation n'est pas ici considérée

uniquement comme une action conduisant à une situation nouvelle, mais aussi comme une intervention débouchant sur une modification des comportements. L'article propose d'évaluer la privatisation en examinant l'appropriation, la gestion et la mission ou les objectifs de l'entité à privatiser. Il examine aussi le recours à l'externalisation par les États comme outil d'interventionnisme étatique sans base réglementaire fortement contraignante.

Resumen

La contratación: ¿una forma de privatización?

La contratación se considera a menudo una forma de privatización, en la que los contratos vendrían a ser el instrumento que hace posible la privatización. Sin embargo, algunos ven también en la contratación un mecanismo por el que el sector privado amplía de manera encubierta su presencia en el sector de la salud.

En este artículo se analiza el significado amplio del término privatización en el sector de la salud, y las distintas formas en que

se concreta. La privatización se considera aquí no sólo como una medida que conduce a una nueva situación, sino también como una medida que propicia otra manera de actuar. Se propone evaluar la privatización teniendo en cuenta la implicación, la gestión, la misión y los objetivos de la entidad privatizada. Se analiza asimismo el uso de la contratación por los poderes públicos como herramienta de un intervencionismo estatal no basado en una regulación autoritaria.

ملخص

هل التعاقد أحد أشكال الخصخصة (الخصوصية)؟

مجرد عمل يقود إلى وضع جديد، بل إنها عمل يؤدي إلى تغيير السلوك. ومن المفترض أن تُقِيم الخصخصة (الخصوصية) وفقاً للملكية، والإدارة، والرسالة، والمرامي التي تتوخى الخصخصة (الخصوصية) تحقيقها. كما تتعرض المناقشة لاستعمال الدولة للتعاقدات كأداة للسياسة التدخلية التي لا تركز على التشريع السلطوي.

لا يزال الناس ينظرون في غالب الأحيان إلى التعاقد على أنه أحد أشكال الخصخصة (الخصوصية)، وإلى أن العقود تحمل وظيفة الأدوات التي تفسح الطريق للخصخصة (الخصوصية). إلا أن البعض ينظرون إلى التعاقد كأحد وسائل القطاع الخاص للتوسع المقنع في احتلال ساحة القطاع الصحي. وتناقش هذه المقالة المعنى الواسع لمصطلح الخصخصة (الخصوصية) في القطاع الصحي والطرق التي تُتبع لتحقيقها، إذ يرى البعض أنها ليست

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Round Table Discussion

Contracting is not an end in itself

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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