Experiences of Sub-Saharan African Countries with Contracting between Government and Private, Not for Profit, Health Care Providers (PNFP)

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EXECUTIVE SUMMARY

1. INTRODUCTION

This review is undertaken to provide background information for an international research project, funded by the European Union[1], and executed by four Central American Public Health Institutes/ Medical Faculties and three European Institutes, co-ordinated by the ULB[2]. The fundamental research question is: *"Can contracting-out of public first line health services to private health care providers facilitate regulation of these private providers and improve equity, sustainability and efficiency in health care provision in Central America?"*

The general objective is to define a systemic and multidisciplinary framework and analyse the local experiences of private first line health services contracted by public sector in Central America. The results should allow better orientation of public policies and allow adapting the regulating capacity of governments to ensure that private first line health care providers are steered towards improving equitable access, and improve efficiency and sustainability in health care provision. In a phased approach the analytical framework will be developed, field-tested and improved before the full scale analysis will be undertaken. The lessons from the analysis will then be compared systematically with the existing health policies and regulation mechanisms to be able to recommend revisions towards the general aims in health care provision.

This review is part of the first phase of the above mentioned research project: defining the systematic and multidisciplinary framework that is to allow analysis of the present experiences in Central America. The specific purpose is to review the lessons from Sub-Saharan countries and their potential to contribute to the framework. More specifically, the review will concentrate on the systemic, institutional and policy implications of contracting from the African experience.

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[1] INCO-DEV Accepted Project Description for the Project: "Regulating Private primary health care for more sustainable, equitable and efficient health care provision: Is contracting-out the solution of Central America".

[2] The Centre for Health Research and Studies (CIES) of Nicaragua, the Medical faculty of the University of El Salvador {UES}, the School of Public Health of the National University of Costa Rica (ESPCR), and the INS (??) of Guatemala) in close co-operation with the International Health Institute of the University of Nijmegen (NIIH) in the Netherlands, the Nuffield Public Health Institute, England, and the Institute of Tropical Medicine, Antwerp (ITG), and the School of Public Health of the Free University of Brussels (ULB), Belgium.

1.1. Limitations

This review is limited to the contracting experiences between Governments (Ministries of Health and/or Local {district} Governments) and the Private Not for Profit Health Care (PNFP) sector. Note that this sector is also often referred to as Non Governmental (NGO) or, in reference to the dominant players, Church related / Faith based. The term PNFP is chosen to indicate the main differences with other private providers: these health care organisations provide services in the context of their religious or humanitarian mission and gains are not distributed to owner or shareholders but put to use for the services.

The reason for this limitation is twofold. First of all, most experiences are found here, as these countries have extensive and longstanding networks of PNFP providers. Private 'For Profit' providers are a relatively new phenomenon in most of these countries as they were only allowed to start practice in the wake of liberalisation policies. Secondly the two authors are well acquainted with the PNFP sector. Both have worked in this sector in African countries, and, since becoming lecturer - consultants continue to work for them but also for or with Governments on issues that touches the interests of both.

The second limitation pertains to the nature of health services considered: public purpose services. In most sub-Saharan African countries the PNFP health facilities are labelled 'private' because they are owned and /or administered by non-government (or non-state or non-public) parties. However they provide services which are largely comparable with services provided by the public / governmental facilities. Also their principles and aims are very similar to those of the public health system[3]:

- a social perspective: aiming at enhancement of the well-being and autonomy of the population within the given socio-economic development circumstances;
- non-discrimination: ensuring accessible and quality services to all without distinctions of any kind while aiming to reach the most vulnerable (e.g. poor, children, disabled, etc.) and/or at redressing specific health problems (specific disease control programmes or provision of specific services);

[3] Giusti, D., Criel, B., Bethune, X.: Viewpoint: Public versus private health care delivery: beyond the slogans by et al in *Health Policy and Planning* 12:193-198, 1997.

- population based: the provider is (wants to be) responsible for - and accountable to - a well-defined population for its health care delivery[4];
- government policy guided: the willingness to comply with the government health policies and to fit in – contribute to - a broader master plan for the improvement of the health of the country's population.
- non-lucrative goals: ensuring that service delivery is not used for profit making but is, as far as possible, self-sustainable in the given socio-economic circumstances.

The authors share the opinion of these PNFP providers that services, which answer to these principles, are public purpose services regardless of their ownership and / or administrative guardianship. It is because of this comparability and consistency of the PNFP services with the goals of national health authorities that solutions need to be sought to ensuring that these services are, or become, part of the public health system[5]. The contractual approach offers possibilities to achieve a functional integration.

This review will not address the pros and cons of the different modalities to organise the payment from public contractor to PNFP provider contractee. This issue, albeit an important one is deemed out of scope of the present review. Extensive and specific literature exists on that subject.

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[4] With a well-defined population can be meant a geographically defined community (e.g. in rural areas), or a population that has subscribed, on a voluntary basis, to a given health care provider (e.g. in urban areas, or in the case of Mutual Health Organisations – see appendix 3).

[5] see Ovretveit, J.: Beyond the public- private debate: the mixed economy of health. 1996 Health Policy, N°35, pages 75-93. The debate about the involvement of private organisations in the provision of public health services, in the developing countries, is to a certain extent comparable to the debate in Europe. For the PNFP providers, and the authors, the main issues revolve around their social mission and equitable access to public funds for their clients. For external parties, in the debate, the efficiency issues play the major role, while the public providers are of the opinion that only publicly owned, managed and funded can answer adequately to the public policy aims of the nation.

1.2. Methodology

The methodology used for this review, mainly, consists of:

i) A comparison of the experiences along time in specific countries, between countries, and with international literature. As very little systematic research has been undertaken in Africa, much of the information and a significant part of the evaluative observations stem from the experiences and insights of the authors. Each author arrived at the subject of contracting through his/her specific fields of interest: BC from his study of Community Health Insurance (CHI) arrangements; MH from her study of the development of structural Public – Private (not for profit) partnerships. Their studies are converging towards contracting, or the contractual approach, as both fields require tools to formalise relations and ascertain commitments between autonomous parties.

ii) Information also comes from the proceedings of the November 2001, WHO Inter-Country Meeting " Lessons from health sector experiences in contracting in Africa", held in Addis Ababa, Ethiopia. MV attended this meeting on behalf of *Medicus Mundi Internationalis*[6].

The experiences will be reviewed along the following questions:

1. What is contracting? And why contracting in Africa? Who is expecting what from it? What are the agendas?
   The authors will define what contracting is and will try to make more explicit the underlying assumptions that have led different stakeholders, and most importantly governments and private non-for-profit health care providers, to engage in contractual relationships.
2. Types of contracts established in Africa.
   In this section, the authors will review, describe and compare the most prevalent types of contracts established.

[6] The WHO report is awaited soon. The report to MMI is available.

3. Evaluation of the impact of contracts

   The current evidence of the impact of contracting will be summarised. In methodological terms the use of case study evaluation[7] will be considered[8] next to a general synthetic view of the available evidence.

4. Why does contracting work? Or why does it not work?

   The authors will reflect here on the reasons that can explain success or failure. They will attempt to highlight the most important conditions that make contracting work.

5. Conclusion:

   Finally, the authors will present a set of lessons and recommendations from the African experience that may help health planners considering to test the option of contracting in a different environment (like for instance Central America).

In the annexes the case studies will be summarised:

Annex 1: Case study Tanzania
Annex 2: Case study Uganda
Annex 3: Case study Guinea Conakry

Further a number of overviews is presented there:

Annex 4: List of conducive / obstructive factors
Annex 5: Comparison of contract types
Annex 6: Assessment of the appropriateness of contract types in relation to health service provision needs

In the annexes 7 and 8 two example contracts are presented.

[7] See *The Good Research Guide for small-scale research projects* by Martyn Denscombe, Open University Press.

[8] Three or four case studies could be considered. A provisional choice is the case of Uganda, Tanzania and Guinea-Conakry. In the latter, it concerns a particular case of contracting: i.e. not one between the government and a private provider, but a contract between a Mutual Health Organisation (MHO) and government-owned health facilities (Health Centre and Hospital).

2. BACKGROUND

In view of understanding a number of issues at stake in the relation between Public Health Authorities and PNFP institutions and around contracting between them, in sub-Saharan Africa, it is worthwhile to take some background issues in to consideration[9].

First of all the design of health systems in sub-Saharan Africa was strongly influenced by the colonial powers, using the example of their country of origin. After Independence the systems were continued without major changes, thus the basic precepts of the colonial system remained in place. However most countries did add one important principle: wishing to develop a social welfare state they aimed at a nation wide public health care system that would be able to provide free health care services for all.

Secondly, in English speaking African countries, the health care systems included, at independence, recognition of - and allocation of recurrent cost subsidies to - the Non Governmental Health Care Providers (then mostly mission/church health care institutions). The bases for this inclusion into the system were arguments of geographical access and financial equity during the period of construction of a full-fledged public system[10] [11]. By the nature of their mission the churches built most of their health care institutions in the rural areas.

The new governments opted to continue this subsidy relationship for the meantime, aiming to replace these units in time with public units. The subsidy relation between government and mission health care providers meant that the latter organised their representation at national level to facilitate the channelling of the subsidies and to facilitate dialogue and negotiation: Catholic, Protestant and/or joint Christian Health Associations were born.

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[9] This chapter is based on MV's experiences and comparisons between French and English speaking African countries and historical documents of Catholic and / or Christian Health Associations. One of these is the White Paper presented to the Ugandan Government in 1953 by the Church leaders and Health Care providers and which led to the allocation of subsidies to the church health units. See also Verhallen M (1994), Integration of church-related NGO health facilities into district health systems: why not? Medicus Mundi International Newsletter, N°53, pp 5-14.

[10] See for instance: Frazer Commission Report, 1956, Uganda; and the General Notices of Government 1957, 1959 and 1961, Uganda Gazette.

[11] Ghana Health Act nr.9, 1958.

In French speaking countries, in analogy of the health care system in France, a similar subsidy relation did not exist and the two sectors developed in parallel and often in strong competition. National representation of church partners followed much later when the parties started to recognise the defaults of lack of co-operation.

In the third place, in most countries, the relations between government and non governmental health care providers came under heavy strain when mutual promises eroded and nationalisation policies were tried to answer to development aspirations (church properties were taken over without compensations to complete education and health care systems). Later, when the economic crisis of the 70's and 80's meant that subsidies were decreased and often disappeared, leading to a souring of the relationship.

And last but not least, current health sector reforms represent major paradigm shifts for the African countries: shifting public roles to other parties, and sharing responsibilities and resources with non government parties require very different institutions and capacities. On top of this, these fundamental changes have to take place while both government and non-governmental health partners are facing major quantitative and qualitative human resource shortages. These shortages result, on the government side, from the earlier crisis and, for the church institutions, from their earlier dependence on expatriate missionary congregations.

In conclusion: an experience of contracting, though poorly conceptualised and structured, between governments and PNFP health care institutions exists in the English speaking sub-Saharan countries. However, in all the sub-Saharan countries, new collaboration arrangements have to reckon with mutual perceptions of distrust and rivalry.

3. CONTRACTING DEFINITIONS, MOTIVATIONS AND EXPECTATIONS

In sub-Saharan Africa, as elsewhere in the developing world, structural collaboration between the Public Health Authorities and Private Health Care Providers has come on the agenda in the context of Health Sector Reform (HSR). A key aim of most HSR is, like in all Public Service Reforms, to improve the responsiveness and effectiveness of the Public Health System. In many countries this entails changing the roles of the State towards concentrating on the stewardship functions and decreasing execution (health care provision) responsibilities. This in turn means that these execution

responsibilities need to be delegated, or handed over, to other parties. The solutions opted for mostly are delegation of service implementation to local governments (decentralisation policies) and / or to the various private providers (privatisation policies). Often liberalisation polices are also installed bringing with them a rapid growth of private practice in health care.

The contractual approach has been tabled in these countries, stimulated by international partners such as WHO[12]. It is proposed as an instrument which can increase certainty / reliability for each partner in situations of delegation and acceptance of responsibilities. The partners can be central government (Ministry of Health) or local government (district councils), as purchaser, and private health units/organisations, of any category, as providers. Some countries[13] [14] [15] [16]go one step further and are considering contracting between government and public health facilities as a means to ascertain performance.

3.1. Definitions

According to the English dictionary:
"A contract is a legal agreement, usually between two companies or between an employer and an employee, which involves doing work for a stated sum of money".

[12] Perrot, J., Carrin, G., and Sergent, F., The contractual approach: new partnerships in health in developing countries, ICO, WHO, Geneva 1997, nr 24.
[13] In Zambia the Ministry of Health, in a bid to ensure an effective purchaser – provider split, proposed contracts between the MoH and the Central Board of Health, between MoH and District Boards of Health, and between District Boards and Hospital Boards. See MoH, WHO, Unicef and World Bank, Independent Review of the Zambian Health Reforms, vol. II Technical Reports Lusaka, 1996.
[14] Examples of contracts between CMAZ facilities and district boards.
[15] McPake B. and Hongoro C.: Contracting out of clinical services in Zimbabwe, Soc.Sci.Med., vol 41, no 1, 1995.
[16] Vander Plaetse, B.: Performance contracting, purchaser – provider split and health sector reform in Zimbabwe, thesis written for the award of MPH degree, Institute for Tropical Health, Antwerp, 2000.

Another definition is:
"A contract is a promise, or set of promises, for the breach of which the law gives a remedy, or the performance of which the law in some way recognises as duty"[17].

The WHO – ICO (Division of Intensified Co-operation with Countries in Greatest Need), in its technical working document for the workshop: "The Contractual approach: New Partnership for Health in Developing Countries".[18], February 1997, defines the contractual it as follows:

WHO definition:
"A contractual arrangement (or contract) is an agreement between two or more legal entities (economic agents) through which they undertake to assume or relinquish, do or not do certain things. A contract is therefore a voluntary alliance of independent partners."

Contracting started in the industrial and commercial sectors at the beginning of industrialisation[19]. The new specialisation of labour (or production of goods) presupposed exchange as only exchange can achieve distribution of the rewards necessary to sustain specialisation. Contractual ways were developed to organise production and distribution of goods and services. The definitions clearly indicate this exchange situation: each partner has something the other wants or needs. The alliance must give each partner (or at least one) an advantage or surplus that would otherwise not be attainable.

At this moment the introduction of contracting in Public Service provision can be traced to Civil Service Reforms, amongst others, in the United Kingdom[20]. In the UK it entered the realm of public health care provision in the wake of the NHS reforms led by the Mrs Tatcher conservative government. Note that the UK NHS, at the time, was an entirely public (state) run and funded system. A private sector existed, until the latter reforms, separately. The 1991-92 reforms aimed at improving

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[17] Macneil I.: The many futures of contracts, Southern California Law Review, 1974, vol. 47: 691-814.
[18] WHO/ICO: Technical Document: The Contractual approach: New Partnership for Health in Developing Countries.
[19] MacNeill: Many futures of Contracts, Southern California Law Review, 1974, vol. 47: 691-814.
[20] Walsh K.: Public services and market mechanisms. Competition, contracting and the new public management. Basingstoke, UK: Macmillan.

efficiency and quality of services by introducing elements of market competition (internal or 'quasi' markets). The roles of purchaser and provider were split: national and district health authorities became the purchasers, and general practitioners, hospitals, and community services, now separated from their local authorities and transformed in to NHS Trusts, became the providers (specialisation of roles or 'labour'). To arrange the exchanges (money for services) contracts between these purchasers and providers were initiated. As the 'competition' was to be on price versus quantity and quality of services these contracts also aimed at ensuring performance[21]. It is this context that the private providers entered the public provision market.

In America comparable movements were initiated, not so much to improve the state system as to include the contributions of private providers towards the public goals and decrease the inefficiencies of too much competition (managed competition)[22].

In other words: contracting was introduced in the UK health system with the aim to manage the purchaser-provider split while the US health system is seeking a better integration of its health system through contracting[23].

In many developing countries, other than public providers exist and reform ideas mainly focus on ways to ensure that the capacity and infrastructure of private providers can contribute more to the attainment of public health goals and duties. The contractual approach has been set on the agenda as a tool to enrol and formalise the inclusion of private providers in the health system, and at the same time abandoning the paradigm that the State should be the sole health care provider. In that respect, the African situation draws on elements from both the UK and US experiences[24] [25] [26] [27] [28].

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[21] Maynard, A. and Bloor, K.: Introducing a market to the United Kingdom's National Health Service. N.Engl.J.Med., 1996, vol 334, no 9, pp. 604-608.

[22]See American literature on Health Management Organisations and Managed Care concepts.

[23] Stoltzfus Jost.,T, et al..: The British Health Care Reforms, the American Health Care Revolution, and the Purchase/Provider Contracts, Journal of Health Politics and Law, vol.20, nr. 4, 1995.

[24] Broomberg, J.: Health care Market for export? Lessons for developing countries from European and American experience. Public Health and Policy Publications Pamphlet. 1994, London, London School of Hygiene and Tropical Medicine.

[25] Verhallen M. Contracting in health care: a tool to enable NGO partners to play a significant role in health care provision. Thesis MPH degree Netherlands School of Public Health, Utrecht, 1995). Published in Medicus Mundi International Newsletter, 1998 no 62, pp 13-30.

How should we interpret the above fundamental aspects, of specialisation, exchange and distribution, in health care delivery by different parties in developing countries?
In most of these countries, access to health care services is a constitutional right. In the context of revising health strategies, the achievements that the government has to ensure are being defined more clearly: public purpose aims, services or goods. In many countries these public purpose services have been defined in the 'Essential or Minimum Health Care Package'.

The changing roles of states, mentioned above, mean that the government is responsible for policy development, planning, financing, regulation, and control (stewardship functions). These are to ensure that public purpose services are equitably available and accessible for the entire population (taxpayers). Others can do the actual provision of services in order to decrease governmental duties. Central governments should continue to 'produce' those services or goods that no other (or private) provider will take on or those that can not be left to others: goods and services that are characterised as having a low contestability and low measurability[29]. Governments then become purchasers of service provision from parties capable of doing it in her place. The contractual arrangements aim at getting others to do what the government wants to have done according to its standards: delegation, specialisation and distribution versus exchange of financial and / or other benefits.

In this light, the term performance contract is used when one, or both partners, wish to ascertain that the specialisation and exchanges achieve well described targets (e.g. of outcome, quantity, and / or quality of services, but also of the level of financial contribution or other benefits). The contract formulation will reflect these targets and link the counter-exchange phases (e.g. money disbursements) to adequate proof of attainment: performance.

And under the title "Involving Private Voluntary Health Care Providers in Better Health for Africa" in World Hospitals and Health Services, the official journal of the International Hospital Federation, 1998.

[26] Perrot, J., Carrin, G., and Sergent, F., The contractual approach new partnerships in health in developing countries, ICO, WHO, Geneva 1997, nr 24.

[27] Mills, A.: Improving the efficiency of public sector health services in developing countries: bureaucratic versus market approaches. 1995 Departmental Publication no 17. Department of Public Health and Policy, London School of Hygiene and Tropical Medicine.

[28] Mills, A. Private Health Providers in Developing Countries: Serving the public interest? 1997 Zed Press, London.

[29] Preker, A.S.; Harding, A. Travis, Ph.: Make or buy decisions in the production of health care goods and services: new insights from institutional economics and organisational theory, Bulletin of the World Health Organisation, 2000, 78 (6).

This potential to link financial exchanges to performance, makes contracting also an interesting tool to improve the efficiency of public providers: contracts between national (or district) public health authorities (purchasers) and district (or more peripheral) public health facilities (providers)[30].

Should contracts have a (legal) binding character?

Between the first two definitions of contracts and the WHO version, the latter lacks the definite reference to a legal bondage. In the industrial / commercial world, from which contracts originate, legislation has been developed to provide external securities to each party of a contract. To ensure that both parties adhere to their promise(s) the exchange is formalised in a manner that is recognised in the legislation of the country (including enforcing measures).

One could conclude that the WHO refers more to a moral commitment. Here the parties adhere to their mutual promises because they share a mission and are convinced that working together is the best way to achieve the common goals. An external 'enforcement' possibility is deemed less necessary because of the internal moral standards, of both partners, their trust in each other, and the public nature of their statement of intent.

The need for recourse to legal remedy for possible lack of adherence or performance thus hinges on the degree of security each, or one, partner requires. This level of certainty is mainly determined by the existing trust in the other party; the extent of the risks (e.g. losses due to unused investments, potential for opportunistic behaviour), and / or the obligations to external parties (e.g. accountability to constituents / funding agencies).

It is also possible to consider this aspect in the light of a continuum:

- with respect to the public – private mix: from a loose collaboration to moral commitment and then to enforceability[31];
- with respect to ascertaining performance: from no specification of targets, to limited specification, then further specification ending in very detailed specification and an enforceable contract[32] [33].

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[30] OECD Public Management Service, Public Management Committee: Performance Contracting, Lessons from Performance Contracting Case studies and a framework for Public Sector Performance Contracting; PUMA/PAC (99)2.

[31] Walker, R. Collaboration and Alliances: A Review for Vichealth, Victorian Health Promotion Foundation, September 2000.

[32] Vander Plaetse, B.: Performance contracting, purchaser – provider split and health sector reform in Zimbabwe, quoting Lidbury, C.: Performance contracting: Lessons from

A gradual development approach would also correspond with pragmatic needs. In most countries, like in Uganda[34], the legislative systems of most countries, at present, do not cater for the use of Public funds by private providers, nor do they cover contracts between public institutions (purchasers) and public providers or private providers. The reason for this is that existing public finance legislation does not yet cater for allocations to private partners and contract legislation only addresses commercial contract relations.

Variations in the definition of contracting:
In some countries the terms 'contracting out' and 'contracting in' are being used to make a difference between kinds of services and kinds of contracts:

- *contracting out*: an independent company/provider is contracted to provide particular services fairly independently of the organisation (e.g. laboratory services, catering services for patients, hospital cleaning);
- *contracting in*: contracting a provider for services that constitute an integral part of the core business of the organisation or system (which basically is what this document is about).

But, as the distinctions are often difficult to make, other countries and organisations prefer to use just the term contracting or contractual approach / arrangements.

In summary, the most important aspects of contracts pertain to the following:

1. Separating functions of provider and purchaser,
2. Organising and formalising exchanges,
3. Moral or legal binding character of the contract between the partners.

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performance contracting studies. A framework for public sector performance contracting. 11-17-1999, Paris, OECD.

[33] Performance Contracting, Lessons from Performance Contracting Case studies and a framework for Public Sector Performance Contracting; OECD Public Management Service, Public Management Committee PUMA/PAC (99)2.

[34] Unpublished report: Verhallen, M.: Review of the existing MoU's and Service Level Agreements between District Health Authorities and PNFP providers: lessons and the way forward. 2002, UCMB, Kampala.

Hence, in the long run, performance can be ascertained, both in terms of quality of care, as in terms of financial commitments.

3.2. Motivations for partnerships.

For the purposes of this paper, we will review here the motives of both governments and PNFP representatives to consider entering into contractual arrangements that formalise their mutual relations, working arrangements and exchanges.

Why do governments want to contract other (non-governmental) parties for health service provision?
Among the most important problems that African health systems currently face are:

- insufficient coverage of the population by health facilities and activities (resulting in unequal geographical and financial access);
- inadequate responsiveness of the public health system to the needs;
- inefficient and ineffective service provision and functioning of public facilities;
- high delivery costs, while budgets are insufficient to cover the needs.

In these countries the PNFP sector has an important network of health facilities, mostly in the rural area's where public health facilities are lacking. Depending on the country studied, the PNFP sector provides between 30 to 60% of the health care services. In certain countries this percentage can reach up to 80% in the rural districts: Uganda and Tanzania report national averages of 45%. And Tanzania has districts where up to 85% of the providers are PNFP facilities[35] [36]. In Ghana the PNFP providers cover 35-40% of the population[37].

Next to this, there is a considerable overlap in the mission of the PNFP facilities and government: ensuring essential services for the poor and vulnerable. The PNFP sector often was, and still is, in the forefront of

[35] Uganda Health Sector Strategic Plan, 2000, and the Policy for Public – Facility based PNFP Partnership, 2001.
[36] Tanzania Presentation during the WHO Intercountry Meeting "Lessons from health sector experiences in contracting in Africa", held in Addis Ababa, Ethiopia in November 2001.
[37] Ghana National Health Policy and Strategic Plan, Ministry of Health 1996.

developing preventive and promotional health care activities (Primary Health Care and Community Health Care[38]). In other words, the services and activities of the PNFP providers match quite closely with the essential package the governments want to provide.

Last but not least, it is increasingly recognised that the PNFP facilities have been able to provide services of good standard and generally function more efficiently then public facilities[39 40 41].

The government can thus, by contracting PNFP providers, increase coverage of - and access to - the essential health care services and obtain good services at reasonable prices. At the same time the available resources are used more efficiently and new investments can be better targeted at deprived areas.

It is important to note that the international donor partners, of governments in sub-Saharan countries, are important proponents of Public – Private Partnerships in health care and actively stimulate (pressurise?) governments to develop partnership arrangements and instruments.

Hidden agendas may however exist: for instance, a possible motivation for governments to engage in contractual relationships with PNFP providers, at least hypothetically, would be to actually weaken the position and strength of the public sector.

Why do PNFP health care providers want to accept delegated responsibilities and bind themselves by contract?

The PNFP sector recognises two important factors that hamper their effectiveness to answer to their social mission.

1) The first is their present relative isolation from the health system. They provide all, or nearly all, the components of the essential package but their efforts fall short in comprehensiveness, consistency, and continuity. The reasons for this are the lack of structural links with the other actors

[38] See reports and presentations leading to the Alma Ata Declaration of 1978: World Health Organisation, United Nations Children's Fund. Primary Health Care. Report of the International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978. Health For All Series, no. 1: Geneva: WHO,

[39] World Bank, World Development Report 1993: Investing in Health. New York: Oxford University Press; 1993. And: World Bank: Better Health in Africa, 1994.

[40] WHO Annual Report 2000.

[41] Minister for Health Uganda: unpublished report: Comparison of efficiency between Government and PNFP hospitals, 1996/97. The result of this comparison was that the subsidies to the PNFP hospitals were re-instated (the bill of 1957, instating the grants, had never been repealed).

in the field and the lack of influence on implementation policy and planning[42]. Operational integration of PNFP providers in the system can be *instrumental* indeed in improving their effectiveness[43].

2) The second motive pertains to their sense of equity as well as to their financial survival[44]. They provide public purpose services but have to finance their own recurrent costs. In the past their external partners (donors, mother churches or religious congregations) contributed heavily. These funds are dwindling quickly for a variety of reasons. Among these reasons, the refusal of NGO donors to continue to finance recurrent costs for services that belong to the constitutional right of each inhabitant is the most important. The PNFP sector introduced patient / user fees a long time before user fees (or cost recovery) became official policy. Increasing these, to cover the full costs, entail financial access barriers exactly for their target population: the poor in rural areas. To keep costs as low as possible preventive services are decreased, quantity and quality of staff is decreased, and maintenance of infrastructure and equipment is neglected. The result is further loss of effectiveness and quality.

The relative importance of these two motivations may obviously differ from one country to the other, *a fortiori* from one continent to the other.

At present, due to the above factors and to the phasing out of religious, specifically expatriates, without sufficient preparations for this inevitable event, the PNFP management capacities have decreased considerably in many countries. In some countries, they have lost, or are losing a lot of their innovative drive and the goodwill they had.

As explained in the introduction, the PNFP organisations perceive their role as similar to that of government: provision of public purpose services. They believe that, when they would be assigned structural roles and responsibilities in the local health systems, they can contribute more effectively to improving health and health care delivery. They are prepared to commit themselves through contracting. The financial allocations to implement the delegated services will improve equity for their catchment population and allow them to function properly.

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[42] Giusti D. (1996) . MPH Thesis.

[43] For instance: assigning populations of responsibility, or improving referral procedures between the different tiers in the local health system.

[44] Giusti D., Criel B., Bethune X.: Viewpoint: Public versus private health care delivery: beyond the slogans. Health Policy and Planning 12:193-198, 1997.

3.3. Expectations of the contractual approach

In the strict sense, the earlier subsidy relation (see chapter 1), between sub-Saharan Governments and the Mission providers, can be seen as a precursor of a contractual arrangement as it was understood that an exchange was expected and due. In exchange for the subsidies of the government, the Mission facilities were to adhere to the national health policy, provide the services, defined for their level, and report on the use of the allocations. These arrangements were largely implicit. When problems started to occur, neither party could hold the other to its promises.

The reaction of governments, to perceived non-adherence, was increasing administrative obligations and more restrictive regulations (e.g. annual re-registration, increasing reporting demands, etc). The mission facilities answered by decreasing communication and participation.

When countries like Tanzania initiated nationalisation policies, the burgeoning fears, of losing their autonomy, deepened among these PNFP organisations. For them, preserving their identity and basic autonomy is essential to their larger social mission.

In countries were civil war disrupted public services (e.g. Uganda), the autonomy of the PNFP organisations proved of key importance to continuing services and surviving[45].

[45] MV increasingly has the impression that the aspect of 'resilience' of a health system has till now received insufficient attention. The resilience of a health system pertains to its internal checks and balances and the capacity to cope with – recover from damaging events. The Uganda experience - similar to experiences in Ghana in the early 1980'ties - show that the presence in a health system of various autonomous actors contributes to the capacity to cope with damage of this system. The relative independence enabled PNFP providers to continue and, to a certain extent, even to fill the void left by the incapacitated public providers. The reciprocal influence and competition, that results from the mere presence of other autonomous providers in the system, maintains a basic drive to perform and provides a degree of internal checks and balances. The autonomy of the various actors does seem to be a key element to ensuring these contributions. This would mean that the contractual approach offers advantages that are more elusive in other co-operation approaches: basic autonomy can be maintained. The need for a measure of resilience seems evident. However as little research is available, it might be worthwhile in these times of rapid changes in health systems, to investigate which factors strengthen resilience and how these can be installed/maintained when re-organising health systems?

Securities

Evaluating the above motives (2.1. and 2.2.) for contracting, one can conclude that these governments and their PNFP sectors need each other to achieve their goals in health care. Their negative experiences mean that both partners want more certainty that the exchange promises will be upheld. Contractual arrangements built either on moral commitment or on legal coverage, offer significant higher degrees of securities than the old arrangements.

Independence and Autonomy

The fact that the partners retain their fundamental independence and that the contractual arrangement can, in principle, be terminated has additional advantages for each. The government avoids extending its civil service and responsibility for infrastructures. It maintains the possibility to opt for another provider if the first does not perform as promised. The PNFP can retain the required level of autonomy and can opt not to prolong / renew the contract if the government does not provide the powers and resources as agreed.

Relating performance to allocations

In view of improving the performance of the health system, contracts offer the possibility to define more accurately the type, quality and quantity of services that will be provided in exchange for the resources allocated (ensure value for money). Vice versa the provider can ensure that the allocations are in accordance with the obligations.
Increasingly the term 'performance related contracts' are used to convey this prospect.
Note that this capacity of contracting is closely related to government's wishes to regulate and control other providers closely.

3.4. Discussion

Need for operational integration of private providers and organisational options to achieve this

Health systems have to function with a high level of cohesion to be effective. Delegation of responsibilities to other actors and specialisation greatly complicate cohesion and integrated operation. It is striking that this aspect

of operational integration is given relatively little attention in the official debates. It actually figures highest on the agenda of the PNFP representatives because for them operational integration is a requirement to be more effective.

When selecting methods and working arrangements to organise and formalise the public-private co-operation (like the contractual approach), the potential to assure that these partners can operate as one entity, will have to be a key criterion.

The authors note that, in their fieldwork, and during their research for this paper, they have not yet come across alternative approaches to organise and formalise the operational integration of private providers. Whether the choice for the contractual approach, in these countries, stems from a deliberate analysis of alternatives or the lack of feasible alternatives, is therefore not clear.

Only in Uganda did we come across the mention of a choice between a general administrative approach and the contractual approach[46]. The general administrative approach here is understood to mean that the inclusion of the PNFP health units will be established through the health administration system: they will be treated administratively in the same way as the public units and become, as such, one of the 'cost centres'. The PNFP organisations are not in favour of this approach, as it will unavoidably erode their autonomy.

Public – public contracting

In the theoretical refinement of the definition in chapter 2.1.'*Interpretation of the fundamental aspects of contracting*' the nature of the contracting partner seems of lesser importance. However, the original definitions of contracting clearly refer to a level of autonomy and independence of both parties and to a deliberate choice to enter into an agreement. The authors therefore wonder in how far contractual relations between different public actors, as proposed in Zambia and Zimbabwe, can be effective. These partners depend nearly completely on each other financially, and certainly public providers have little to no choice to opt for another contractor. This mutual

[46] Uganda Ministry of Health, Draft Policy for Partnership with Facility-Based Private Not For Profit Health Providers, 2001. The general administrative approach here is understood to mean that the inclusion of the PNFP health units will be established through the health administration system: they will be treated similarly to public units and become a 'cost centre' like the public units.

dependence is even stronger in public systems where no cost recovery is allowed.

Evidence from case studies on 'Performance Contracting' between central and decentralised governmental institutions, in Europe[47], indicate that it is feasible and effective in improving output and efficiency. However, these countries have a longer tradition of critically reviewing performance of public institutions and with decentralisation. In how far these traditions influence the positive lessons can not be established from the cited presentation. The sub-Saharan African countries have only just started decentralisation and are still struggling to find the right balances between central and district responsibilities and decision making scope. (For instance: in Uganda the first trial to devolve of budget responsibilities to districts, through the allocation of unconditional grants to districts, ended in near disaster for education and health as these were left out in the majority of the districts). This would mean that performance contracting could be a possible tool between central government and district health authorities. Districts, however, may first need to gain more experience in their basic roles before they can start acting as purchasers of services / contractors towards public health units.

Next to this, the conclusions of the case studies bring the OECD to stress that performance contracts have to be part of a broader performance management and resource allocation regime (e.g. result oriented planning, budgeting, and public accounting). Experience with dis-aggregation of programmes is another important prerequisite (dividing a programme into separate sub-programmes or activity packages that can be quantified and measured). These conditions still have to be developed in sub-Saharan countries.

Contracting private providers and governmental responsibilities

Critics of involving private providers in public health duties and of contracting private providers point to the potential dangers of Governments disposing of their responsibilities towards the poor[48]. However, no private

[47] OECD Public Management Service, Public Management Committee, Performance Contracting, Lessons from Performance Contracting Case studies and a framework for Public Sector Performance Contracting; PUMA/PAC (99)2.

[48] Amongst others: Medicus Mundi International, Report Partner Consultation East Africa, Dar Es Salaam, 1999. The same criticisms were heard by MV during the ICO workshop in 1997, during the WHO Inter-country Meeting and during interviews with representatives of MoH and PNFPs during the last years.

provider will agree to a contract that does not contain a reasonably equitable exchange (financial or other benefits). In other words the contractual approach allows ensuring that governments realise their responsibilities towards these groups. Legal enforceability would be the best protection for both the target groups and the contractees [49].

Another often heard criticism is that handing public duties to private parties excuses other parties from social solidarity. But as the financial exchanges of the public contractor mainly come from the national budget (tax revenues), contracting offers a means to institutionalise social solidarity. The government even gains a tool to prevent urban elite from obtaining undue benefits when the moral commitment is publicly known, but better still, when legal backing of the contracts can be established[50].

Governmental reluctance

The resistance against contracting most often pertains to the costs to governments. These costs are related to two aspects:

- funding of services provided by other providers;
- the cost of designing, negotiating, implementing, monitoring and evaluating contracts (transaction costs).

With respect to the first aspect, this resistance is at odds with the stated objectives of many sub-Saharan countries: public services should be accessible for the poor. The PNFP providers target exactly this same group. Thus, enabling the PNFP network to provide the public goods, by subsidising them, would allow governments to enhance equitable access. The reluctance – in spite of the lip service authorities pay to the strategy of contracting - actually stems from the chronic resource constraints, in most of these countries: politicians and civil servants find it difficult to contemplate sharing meagre resources with non-governmental actors[51].

Transaction costs are, in principle, additional to present costs of service provision. The net effect of these costs, however, will depend firstly on the type of approach selected and on the degree to which the more efficient use

[49] Walsh, K.: Public Services and Market Mechanisms, Competition, Contracting and the New Public Management; Public Policy and Politics Series, Macmillan Press, 1995.
[50] Contracts can prevent that money is actually diverted to more powerful institutions like for instance University Teaching Hospitals at the expense of district hospitals.
[51] The author (MV) attended the April 2002 Joint Review Mission In Uganda: when it was announced that the Health Budget would not be allowed to increase because of the effects of additional foreign funds on the macro economic policy, the immediate reaction of politicians was to question the subsidies to the PNFP.

of the resources offsets the costs. Unfortunately experience is yet too sparse to evaluate the net effect. The doubts concerning the net effects together with the doubts concerning sharing resources, might explain the slow implementation of the contractual approach.

Involving beneficiaries

An area that has not been touched upon above is the relation between purchaser, provider and the clients (beneficiaries of health services). This is because no actual experience is yet available in Africa. Theory would suggest, and examples from Peru and Brazil[52] provide evidence, that involvement of beneficiaries has positive effects on contract implementation and compliance. Slack reports that community involvement in the contracting negotiation process lead, amongst others, to better local support, control of compliance, higher degrees of accountability, faster improvements in service delivery and greater access for specific groups.

In the authors' view, a three party contract (purchaser – provider – beneficiaries) would seem ideal to ensure responsiveness and compliance in contractual arrangements.

Many sub-Saharan African countries are institutionalising community participation in the management of public and PNFP health facilities through representation of the communities in the advisory or management bodies of health units (health unit management committees). In many of the same countries experiences with participation (of the representatives) of the beneficiaries in selecting providers and service packages, are being gained by Mutual Health Organisations (MHO's) [53] – or *Mutuelles de Santé* in French. Although the evidence found in this study is still sparse, the potential power of these organisations is great: directly or indirectly communities can thus influence health care provider behaviour and contribute to the governance of the sector[54] [55].

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[52] Slack, K., Savedoff, W.D.: Public Purchaser – Private Provider Contracting for Health Services, Examples from Latin America and the Caribbean; sustainable Development Department Technical Papers Series (No SOC-111), Inter-American Development Bank, Washington D.C., Jan. 2001.

[53] Atim, Ch.: The Contribution of Mutual Health Organisations to Financing, Delivery and Access to Health Care: Synthesis of Research in Nine West and Central African Countries, Abt Associates inc., report of a study initiated by USAID.

[54] Criel B (2000). Local Health Insurance Systems in Developing Countries: a Policy Research Paper. Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium.

Platforms like health unit management committees and beneficiary organisations such as MHOs could be valuable entry points to involve communities in the contracting process. A gradual approach may be the most appropriate: from information, to involvement in the negotiation process and monitoring and then to full contract partnership. This would certainly give these community participation platforms much more co-responsibility and foster ownership.

4. TYPES OF CONTRACTS

4.1. Typology

In general, but certainly in sub-Saharan Africa, contracting for public purpose service delivery is relatively new. Therefor few contracts exist which can be used to develop a specific typology. Scientific literature, from law institutions, learns that there are three types of contracts[56]: In annex 5 an overview of the different characteristics is given and in annex 6 they are compared to the needs of the health care sector.

A. Classical or transactional contracts

This is the earliest form of contract. It formalises a discrete transaction between two parties and covers a very short time frame (the present or very near future). The contract pertains to the substance of the exchange

[55] *Le Projet* PRIMA *Guinée Conakry. Une expérience d'organisation de mutuelles de santé en Afrique rurale* (Eds. Criel B, Barry A.N & von Roenne F), Medicus Mundi Belgium, Brussels, June 2002, 255p.

[56] Macneil I.: The many futures of contracts, Southern California Law Review, 1974, vol. 47: 691-814.

And: MacNeil I.: Contracts: adjustments of long-term economic relations under classical, neo-classical and relational contract law, North Western University Law Review, 1978, 72:854-905.

(e.g. the product and the price)[57]. The relation between the contractor and the contractee is considered as non-existent or of limited importance. The 'commercial market' and the competition between potential contractees offers the purchaser, or contractor, the possibility to get the best price, i.e. choose another contractee for the next exchange.

B. Neo-classical contracts

As industrialisation advanced and specialisation increased, the need for more complex and long term contractual arrangements arose. These contracts needed a greater in-built flexibility and thus the planning could not be complete before the agreement was formalised. These contracts still mainly cover the substance of the exchange and not the relation between the two parties. Specific processes and techniques were introduced to enhance discreteness (distinct and separate definition), expand and intensify presentiation[58] as well as ensure flexibility and reduce risks. Among these figure the use of standards determined by independent parties, direct third party determination of performance, and arbitration. The arbitrator in neo-classical contract disputes will uphold the exchange 'rewards'.

C. Relational contracts

The advanced economies of nowadays have achieved a level of specialisation that entail long term interdependencies between parties and demanding an even higher level of flexibility and gradual planning (e.g. consortia, corporations, etc). Thus ongoing relations between, more or less, independent partners, have come to dominate the organisation of economic activity. There where the former type of contracts only deal with the end products of the exchange, relational contracts address the entire partner relationship and the various processes the partners will use to ensure the continuous change required. This does not mean that discrete description of the 'exchange products' and framing the exchange as much as possible in the 'present' has disappeared completely. They

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[57] Clear examples of classical contracts in health care are contracts for non-clinical services (e.g. laundry, security, cleaning, ...) or for clinical services like child immunisation. In all these case, the expected outputs can be described discretely and measured accurately.

[58] "Presentiate" is defined in Oxford English Dictionary as " to make or render present in place or time; to cause / to be perceived or realised as present. Or in other words: a way of looking at things in which the person perceives the effect of the future as the present.

remain, as they are inherent to planning and therefore influence the relationship. However as the need to co-operate, to achieve the individual and/or common goals, is recognised by both (e.g. too few competitors, or no market) the contract terms aim at harmonisation and preservation of the relationship.

Abbreviated overview of the differences between the types of Contracts (in annex 5 a complete overview is presented)

Factor	Classical contract	Neo-classical contract	Relational contract
1. Transaction (object / substance of contract)	-distinct and isolated definition (discrete terms) -formulated in present tense (presentiated)	-discreteness and presentation require technical enhancement	-discreteness can only be approached; -terms leave room for future planning and context changes
2. Contestability of transaction	-high	-high to medium	-medium to low
3. Measurability	-direct -complete	-indirect -needs standards or third party	-exchanges are difficult to measure
4. Relation between contracting parties	-no relation required or wanted	-limited exchanges needed	-relation is prime instrument to achieve transaction aims.
5. Flexibility	-not required	-limited need	-high need
6. Primary focus of planning	-substance of transaction	-substance of transaction	-structures and processes of relation -substance planning in initial period
7. Sources and forms of mutual planning	-mere agreement to price/ product by seller -short bid-asking bargaining	-some bargaining price/ product specifications -post commencement negotiation to finalise planning	-extensive bargaining prior to formalisation limited use of commands -mutual planning merges into ongoing relationship and 'joint effort'
8. Prime focus of arbitration	-protection of the exchange	-protection of the exchange	-harmonisation of the relationship to safeguard continuation

In many publications 'Performance Contracts' seem to be presented as a fourth type of contract. The definitions and explanations presented in the OECD publication[59], however, show that these contracts fall within the group of relational contracts.

Slack[60] and others are developing a categorisation of contracts on the basis of key characteristics. The underlying assumption seems to be that there is only one type of contract, i.e. one type of relation: the transactional type. For the selection and evaluation of contract terms the key characteristics which this group identified might be valuable at a later stage.

4.2. Contract types used in health care provision

During the WHO Inter-Country Meeting[61] only few concrete examples of contracting of health services were presented. Most examples concerned contracts for non-clinical services[62]. These types of contracts are by nature transactional with elements of the neo-classical type. There is a market of providers (competition / contestability), the exchanges are discrete, measurable, the time frame is short, and the need for flexibility and gradual planning is limited (maximum presentiation).

In several sub-Saharan African countries (e.g. Benin, Ghana, Uganda,...) a *two-tier* contractual approach is being experimented with:

- on the one hand, an agreement of intent morally committing the partners to the more general aspects of the co-operation/partnership for a medium term period (e.g. Memorandum of Understanding in English-speaking Africa or *conventions* in French-speaking Africa);
- on the other hand, service delivery agreements or contracts settling in more detail the specific exchanges for a limited period of time.

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[59] OECD Public Management Service, Public Management Committee: Performance Contracting, Lessons from Performance Contracting Case studies and a framework for Public Sector Performance Contracting; PUMA/PAC (99)2.

[60] Slack, K., Savedoff, W.D.: Public Purchaser – Private Provider Contracting for Health Services, Examples from Latin America and the Caribbean; sustainable Development Department Technical Papers Series (No SOC-111), Inter-American Development Bank, Washington D.C., Jan. 2001.

[61] WHO Inter-Country Meeting " Lessons from health sector experiences in contracting in Africa", held in Addis Ababa, Ethiopia, November 2001.

[62] See also the examples form Africa presented by Mills, A. et al. in Private Health Providers in Developing Countries: Serving the public interest? 1997 Zed Press, London, 318p.

A number of draft Memoranda of Understanding and contracts for service delivery could be studied by one of the authors though (see list in item 40 of the list of references). This analysis learns that the Memoranda of Understanding (MoU's) contain a number of the elements of relational contracts (overall co-operation principles and commitments, inter – organisational linkages, communication and accounting procedures, amicable conflict resolution and mediation). Sometimes the level of autonomy of the partner is defined. The aspects least included or developed are: procedures for common planning, monitoring and evaluation, arbitration, and sanctions. The time frames vary from one to five years.

The existing actual contracts or Service Level Agreements (SLAs) are often, not always, formulated in relation to the MoU, and cover the actual exchange. In these, efforts have been made to make them as conversant as possible with transactional contracts (or to relate them more to output): i.e. short timeframes, legal formulations, detailed definitions of services to be provided and/or inclusion of quality definitions, strict sanctions (in the latter case parity is often skewed as only sanctions of the purchaser are mentioned). In strict transactional contract terms, though, these contracts remain incomplete as the substance of the exchanges is not made discrete and measurable. On top of this, except for Ghana and Zambia, the financial counter exchange is only a proportion of the costs to provide the service responsibilities described! (e.g. in Uganda 30%).

The examples of Benin and Ghana are exceptions. In both countries the MoU and contracts contain some features of a relational contract and the MoU's are for five years and the contracts cover two years. The annual evaluation and negotiation process is to result in the roll for the following year.

In the cases where the MoU covers a longer period than the contract or SLA and the combination sets the principle of rolling on contracts the scope to develop the relationship is present as well as the necessary degree of certainty to enable the contractee to invest in infrastructure or equipment.

But often the time spans of MoU and contract practically overlap (e.g. Uganda) and neither defines the future or the relationship. In Uganda, the absence of a minimal level of commitment, towards the continuation of the relationship, means that neither party fully invests, morally, financially or physically in the co-operation. Thus each party has to ensure that the available options for a different future are kept open and the relation does not evolve.

Analysing the discourses of government representatives and the discussions, during the WHO workshop[63], as well as in other fora in various countries[64], we have to conclude that knowledge of other types of contracts is very rare. This is not surprising as in most countries the experiences with contracting have mainly been gained in fields comparable to the commercial world: construction, procurement, non-clinical services, etc. Thus the perceptions, regarding contracts, are mostly classical or transactional: the short-term transaction or product is the main point of reference and the relation between the contractor and the contractee is seen as one-off. Another important perception of both governments as PNFP, derived from these types of contracts, is that competition between providers is a necessary condition to obtain the best price.

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[63] The WHO Inter-Country Meeting of November 2001 held in Addis Ababa, Ethiopia, was entitled " Lessons from health sector experiences in contracting in Africa". The aim was contribute to the improvement of contractual approaches. More specifically: to share country experiences; to identify specific procedures that assist the process; to identify the support requirements; to review draft proposals for evaluation methodology; and to consider the need and possibilities to develop specific policies. The countries represented were: Ethiopia, Ghana, Kenya, Mozambique, Tanzania, Uganda, Zambia, Zimbabwe. The delegations consisted of both governmental and PNFP representatives.

[64] The WHO-ICO workshop 1997; Medicus Mundi International Partners Consultation East Africa; Zambia discussions with government officials and PNFP representatives 1999; Email interviews for review of Public-Private partnership developments for MoH Uganda with Government, PNFP representatives and International Technical Advisors 2001 in Benin, Ghana, Tanzania, Zambia, Lesotho and Uganda; Joint Review Missions Uganda April and October 2001 and April 2002;

Examples of these perceptions or misunderstandings of mostly government representatives, are:

- at least four out of the eight countries represented in Addis Ababa were convinced that tender procedures have to be adhered to in contracting for health service provision for specific geographical areas. In these countries the providers in the rural areas are either public or PNFP and a tender will not yield competitive bids.
- various countries have tender boards at national, or district level, and existing legislation rules that all contracts, above predetermined ceilings, should be vetted by these boards. The representatives allocated negotiating and controlling functions to these boards also for health service contracts. However as these boards mainly have expertise / experience in judging construction and procurement contracts it is questionable whether they would be the appropriate platforms to evaluate health service package offers and negotiate with providers on compositions, quantities and costs.
- capacity of the purchaser to dialogue and negotiate service packages and contract terms rarely figures in the lists of requirements for effective contracting, cited by governmental representatives. They concentrate much more on contract design and controlling capacity needs.

  a quite striking example of misconceptions, is the following. A local government official explained how contracting assisted them in ensuring adequate services in a municipal facility: they had contracted health care staff, from a nearby government hospital, to work in this unit. The fact that they stimulated 'dual' employment and 'robbed' the government of staff availability did not figure in the assessment of the advantages and disadvantages.

These dominant perceptions certainly influence the reasons for considering contracting as a feasible tool or not. The control over the exchange substance and the absence of a direct relation with the provider seem to attract governments. On the other hand their fear of opportunistic behaviour (or mistrust) is great, most of all in countries that have a very centralist tradition (e.g. Ethiopia). This fear gives rise to serious hesitations, probably, because they are aware that their inspection and controlling capacities fall far short of what would be needed to protect their interests.

4.3. Discussion

The authors are of the opinion that the study of the types of relationships and the types of contracts has up to now been least developed. At present the assumption seems to be that the principles of contracting, which everyone knows from daily life, provide sufficient basis to develop this approach for health services provision. However the system's needs and the prevailing conceptions do not fully match.

Health system needs and transactional contracts

Contracting is not a goal in itself: it is a means to an end. If the objective is to contribute to more effective and equitable health care delivery systems, then the contract type has to fit the health system needs.

1) Current health reforms whereby service responsibilities are delegated to private providers aim at strengthening the service delivery system. On the other hand the cohesion of the health system needs to be assured. Such aims inherently call, first of all, for long term relations within the district health systems. These Public – Private relationships need to be built, fostered, and institutionalised in sub-Saharan Africa. Short-term contracts without assurances for the future will not facilitate the development of these relations.
2) Secondly, in most developing countries competition is hardly an option, certainly in rural areas, where no or very few other providers exist. Even if they would be available, competitive bidding, frequent changes in providers or continuous uncertainty are not conducive to constructing operational pluralistic systems.
3) Thirdly, transactional types of contracts, used in the commercial world, would not be able to capture every eventuality of health care service delivery and promotional activities. Important limitations are:

- the substance of the contract (the services) is difficult to describe in discrete / present terms (though the descriptions of the essential health care packages have made it somewhat easier);
- quantities are difficult to determine on the forehand: e.g. utilisation of services by the population are subject to a large variety of direct or indirect influences; epidemics are not predictable, key population data may not be available to allow to calculate requirements;

- the costs of services need to be known in detail to be able to link services to the financial exchanges (in very few developing countries these details are known);
- the need for flexibility is great: the provider has to be able to react instantly to increased and changing needs or changing awareness of the population (e.g. epidemics, delayed uptake of prevention, opportunities for promotion activities, etc.)
- outcome and impact are difficult to measure directly, certainly in prevention and health promotion.

In other words, if the requirements of a transactional contract - i) high degree of presentiation, ii) discreteness and iii) measurability - need to be satisfied, the contract specifications will have to be highly detailed and very lengthy. This level of detail will exclude flexibility and responsiveness. At the same time the demands of control and transaction costs increase linearly.

That none of the available contracts answer completely to the requirements of transactional contracts certainly indicates that the fit between the aims, the exchanges and these terms is inadequate.

Alternatives

The relational contract, as defined above, seems to fit much more closely to the needs of collaboration between autonomous health care partners[65]. The contract itself represents a formal step in the development of the relation between the two. It is a product of their negotiations as well as the instrument for ongoing dialogue for purposes of planning, monitoring and evaluation. This process is of utmost importance because it serves to continuously enhance performance and strengthen the relationship.

The stipulations of the contract are then subordinate to the need to harmonise the actions, towards the common objectives, and to preserve the relation.

In this perspective, contracts can be more general and less detailed by linking the other instruments of the health system to the contract.

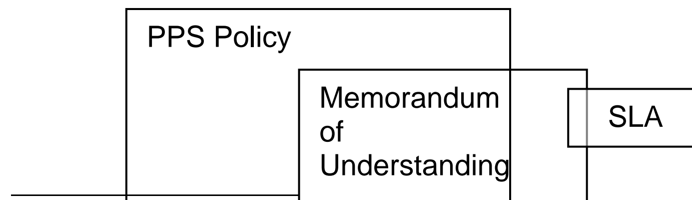
[65] Natasha Palmer: The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries, Bulletin of the WHO, 2000, 78 (6). In this article the author shows e.g. that contracting experiences in the NHS, in Great Britain, indicate an evolution towards relational contracts for reasons of coherency, planning time span, contract design and transaction costs.

Instruments that concord with the needs of relational contracting are for instance:

- national health policy and strategic plans;
- essential health care package descriptions;
- implementation guidelines;
- quality standards;
- accreditation criteria and assessment procedures;
- district and / or health unit mid to long term health plans.

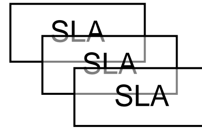
In Uganda the own experiences and those of other countries[66] have lead to the decision to first develop and adopt a generic policy on the Public – Private Partnership. On its basis a more specific policy for the partnership with the Facility Based PNFP providers[67] has been developed in dialogue with the sub-sector. This policy and its implementation guidelines will be part of the Memoranda of Understanding (MoU) with the owners of the facilities for a period of several years. The MoU in turn will constitute the basis for annual contracts or Service Level Agreements (SLAs) between the district health authorities and the facilities. This step-wise approach (see figure 1) preserves consistency and security, reduces transaction costs, and ensures at the same time maximal flexibility to adapt to changing needs.

Figure 1.



[66] A review of the experiences in other Sub-Saharan countries learnt the following: in Ghana, the process towards signing the contracts between PNFP hospitals and Ghana health Services is on hold because it does not match with other developments and policies; in Tanzania the lessons from the DDH contracts have not yet been drawn and no plans for the future exist yet as there is no framework for Public -Private co-operation; the need for this framework also became apparent when the Tanzanian Ministry for Economic Affairs installed taxes on earnings of Private businesses and organisations, including PNFP health units, which meant in practice that the subsidies of the MoH went back to government via the Ministry of Economic Affairs.

[67] Uganda Ministry of Health, Draft Policy for Partnership with Facility-Based Private Not For Profit Health Providers, 2001. See also guidelines for the Implementation of the FB-PNFP Partnership Policy, 2002.



In our opinion relational contracts do not mean that contracting cannot play the desired role in improving performance and efficiency. The cyclical process, of negotiation – drawing-up the contract – implementing – monitoring / evaluating the outcomes, allows the partners to work towards improvements on a continuous basis (flexibility and need for continuous planning). At the same time the process will allow to constantly develop the relationship in the direction required to sustain and extend the intended pluralistic health system. The OECD study[68] confirms these expectations: *"In many cases it is the relational aspects of contracting, such as trust, dialogue, clarity of purpose and expectations, commonly agreed frameworks for performance review and improvement, rather than legal or administrative underpinnings that foster the necessary environment for achieving the aims of performance contracting".*

Legal backing of relational contracts is more difficult to establish as most legislation has been developed on the premises of transactional contracts. In the Sub-Saharan context the partners' need for assurance is relatively high: the past has eroded mutual trust (see chapter 1) and governments change often. Whether moral commitment can provide sufficient certainty will depend on the overall framework for Public-Private Partnerships and in how far national governments succeed in convincing lower level governments.

Conclusion

If a contractual approach is really to become an instrument that allows to formalise co-operation for public purpose service distribution, it will be essential to develop theory and practice about the type of relationship and the type of contract needed.

5. EVALUATION OF IMPACT OF CONTRACTS

[68] OECD Public Management Service, Public Management Committee: Performance Contracting, Lessons from Performance Contracting Case studies and a framework for Public Sector Performance Contracting; PUMA/PAC (99)2.

The aim of the CAPUBPRIV study is to establish whether contracting between public health authorities and private first line health care providers can contribute to improving equity, efficiency and sustainability of health care delivery systems. During the first consultative meetings the researchers[69] determined that a number of additional indicators should be studied, as these are deemed essential to improve the performance of the health systems in the concerned countries. The list of criteria was as follows:

1. Equity and accessibility
2. Efficiency
3. Sustainability
4. Reversibility
5. Quality
6. Accountability
7. Acceptability, participation, and democracy.

While preparing this review, the authors recognised that the following two criteria are also important as they are directly related to the contractual approach and its potential application:

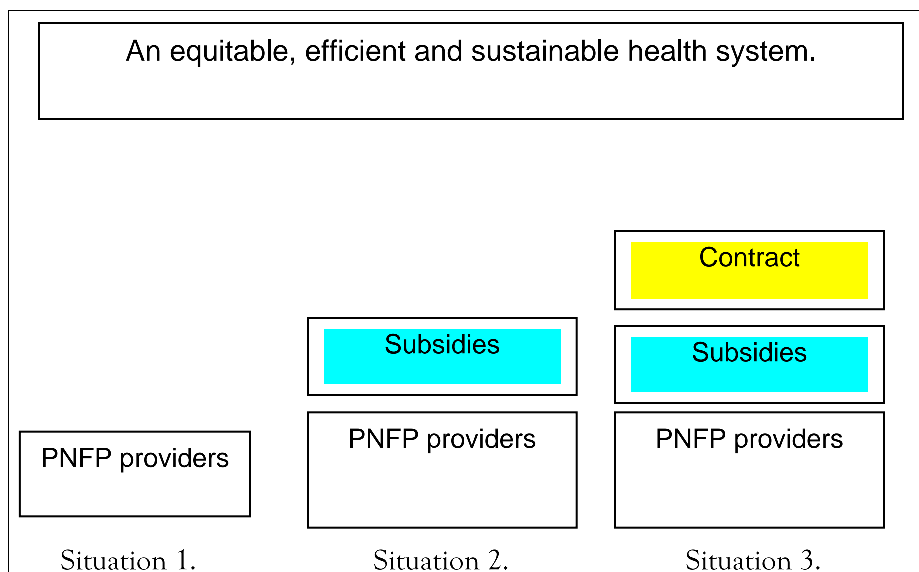
8. Offer of integrated care by the health services;
9. Operational integration of the different tiers in the local health system.

In this chapter we will try to evaluate the sub-Saharan experiences using these same criteria to assess their suitability and increase comparability. Note also that there is a significant overlap between these indicators and the motives of the Governments and PNFP organisations to consider contracting (see chapter 3.2).

To establish whether contracts between public health authorities and the PNFP health care facilities/providers have an impact, a comparison of their functioning and their contributions to the health system before and after the introduction of contracts is needed (comparison of situations 1, 2 and 3 in figure 2). As the present, health systems in sub-Saharan Africa are far from what they should be. The actual comparison is forcibly with the desired situation and with the functioning of governmental health units.

Figure 2.

[69] The researchers from ULB, CIES,ESPCR,INS,ITG, NIIH, and UES.



Unfortunately required comparison is not fully feasible as the existing pilots (Ghana and Uganda) are too young to show impact, and/or little specific research has been undertaken. Some evidence is emerging now from studies executed for other purposes, e.g. a recent study in Uganda concerning the effects of the re-instatement of government grants to PNFP facilities[70] and a study of the effects of the abolition of user fees in government health facilities in the same country.

More research and empirical evidence does exist for the effect of subsidies to the PNFP health care facilities from:

i.) the old subsidy relation between governments and Mission facilities;

ii.) the precursory contracting experience in Tanzania (DDH contracts, see annex 1).

This allows a comparison between situation 1 and 2 in figure 1. From this comparison assumptions regarding the outcome of a comparison between situation 2 and 3 can be derived.

The authors hereby propose the following hypothesis:

[70] Giusti D., Lochoro, P., Mandelli, A.: Public–Private in Health. What is its effect on the Performance of The Health Sector? Uganda Health Bulletin, MoH, April 2002.

Hypothesis:
If subsidies to PNFP facilities prove to have an impact on the key indicators of a well performing health system, then the contractual approach will further enhance these effects.

5.1. Equity and accessibility

With respect to this indicator the evidence of a positive impact is clearest. In all the above-mentioned cases there is evidence that subsidies to the PNFP facilities did improve equitable access. In the cases of the old subsidy relation and the DDH contracts, the proof can be found in the loss of equity and access after, respectively, the abolition and the drastic decreases of the subsidies. In the first case no contract was available. In the DDH case there was a contract, though no specific performance, monitoring and enforcement clauses were included. The agreement was clear though: free access to first referral hospital services for all the patients from the district. These hospitals succeeded to maintain the free access till the subsidies went below 75% of the required budget.

In the case of Uganda: data, from the catholic network (study mentioned in footnote 67), show that the PNFP facilities were in a steep downward spiral since 1995: of increasing fees and decreasing utilisation, decrease of preventive and promotional outreach activities and loss of quality. In the fiscal year 1996/97 the Government grants were re-instated first for the hospitals in greatest need, and gradually all units received subsidies. The level, achieved at present, stands at +/- 30% of their recurrent cost budget. Though the actual contracts were initiated later the stipulations were clear from the outset: decreasing the fees, increasing preventive services, and improving staff remuneration. The data show that the decline in utilisation/accessibility has been reversed, preventive services provision is rising again (immunisation numbers), and quality is being restored (as proxy: number of qualified staff).

A very recent report of WHO, regarding the effect of the abolition of cost sharing in 2001 in Uganda[71], shows that the abolition did increase accessibility in state health units but hardly affected utilisation in the PNFP

[71] Mwesigye, F., Desmet, M. and others, Effects of Abolition of Cost sharing and the Government Response, in Public Health facilities in Uganda 2000 – 2002, WHO report to the Joint Review Mission, April 2002.

units. A comparison of utilisation per socio-economic (SE) group indicated that neither the 'free' public facilities nor 'the low fee demanding' PNFP units succeed in improving utilisation by the lowest SE group. The reasons are not yet clear, but actual and perceived quality loss in the public units may play a role (drugs out of stock, decrease in staff moral), but it might also be that informal payments have returned.

In conclusion: contracting PNFP facilities can improve equitable access.

5.2. Efficiency

Older comparisons between governmental and PNFP hospitals[72] indicated that, during the times of subsidies to the PNFP sector (which then did not cover full running costs), these units generally obtained a higher degree of efficiency than public facilities. These results were probably heavily biased as in those times religious managers certainly did not include material donations received from abroad. And on top of this: religious personnel did not receive normal salaries.

In later years studies[73] [74] often confirmed relative high degrees of efficiency in PNFP units. What cannot be traced often, is in how far the comparisons were controlled for the effects of economising measures (decreasing staff numbers, employing more auxiliary staff instead of qualified staff, neglecting maintenance, etc.) However even taking that into account the differences are still quite important.

Unfortunately, no comparisons are known to have been made between government district hospitals and DDHs, in Tanzania. This would have been a sound basis for comparison as both categories received the same budgets for running costs.

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[72] Unpublished: Kok, P. Comparisons between African Hospitals, Memisa Medicus Mundi, 1988.
[73] World Bank: World Development Report 1993: Investing in Health, Oxford University Press. And World Bank: Development in Practice: Better Health in Africa: Experiences and Lessons Learned, 1994.
This report cites: De Jong, J.: Non governmental organisations and Health Delivery in sub-Saharan Africa, Pre-Working Paper 708, World Bank department Population and Human Resources, 1991.
[74] Country studies confirm this as well: Reviews for revision of National Policies and / or Strategic Plans mention observed differences.

The Uganda study provides some proof of efficiency: these units provide the comparable outputs with far lower budgets. Low staff numbers and low salaries do present a bias but do not eliminate the difference.

The above evidence allows to expect that by contracting PNFP health facilities the health systems can benefit better from this higher level of efficiency in PNFP units as well as from the experience they have gained in achieving it.

5.3. Sustainability

This cannot be proven with existing data. The assumption, that the sustainability of a country's health system can be greatly improved by ensuring inclusion of PNFP facilities seems quite obvious though. We only have to think of the capital investments needed to replace them, i.e. the investments that will be lost by disbanding them. According to it's principles and mechanisms, the contractual approach enables governments to gain a higher level of certainty that the PNFP capacity remains available for the national system.

5.4. Reversibility

The researchers defined 'Reversibility' as the degree to which the situation of before the intervention can be re-instated after terminating it (here the intervention is the contract between the contractor and contractee). In principle the co-operation is reversible: the agreement is for a fixed duration. But in practice this might be quite different. For instance, in the case of the Tanzanian DDHs the hospitals have become part of the health care system and breaking-off the relation (and the exchanges) will have serious negative effects on accessibility to services and equity in health as no alternatives exist for the population. These PNFP units will have to install (higher) fees to be able to continue services.

It can be questioned though if reversibility should be desired if the previous situation was far from optimal with respect to equity and accessibility and reversing would imply new duplication (e.g. for new constructions).

The authors wonder whether reversibility is a relevant criterion to measure the suitability and the impact of contracting. It can even be

questioned whether it is a relevant criterion for other interventions towards improving heavily deficient health systems.

5.5. Quality

The evidence here actually only stems from comparisons between governmental health units and PNFP units. In most cases these comparisons were done in position 0 (see figure 1: PNFP facilities without subsidy). The information from Uganda and Ghana come closest to our actual evaluation question: for Uganda the latest studies reflect the effect a of subsidies and contracts (position 3) and for Ghana they reflect the effect of subsidies and the preparations for contracting (position 2).

A recent study on duplication of services in Uganda[75], the National Household Survey 2000, and the preliminary report of a study of Lower Level Units[76], all indicate that the quality perception of the population with respect to PNFP facilities remains high. Given a choice and the financial means the population prefers to go to a PNFP unit. This is in spite of considerable improvements in the government units since the start of HSR and the Health Sector Strategic Plan. The recent abolition of user fees has occasioned some decrease, though[77]. This study also showed that the abolition of user fees in the government units hardly affected utilisation in the PNFP units. The reasons to seek treatment at the PNFP unit, cited by interviewed patients, are mostly related to perceptions of quality (staff attitudes favourable, staff always available, drugs always available, etc.). Further research would be needed to verify the reasons (vicinity versus opportunity costs, social acceptable responses,...?)

The study of the Mutual Health organisations[78] reports high regard for PNFP providers in Senegal and Ghana. In those cases where the MHO

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[75] Jitta, J. Duplication of services by the PNFP and Government health Facilities. Research commissioned by the Public – Private partnership Desk, MoH, supported by SIDA, Uganda.
[76] Reinikken, R. et al: Health on the Frontline, Preliminary Survey Evidence from Uganda; World Bank Development Research Group, 2002.
[77] Mwesigye, F., Desmet, M. and others, Effects of Abolition of Cost sharing and the Government Response, in Public Health facilities in Uganda 2000 – 2002, WHO report to the Joint Review Mission, April 2002.
[78] Atim, Ch.: The Contribution of Mutual Health Organisations to Financing, Delivery and Access to Health Care: Synthesis of Research in Nine West and Central African Countries, Abt Associates inc., report of a study initiated by USAID.

started around a PNFP facility dialogue between MHO and provider regarding quality was hardly taking place: the prevailing perception of the quality of the provider inspired the start of MHO and there was no felt need to improve the quality.

The mentioned World Bank and WHO reports indicate that users in other countries also rate quality in PNFP health units higher than in public facilities. They also report that the PNFP units score well with respect to objective quality criteria (e.g. permanent availability of drugs, staff presence, cleanliness, etc).

The evidence for a higher quality of services in PNFP units is significant. As they were able to achieve this level mostly without subsidy and / or contract, it is highly probable that this quality can be mobilised better for the health system by contracting these providers.

5.6. Accountability

Accountability and transparency are the 'hottest' subjects of debate in the Public – Private collaboration as well as the discussions on future contracting. As yet there is little to no proof that the contractual approach will influence this either way.

For the negative effects, of the lack of reciprocal accountability, there is evidence from the past subsidy relations. The public authorities felt that the accountability of the PNFP sector, during the subsidy period, left a lot to be desired. As the mission facilities then only accounted for the subsidies (often occasioned in turn by bad experiences when giving full insight), while they visibly performed better and did more, this gave rise to suspicions. On the other hand governments seldom gave reports or feedback and visible misappropriation of public means fed into mistrust on the side of PNFP providers [79] [80] [81]. The resulting mutual mistrust is hard to overcome on both sides. It is a reason for PNFP and governments to want contracting, but at the same time it makes contracting difficult because not everything can be

[79] Verhallen M.: Integration of church-related NGO health facilities into district health systems: why not? Medicus Mundi International Newsletter, 1994, N 53, pp 5-14.
[80] Medicus Mundi International, Report Partner Consultation East Africa, Dar Es Salaam, 1999.
[81] Verhallen, M.: WHO Inter-country Meeting "Lessons from health sector experiences in contracting in Africa", held in Addis Ababa, Ethiopia in November 2001, report to MMI.

spelt out in contracts. To (re)build relations, this trust is a prerequisite. This might prove to be the test stone for the contractual approach.

5.7. Acceptability - participation - democracy

These criteria are relatively new for health systems. Evidence for the effects of subsidies and / or contracts on the levels of acceptance of - , participation in - and the democracy of - the PNFP facilities or their influence on these aspects in national systems is therefore difficult to establish

Acceptability has different aspects:

- Acceptability of the services provided;
- Acceptability of the provider as part of the system.

The information available provides the following indications:

- acceptability of services provided: high levels of utilisation are the best indicator. We refer to the sub-chapter on access and quality.
- acceptability of the provider as part of the system: indications for this have to be derived from the perceptions of the clients and the politicians. Inevitably these are interrelated. Health care is often an easy area for election rhetoric's, and comparisons between constituencies serve to measure the effectiveness of local politicians to secure a fair share of the national budget. In addition the number of governmental institutions measures the importance of the constituency. These are the reasons why politicians and the population continue to call for 'an own' health facility, even if a church health facility is available[82].

Setting in place mechanisms that ensure effective participation, of authorities and population, in the management of the PNFP units is the only way to allow the sense of ownership to develop. Churches, were till recently, unfortunately, not in the forefront of these kind of innovations. That participation can be fostered through contracting is shown in Ghana and Uganda. In Ghana the MoU and contracts will demand that the PNFP hospitals install Community Advisory Committees. In Uganda the demand, to install Health Unit Management Committees, was more implicit. In both countries these committees have been put in place and are progressively taking up their role as voice of the users.

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[82] Contributions of e.g. Ghana, Tanzania and Uganda during the WHO Inter-country meeting in Addis Ababa.

5.8. How is the health care package and division of responsibilities influenced by contracting?

The PNFP sector has health units that are comparable to those of government in level of care and capacity to provide the essential package. This situation has partly developed historically: authorisation to start a health facility was required and often the subsidies were related to the level of recognition (dispensary, health centre, and hospital). As said earlier, the PNFP units included PHC and CBHC services and activities in their programmes. Thus they have, or had, the capacities to perform the essential package. Uganda offers the clearest indications that subsidies, with particular conditions attached, (contracts) steer the partner to adapt services according to the package. The statistics[83] show that preventive out-reach services were re-instated and increased (the immunisation data served as proxy).
In the Tanzanian case, the contract did not include any contract stipulations with respect to the relations between the district hospital and the DHMT. Comparison between districts showed that co-operation between the hospital and the DDH / DHMT thus hardly occurred or only when the individual DMO or hospital manager thought it important and actively pursued co-operation.[84]

In sub-Saharan Africa no examples of contracts, for specific components of the essential package only, exist at the moment. Mills reports examples of contracts for specific service contracting in Asia[85]. The examples mostly concern contracting for specific Public Health components to private practitioners or NGOs in urban settings (TB treatments, Antenatal Care, immunisations, etc). This shows that governments can use contracting to ensure increased access to - and / or efficiency gains in – specific Public Health Care services in these settings.

As in rural sub-Saharan Africa the choice of providers is nearly non-existent the option for contracts covering full provision of the essential package for a

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[83] Giusti, D., Lochoro, P., Mandelli, A.: Public – Private in Health. What is its effect on the Performance of The Health Sector? Uganda Health Bulletin, MoH, April 2002.
[84] Annual Reports 1990 – 1999 of e.g. the DDHS: Isingiro, Sumve, Biharamulo, Horuma, and others.
[85] Mills, A. Private Health Providers in Developing Countries: Serving the public interest? 1997 Zed Press, London.

specific target population in a well-defined geographical area, would seem obvious.

In principle disintegration of services might be a danger of contracting[86]. To avoid it, governments should have a clear policy for co-operation with private providers and select contractees on their potential to provide a full package or to complete the service range provided by public providers. In addition the wider framework of the co-operation and the contracts should ensure communication between the partners, common planning, monitoring and evaluation (relational contracts). Lastly, systematic monitoring and evaluation of the effectiveness of the pluralistic district system should particularly follow indicators of disintegration.

5.9. How do contracts affect operational integration?

Health systems need to operate as an entity at and between all levels. It will be obvious that this is easier to achieve when all actors belong to the same proprietor (monolithic systems). In the context of decentralisation, especially devolution, the existing cohesion of state systems is already under some strain[87]. The integration of providers, which belong to other owners, or in other words, constructing a pluralistic system, represents a daunting challenge.

The criterion 'operational integration' is considered particularly important by the authors because being a more process and output related criterion, it is more easily measurable then the classical impact criteria like for instance equity. In that perspective, the extent of operational integration a system achieves can serve as a proxy, or intermediate, criterion for the assessment of the effect of contracting on the overall performance of that very system (see figure 3).

Figure 3.

[86] See the PRIMA report from Guinea-Conakry.

[87] Country and WHO / WB Reports of the progress of SWAp processes in Ghana, Tanzania, Uganda and Zambia.

The authors, however, are aware that there exist other strategies that contracting to achieve operational integration within a health care delivery system; and also that other factors than operational integration effect the performance of the system.

There is quite some proof that the subsidies to PNFP facilities did not give them the necessary recognised position in the health systems (see 3.2: motives for PNFP units to consider contracting and a large number of the reports cited earlier).

Our hypothesis does not really help here. The belief in the potential of the contractual approach, of governments and PNFP representatives, is for now the only indication we have. The key elements for them are the possibility to negotiate and specify the exchanges together with the expected preservation of the basic autonomy. A more systematic evaluation of the experiences in the UK and US might provide evidence and lessons to facilitate the desired operational integration.

5.10. Conclusions

There is actual proof that contracting PNFP providers will improve equity and accessibility, participation and democratisation, and that it can be of assistance in assuring integrated service delivery. Evidence, from the period of isolated functioning of the PNFP facilities, and of the period of subsidising them, allows to assume that efficiency and quality can be improved with the application of the contractual approach. For the other criteria (sustainability, accountability, and operational integration) no conclusions can be drawn from the existing knowledge. With respect to the indicator 'reversibility' we doubt whether it is a relevant criterion here. The reasons are that it is questionable whether it should be aimed at and it will be nearly impossible to prove either way.

6. FACTORS INFLUENCING SUCCESS OR FAILURE

It is important to be able to assess which factors contribute to successful contractual approaches and which represent danger. In sub-Saharan Africa these lessons have to come from the analysis of the precedents / precursors and the progress in countries which are putting contractual approaches in place. The observations and comments, presented here, result from the authors' experience and assessment. Though an effort has been done to isolate the most important factors, it should be noted that they are definitely inter-linked and therefore influence each other. An exhaustive overview of these factors is presented in annex 4.

6.1. National representation of the PNFP sector

- At the time the Tanzania DDH contracts were put in place, the Christian Medical Bureau of Tanzania (CMBT) had a strong team and was recognised by the affiliated members as their national representation.
- In Ghana the initiative to start a process to arrive at a contractual approach emanated from the Christian Health Association of Ghana (CHAG) and National Catholic Health Department. The officers, at this level, together with a number of intermediate level managers (Diocesan Health Co-ordinators and hospital directors) recognised the need for stronger mutual commitments in face of the HSR plans and the SWAp process. They enlisted the support of their donors for a process, of training, dialogue and negotiation, which resulted in clear recognition for the role of the PNFP sub-sector, the draft Memorandum and draft district contracts.
- In Uganda the Catholic Medical Bureau played an important role in the SWAp policy debates and thus ensured recognition for the PNFP in the National Health Policy and Strategic Plan. The Policy for the Public – Facility-Based (FB)-PNFP sector resulted from a strong lobby to ensure a general framework for contracting before going into the actual process.
- In Ghana and Uganda the actions at national level strengthened the members' recognition of - and adherence to - the national umbrella organisations. In both countries these activities also lead to the

installation of a desk for public-private co-operation within the Ministry of Health.

- Benin shows a very similar development.

Comparisons with other countries learn that a clear vision and expertise at the level of the PNFP national co-ordination office make a crucial difference. In addition, the owners and affiliated members need to recognise the importance of a capable national representation and mandate these offices with the necessary powers and scope to negotiate in their place.

6.2. Level of harmonisation of the PNFP actors

In most sub-Saharan countries the main PNFP providers belong to the Catholic and Protestant churches. The above positive results are also related to the level in which these partners succeeded in harmonising their objectives, strategies and actions.

In the countries where, the PNFP sub-sector is less clearly recognised, and treated, as an important partner, the level of harmonisation is often minimal.

Lack of harmonisation can also hamper further development. In Uganda the differences between the capacity and vision of the Catholic Bureau and the Protestant and Muslim Medical bureau's is becoming an obstacle (e.g.: a recent study, regarding the loss of staff from the PNFP hospitals, lead the MoH to propose to put all the PNFP staff on government payroll. The Protestant Bureau opted for this solution without reviewing the consequences with respect to the autonomy of the units and without prior consultation with the others. Another example: during the last Joint Review Mission, a clear position regarding the PNFP nurse training schools {60% of the training capacity} was required but only one of the three Bureau's was present. The concerned Ministry officials, rightly, questioned the commitment of the partners.)

In Benin the dialogue with the government could only start when a new national representing organisation, owned by all the NGO hospitals, could be put in place.

6.3. Prior history of relationship

The history of the co-operation between the Ministry of Health and/or Local Health Authorities has an effect on the development of new forms of co-operation. In Kenya the mutual mistrust reached acrimonious levels and this presently obstructs renewal of relations. In Zambia, during the period of free health services, the Church health facilities received recurrent budgets from government which were very similar to those of state units. In a way this has caused a sense of complacency within both partners which hinders the development of innovative approaches. On the other hand, the enormous financial constraints, the country has been facing for years now, and which result in a continuos lack of adherence to budget allocations, have eroded hope that improvements are possible. In Ghana the mistrust never reached high levels because subsidies remained at reasonable levels, PNFP units continued to answer to their obligations, and dialogue at national level was always maintained.

At Local Governmental level district health authorities often have little experience with working together with other actors. In the past the subsidies for the PNFP facilities were channelled through their national offices and reports followed the same route in reverse. The resulting parallel existence and the echo's of national tensions do not favour co-operation. In Ghana and Tanzania good examples of PNFP hospitals, acting as district hospitals, exist and these have a positive effect on the dialogue at this level. In Uganda, district medical officers, who have worked in PNFP hospitals, are fostering effective co-operation.

6.4. National Health Policy and Strategy

In the context of HSR and Sector Wide Approaches most sub-Saharan African countries have or are revising their National Health Policies and Strategies. In the past the basic aims of these plans pertained to developing a full fledged State health care system. The PNFP partners were, at most, acknowledged. The subsidies to them were seen as temporary until governmental units could replace them. The new policies are more realistic and rational. They recognise that the private partners are needed to achieve the objectives, especially the PNFPs, and integrating them into the system can enhance that sustainability. Translating this Public-Private co-operation

into practical measures is then the next step. The inter-relations with other measures does not always make this translation evident. Ghana opted to develop the contractual approach in a relatively early phase. The process is now halted as the Purchaser-Provider split in the Ministry of Health (Ministry to concentrate on policy-making and regulation and the Ghana Health Service on purchasing and implementation) has not yet been completed.

It is important to keep in mind that there can be essential differences between the technical level and the political level. In Ghana the technical experts of the Ministry are convinced of the rational of Public – Private Partnership and the contractual approach. When trying to analyse the obstacles to the last step, the actual signing of the agreements, information showed that in actual fact many politicians still strive for a State system (e.g. plans, presented to donors, for new district hospitals where a PNFP hospital is supposed to be allocated this function). In Uganda similar hesitations can be deducted: this year the Ministry of Finance and Economic Development decided that the health care budget can not be increased, as this would endanger the country's macro-economic policy. Immediately politicians proposed to decrease the budget for the PNFP sector.

Similar conducive or obstructive influence of policies can be recognised within PNFP organisations. As far as known to the authors, only the Ugandan Roman Catholic Church has adopted a Mission and Policy Statement that clearly opts for partnership with government[88]. This policy certainly facilitates national advocacy actions and local implementation decisions.

6.5. Decentralisation Policy

Nearly all new health care policies aim to decentralise implementation of health services. In general two approaches can be recognised:

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[88] Uganda Roman Catholic Church: Mission and Policy Statement for the RCC Health Services, June 1999. In the Policy Statement, page 3, sub-section 16, states: 'Catholic health units do not work in isolation and must always remember that there are other providers in the country, which need to be recognised and respected. The Catholic health units will operate as part of the national health system. Therefore, a sound working relationship within the church services, with government institutions and with other health care providers is of paramount importance and will be pursued.

- de-concentration: the implementation responsibilities are delegated to the districts but the centrally decided policies and strategies are binding and the budget allocation powers remain at central level (a.o. Ghana, Zambia and Benin).
- devolution: the districts are to be accorded more decision-making powers and a higher degree of autonomy including budget allocation (a.o. Tanzania and Uganda).

The implications for Public–Private co-operation are not yet clear. It will be evident that in cases of devolution the need to build consensus, between central and district authorities, is much larger. In Ghana and Benin the impression emerges that the central policy will be challenged less. In Uganda the first attempt to decentralise budget allocation powers does give rise to serious hesitations (see 2.4). These are underscored by the practice in some districts to delay releases of earmarked funds to PNFP facilities as long as possible. Tanzania devolved powers to pilot districts in an early phase, when the development of practical guidelines for the Public-Private co-operation had not yet been initiated. Listening to the stories, it is highly probable that the perceptions of the district autonomy and absence of central guidance now hinder the development of the co-operation at district level.

Within the PNFP organisations comparable mechanisms are at play. For instance in the RCC network the dioceses are autonomous and the national co-ordinating body only has advisory powers. In most countries examples of dioceses going their own way can be found. Deviations and disputes with district authorities, at this level, often hamper national dialogue.

6.6. National / District organisation

The organisational set-up selected by government and districts facilitates or obstructs the development of co-operation and contracting mechanisms. This is of course closely related to the former factor. Some examples are:

- *Interdependencies between Ministry of Health and Local government:* in Uganda appointment of officers in the Local Government planning bodies belongs to the realm of the Ministry of Local Government (MoLG). The MoH decided that PNFP units lead the sub-district, and that their Senior Manager should be Assistant Director of Health Services and member the District Health Management Team. But the regulations of MoLG do not allow for

participation of other actors in the planning fora and the sub-district as well as the DHMT are not recognised as statutory bodies. The result is that participation in planning and evaluation is hindered considerably.

- *Interdependencies between Health and Finance:*
  the most evident is that, in most countries, the MoH decides on the contract terms and exchanges (budget allocations) to the PNFP facilities. The Ministries of Finance decide on the fund releases. In Zambia the first trials with contracts failed because the releases were always lower as agreed and seriously delayed. The MoH-contractor could not comply with its obligations for external reasons that it could not control. Until this has been resolved the contractees (PNFP hospitals) will not wish to be bound by a contract.
  In Uganda: the directives of the Ministry of Health for the use of funds make it very difficult to use the allocations effectively (the funds can only be used for agreed budget items and only for expenditures in the period between release and end of the quarter). The MoH would like to work with block grants but the Finance rules and regulations do not allow for this.

- *Internal division of responsibilities and mandates:*
  in Zambia the purchaser – provider split lies between MoH and the Central Board of Health (CBOH), then between CBOH and district and hospital boards and subsequently between District and Lower level Health Units. However the draft MoU is to be signed between the MoH and the Christian Health Association. This inconsistency complicates further development for two reasons:
  - the Ministry can not be the signatory if other ministerial bodies will the contractor;
  - the CMAZ is an Association it can not be signatory for the actual owners.

  Ghana was to follow this example but installation of the Ghana Health Service (the equivalent of the Zambian CBOH) has been halted. The reasons are not clear but it does directly influence the process. The allocation of signatory mandates is more consistent in the Ghana proposal: Ghana Health Services and a representative of each church (owner).

In Uganda the first service delivery contracts (Service level Agreement: SLA's) were signed between the DDHS and the manager of the PNFP health facility. As neither have the mandate to commit exchanges (the Board of Trustees of the owner and the MoH are the statutory bodies) these contracts are actually invalid.
In Benin the responsibilities within both partners are quite clear and do not lead to inconsistency or doubts regarding mandates.

6.7. Recognition of the identity and operational autonomy of the partner

The identity of the PNFP organisations stems from their mother bodies. In most case these are the different churches. Respect of their identity entails taking the ethical codes of the concerned church into consideration in the agreements. (e.g. the catholic church teachings regarding artificial means of family planning). The Ghanaian and Ugandan draft contracts MoUs and contracts contain clauses which allow for differences in service packages in order to respect these ethical codes.

In general the PNFP organisation want to retain their basic or operational autonomy. This need is related to their wider social mission and to their desire to offer services that go beyond the classical package of activities (e.g. care for disabled people). On the other hand the fierce defence of this autonomy is often based on past experience (e.g. the past nationalisation policies of Tanzania meant that the churches lost a lot of property). In Uganda the autonomy of the PNFP health facilities proved their worth when they were able to continue services where the government system ground to a halt.

For government officials it is difficult to conceive that other actors operate in other ways. When one analyses the discussions, on accountability and transparency, it is striking to notice how often the doubts have their origins in inability to recognise differences in organisational culture and methods of working (churches are organised differently from government, financial systems differ, etc). The tendency is then to oblige PNFP organisations to harmonise their modes of operation, with those of the

government, as condition for subsidies and contracts. For the PNFP these conditions can endanger their efficiency and sometimes represent threats to their autonomy. For instance: in Uganda the PNFP units had to adapt their budgeting and accounting system to the requirements of the Ministry of Finance and had to follow the strict rules for the use of the funds. The result was that many units ended up with double accounting systems, funds could not be used in time, and these funds had to be returned. Several District Directors have recognised the problems and now allow the units, in spite of the rules, to use the subsidies as block grants and account in a modified way.

In several countries the first allocation of subsidies was conditional to purchasing drugs at the national medical stores. In the past the churches had set up medical stores to ensure adequate provisions. If the condition had been implemented these church medical stores would have stopped functioning resulting in a higher level of dependency of the PNFP facilities. Fortunately the owners succeeded in reversing this condition.

6.8. External pressure

The Bilateral, Multilateral and International funding agencies have recognised the extent of the contributions of the PNFP providers. They often actively pursue inclusion of Public–Private Partnership, and even contracting, in their discussions with governments. This pressure can be valuable. For example it would have taken another year or two to achieve a policy for the partnership in Uganda, if the World Bank had not pushed to ensure that it was on the agenda for 2001[89]. On the other hand it may also be a danger. In the same country it can be questioned whether the new political opposition to the PNFP subsidies does not find its origin in the past donor pressure to extend these grants.

For donor negotiators, the balance between convincing the recipient, on the basis of sound arguments, and budget pressure is a very slim line.

The authors also notice that a number of donor advisors pursue Public-Private Partnership but lack knowledge of the different private partners (PNFP actors are often regarded as identical to private 'for profit' practitioners), the history of the development of the private sector and the church or NGO involvement in health. They also often have little access to - or knowledge of - practical solutions to co-operation problems.

[89] Ministry of Health of Uganda: Aide Memoire Joint Review Mission April 2001.

7. AREAS FOR FUTURE RESEARCH

7.1. The Tanzania DDHS contracting experience

An analysis of the approach and effects of this experience could provide some lessons for a new phase in Tanzania and other Sub-Saharan African countries. It may, however, prove difficult to execute, as much will have changed during the last 5 tot 10 years (financial crisis in the health system, turnover of key staff members in the MoH and the CSSC and at the level of the hospitals and districts, etc) meaning that the intended contract relation may hardly exist now.

7.2. The perceptions of clients and politicians regarding co-ownership of PNFP health facilities

In many of the sub-Saharan African countries Public - Private co-operation in health is now a national policy. However at local level this is not understood or a politically volatile commitment. Thus election promises still result in new duplication of infrastructures. Further study, of the mechanisms at play, and of appropriate ways to foster co-ownership, is needed to ensure that the public – private co-operation can really achieve more rational use of resources and maximise national coverage.

7.3. Comparative advantages of Private Not For Profit Providers

Closely related to the above subject is the lack of adequate information on the relative strengths and weaknesses of PNFP providers. Transparent instruments to evaluate private actors and scientific evidence from other countries could assist local authorities to evaluate their PNFP actors and determine co-operation strategies on more rational grounds.

7.4. Evaluating performance of public purpose functions

The need to evaluate performance of public purposes functions increases with the increase of choice of providers. To be able to ensure that the choices can be made on rational and objective grounds, there is need – as

advocated by Giusti et al (1997) - to design and test operational indicators to assess public purpose functioning of the various providers.

7.5. Involving beneficiaries in the contractual approach

Three party contracts would seem to offer substantial additional benefits to ensuring community participation as well as to strengthen responsiveness and compliance in contracting. More insight is required, however, regarding:

- how to install an effective participatory approach which actually allows the entire communities to be heard and not only the elite or vociferous;
- how to assure symmetry of information for communities so that they can be full partners and do not become instruments for one or both contracting partners;
- how to assure that the real needs and effective / sustainable health care measures are kept in focus and a swing towards responding to demands is avoided?

7.6. Relational contracts in health

This is a new perspective. Research is required to establish whether the assumption that they are appropriate is correct. Then, what the specific requirements in capacity and system adaptations are and which steps are essential for participatory approach and process. Lastly more information will be needed with respect to defining clear relationships and contracts terms.

7.7. Legislation

In all scenarios there is an ultimate need for legislation that recognises contracting in health care provision and provides the basic assurances for the contracting partners. There are three area's which require clarification:

- allocation and use of public funds: in many sub-Saharan countries existing legislation forms obstacle to contracting;
- adaptation of the juridical identities / mandates: the levels of authority within each partner and the level at which contract commitments can be undertaken are quite different. They need to be harmonised to ensure that signatories to contracts are

equal and that the commitments only concern the actual service delivery.

- adaptation of contracting legislation to the requirements of not for profit partners and non commercial aims: present legislation is based on commercial realities;
- relational contracts: most laws only recognise transactional contracts.

7.8. Health System Resilience

Health systems require a level of in-built resilience. Little is yet known about the factors that determine the capacity of a system to ensure internal checks and balances and to cope with damaging events. At present, health systems all over the world are undergoing rapid change. Research could assist in determining the key factors determining the resilience of a system, as well as how these can be installed and/or maintained when re-organisations of health systems are being envisaged.

The Ugandan experience illustrates that a minimal level of autonomy is crucial for the survival of private providers in a context where public provision is on the verge of collapse. Contracting has the potential to strengthen operational integration while allowing partners to maintain a basic level of autonomy. The effect on resilience of other strategies and instruments to improve operational integration of private providers in public systems remains to be explored.

8. CONCLUSION

Emerging evidence of the impact of contracting on key criteria for an effective and equitable health system. The effect on operational integration is, however, the easiest to be measured.

Contracting is not a quick fix: it has substantial systemic, institutional and policy implications for both partners.

- systemic
- institutional
- policy

Relational contracts seem most appropriate in the case of contracting for better health system performance. Two tiers! Rolling on SLAs.

Even if this is not the primary purpose of contracting in sub-Saharan Africa, this review lead to the recognition that contracting policies might actually prove to be an valuable opportunity to enhance the regulatory capacity of governments.

9. ABBREVIATIONS

AMCES	Association des Œuvres Médicales Privées Confessionnelles et Sociales au Bénin
CBHC	Community Based Health Care
CHAG	Christian Health Association of Ghana
CIES	The Centre for Health Research and Studies of Nicaragua
CMBT	Christian Medical Bureau of Tanzania
CMAZ	Christian Health Association of Zambia
CSSC	Christian Social Service Commission Tanzania
DHMT	District Health Management Team
ESPCR	The School of Public Health of the National University of Costa Rica
FB-PNFP	Facility-Based Private Not For Profit Providers
HSR	Health Sector Reforms
INS	?? of Guatemala
ITG	Institute of Tropical Medicine, Antwerp
MoH	Ministry of Health
MoU	Memorandum of Understanding
NCS	National Catholic Secretariat (in Ghana)
NGO	Non Governmental Organisation
NIIH	International Health Institute of the University of Nijmegen
PHC	Primary Health Care
PNFP	Private Not for Profit
SLA	Service Level Agreement
UES	Medical faculty of the University of El Salvador
ULB	Université Libre de Bruxelles
VA	Voluntary Agency
WHO	World Health Organisation

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    - Lesotho: Draft Memorandum of Understanding between the Ministry of Health and the CHAL and draft the Operating Agreement for the first three years.
    - Zambia: MoU's between MoH and CMAZ 1997 and draft 2000, proposed contract between CMAZ member facility and District Health Board;
    - Uganda: existing MoU between District Council and PNFP facility, Service Level Agreement between District Council and PNFP facility. Draft format proposals for MoU's between MoH and PNFP Umbrella organisations, between District Council and PNFP owner, between District Council and PNFP facility management. Draft format proposed for Service Level contract between District and PNFP facility.

ANNEX 1: CASE STUDY TANZANIA

1. Country description:

2. Health Sector description:

At the time the Tanzania contracting experience was initiated, the Ministry started decentralisation. The district health system was to be composed of dispensaries and health centres at first contact level backed-up with a first referral hospital (district hospital) and a District Health Management Team (DHMT). The next levels consisted of regional hospitals and three tertiary and teaching level hospitals (Muhimbili Hospital in Dar Es Salaam, Kilimanjaro Medical Centre in Moshi, and Bugando Hill Medical Centre in Mwanza).

All policy and implementation decision powers as well as the resource allocation powers for health care service delivery, remained concentrated at the Ministry. The existing public health network fell far short of the needs of the population and of decentralisation.

3. Contribution / role of the PNFP partner:

The Catholic and Protestant Churches had then, and still have now, an extensive network of hospitals and lower level health units. The estimates of the contribution, of these PNFP parties, to health services lie on average around 45%. However there is a large variation per region where there are rural districts in which up to 85% of the services are provided by PNFP facilities (here called Voluntary Agencies). The allocation of subsidies for running costs started before independence and continued thereafter.

Initially the different churches had their own national representation offices, but in the course of 1980 a joint office was initiated: the Christian Medical Board of Tanzania (CMBT). Around 1996 the Christian Social Services Commission (CSSC) was set in place to cover all church social service programmes.

4. Historical events of importance:

In the 1970'ties the Government annexed a large number of church health and education institutions. A number were returned towards the end of the 1980'ties.

Tanzania was one of the first countries to embrace the Primary Health Care concept (PHC)[90] as it fitted closely with the, then, President's social policies. Thus it was also among the first to start decentralising the health care system and include the PNFP facilities in this planning.

5. Government motives to start contracting:

At the beginning of 1980, the main reasons for the government to undertake decentralisation were improving coverage and performance of the health system. The objective was to ensure that the PHC, and the ensuing Community Based Health Care (CBHC), strategies would become the mainstay of the district system and that the entire system would become more responsive to the needs of the communities.

The government network of facilities could not ensure that each district would have a first referral hospital. Around 20 of the PNFP hospitals were ideally located to take up that function. Contracting these hospitals as District Designated Hospitals (DDH) allowed the government to improve coverage / access quickly and to a major extent. It should, however, be noted that, at that time, this approach was still seen as temporary i.e. the government still foresaw building own hospitals in these districts in the future.

6. PNFP partner's motivation:

The PNFP hospitals main motives to answer the invitation to become DDH concerned their effectiveness and financial survival. Many of these hospital had started PHC / CBHC programmes but their curative and preventive effectiveness was hampered by lack of structural relations with other levels and other actors in the field of health as well as in the directly related fields. Next to this their financial position was very weak: external funds for running costs were dwindling, the MoH subsidies did not adequately cover the costs, and increases in user fees meant that financial access for the poor decreased dangerously.

7. Type of Contract:

The MoH and the church owner of an intended DDH signed an agreement in which the hospital was assigned all district referral duties and allocated a block grant to cover all running costs expenditures to the same extent as government district hospitals.

[90] WHA Alma Ata declaration, 1972

The agreement can be categorised as a relational contract[91]. The main clauses pertained to each parties general responsibilities, the governing and management structure of the hospital and management of human resources. The agreement states, in two clauses the need to present an annual budget and the annual audited accounts. One clause concerns the need for mutual consent for amendments and one covers the need for approval for capital investments that will incur major increases in recurrent costs. There are no clauses which cover: planning of activities and services, relations to other structures in the district, measurement of performance, monitoring, mediation or arbitration let alone sanctions in case of non compliance of either party. The most striking aspect of the contract is the high degree of provider autonomy (governing, managing, hiring and firing of staff). The contracts were signed for an indefinite time, but could be terminated by either party giving the other a one-year notice period, or by mutual agreement.

8. Process followed:

Once the principle of designating PNFP hospitals for district functions was accepted, at national level, a standard contract was developed (this standard can be found in Annex 7). When the contract was proposed to an owner the signing was often a formality with little prior negotiation. The main actors were the Ministry, the Christian Medical Board of Tanzania (CMBT) and the owners (at the instigation of the managers of the units). The district authorities and the communities had little say in the decision nor in the implementation.

9. Implementation:

Most of the DDH agreements are still valid. In the course of the years a small number of new DDH contracts were signed. For a number of DDHs with a nurse training school attached, the agreement was extended to cover the running costs of the school. Since 1993/94 no new DDH contracts were accepted. Up to 1995/96 no major disputes arose at national level. These hospitals are generally regarded as performing well and providing quality care, certainly by the users. Observations of one of the authors (MV) learnt

[91] MacNeil I. Contracts: adjustments of long-term economic relations under classical, neo-classical and relational contract law, Northwestern University Law Review, 1978, 72:854-905. And of the same author: The many futures of contracts, Southern California Law Review, 1974, vol. 47: 691-814.

that, per district acceptance and participation of the DDH hospital, as integral part of the system, does vary greatly: ranging from full collaboration in achieving the district objectives to parallel existence of hospital and DHMT with no effective collaboration and even competition. The cases in between forming the majority.

The troubles started when the government ran into serious budgetary constraints and the allocations to the DDHs were decreased from 100% recurrent costs, to 80% and now it stands at less than 50%. At first the DDHs were not allowed to compensate for the short fall by introducing user fees. When the government initiated cost recovery this was allowed, although to a limited extent. The DDHs are continuing to function according to the agreement but allegiances to it are waning quickly.

10. Impact:
Though no systematic evaluation has been undertaken, Tanzania has drawn some lessons[92]. The achievements are quite significant:

- the health infrastructure was developed;
- access increased to 93% of population living within radius of 10 km of hospital, and 75 within a radius of 5 km.
- equity improved;
- manpower training was extended.

As such one can say that the initial motives of both partners, to engage in the DDH agreements, were answered to a large extent up to 1995/96. For the government, building an integrated and responsive system was an underlying motive, while the pendant participation was an express motive for the PNFP hospitals. The agreements have not been able to secure this aspect. From the perspective of improving performance this is unfortunate.

11. Success and failure factors:
Factors that played a major part in the achievements, according to the author (MV), are:

- the strong need on both sides to collaborate to achieve their goals and the recognition of this need at national level. Comparing the developments to other countries, the fact that CMBT, at that time, was strong, had a vision towards collaboration and the capacity and mandate to negotiate, seems to have been of importance;

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[92] Presentation during WHO Inter-Country Meeting.

- the fact that the mutual commitment was formalised in a written agreement, making it much more difficult for subsequent governments and / or church hospital representatives to abandon the commitment;
- the relatively comparable weight of the responsibilities;
- the high degree of autonomy given to the DDH to manage the hospital services and funds effectively;
- the moral commitment of the DDH owner and staff.

At present the main problems are payment difficulties due to budgetary constraints and lack of monitoring and evaluation.
For the Tanzanians, the important weaknesses of these agreements are:

- there are no provisions for non-compliance of either party (e.g. the decrease of government grants could not be followed by sanctions of the DDHs)
- no indicators were established to follow output.

The author (MV) is of the opinion that the failure to establish an integrated system results from several other weaknesses. To start with, the absence of specific clauses was certainly of decisive influence. The fact that there were no precedents to such agreements, which could be built upon, underlies this weakness. But also, the views, on how districts should function, were still in full development as well as the instruments to implement them. In addition, the district health authorities, not being implicated in the decision and negotiations for DDH agreements, did not feel party to the agreement. Last but not least, as the contracts were for an indefinite time, adaptations to new insights and experiences did not take place.

12. <u>Future Plans</u>:
In the context of the Civil Service Reforms the government is considering extending contracting to non-core services.

In the Health Reforms, promoting health service delivery by all private sector partners in close collaboration with the public sector, figures high on the agenda. Implementation is being done gradually: at present five zones have started. The PNFP agencies welcome the new structural attention for collaboration and are preparing themselves for it. Both MoH and the CSSC foresee that the contractual approach can be a valuable tool to realise this Reform strategy. The experiences with the DDH agreements will be used to improve the approach.

ANNEX 2: CASE STUDY UGANDA

1. Country description:

2. Health Sector description[93]:

Health Sector Strategic Plan 2000/01-2004/05, of August 2000 states the national coverage by health institutions at 49%. This includes the PNFP units.

The Ugandan health sector traditionally counted at least five levels: at primary level dispensaries and health centres, first referral hospitals, regional second referral level hospitals and one tertiary teaching hospital, Makerere University hospital. The health sector reforms were started around 1996. Both in health, as in the other sectors, decentralisation is the main theme. Eventually all planning, budgeting, and implementation powers will be devolved to district level and subsequently to county level. The health sector's essential level is already, since 1998/99, the Health Sub-District (HSD) which corresponds with a county. Comparable to districts in other countries, it covers a population of around 100.000 to 200.000 and consists of Lower Level Units (LLUs, the former dispensaries and health centres) and a referral unit, health centre / hospital with emergency surgery capacity and medical officer. The HSD headquarters is based at the referral unit and the team is responsible for planning, implementing, supporting and supervising the first level curative, preventive and promotional services in the sub-district. A medical officer is the HSD core team leader and is Deputy Director for District Health Services, thus linking HSD with the next level. The Health District is the next level. It covers several HSDs. The District Director of Health Services (DDHS) and District Health Management Team direct, support and supervise the HSDs and are the link with the national level, MoH.

To support the districts and sub-districts five hospitals will be developed to regional (secondary referral) hospitals. Also an additional teaching hospital has been started: Mbarara Medical School.

3.

[93] Uganda National Health Policy and Health Sector Strategic Plan, Ministry of Health 1999 and 2000.

Historical events of importance:

During the long period of civil unrest in the country the public health system virtually collapsed. The PNFP network succeeded in assuring health care services, with the assistance of their external partners. This experience motivates the PNFP organisations to protect their basic independence from the public system.

In 1995/96 a number of the PNFP hospitals ran into serious financial problems due to rising costs and decreasing external aid. They requested assistance form the government. The, then, Minister for Health initiated a 'quick and dirty' study to compare the public and PNFP hospitals with respect to utilisation and efficiency. The conclusions lead to the re-instatement of subsidies to the PNFP hospitals in 1996. Since then they have been extended and increased considerably. The criteria for allocation of the subsidies were gradually refined and now consist of: workload, socio-economic conditions of the target population, presence of a training school, and presence of outreach services.

In 1996/97 the MoH decided that PNFP units which are centrally located and have the capacity to act as HSD referral unit and HSD headquarters be assigned this function: 29 PNFP health facilities have been appointed HSD leader, representing 13,5% of the 214 sub-districts.

In 1997/98, when the Sector Wide Approach was initiated, the PNFP umbrella organisations were invited to join the policy debate, firstly by the donor partners. In the context of the country's Poverty Eradication Plan, the Health Sector Reforms and the SWAp, a collaborative framework with the private sector is now established and reasonably accepted at national level.

In 1999 the Catholic Church adopted a Mission and Policy Statement for the RCC Health Services which clearly opts for the poor and for partnership with government to ensure access, equity and effectiveness towards improving health[94].

4.

[94] Uganda Roman Catholic Church: Mission and Policy Statement for the RCC Health Services, June 1999.

Contribution / role of the PNFP partner:

The PNFP sector provides approximately 45% of the services in the country[95].

The PNFP network consists of 418 LLU's (30% of the total1550), 42Hospitals (38% of the total110) and 18 Health Training Institutions (37% of the total of 48). The PNFP Health Training Institutions mainly consist of nursing schools meaning that they train more than 50% of the countries

From the start of the SWAp process (1998) the PNFP co-ordinating organisations (medical bureau's) have been full member of the Health Policy Advisory Commission (HPAC). A number of structures have or are being put in place to ensure structural dialogue at national and district level (Public-Private Partnership in Health (PPPH) desk and working group in MoH, district PNFP desk officer and PNFP co-ordination committee).

5. Government motives to start contracting:

The PNFP sector is important for the Ministry of Health. Their contribution to service delivery is essential to achieving the objectives of the HSSP. The HSD plan assigned a formal position to a considerable number of PNFP units. The re-instated subsidies aim to enable PNFP hospitals to decrease fees, increase prevention activities and improve the remuneration of their workers. These objectives reflect the key aims of the Health Sector Strategic Plan (HSSP): improve access, equity, and quality. The plan foresees developing a contractual arrangement with the PNFP to install formal co-operation.

In 1997 the fact that the grants were funded out of the Poverty Alleviation Funds (PAF - donor funds) raised the need a more formal agreement to assure attainment of the objectives and the correct use of the grants.

6. PNFP partner's motivation:

The hospitals, which received the first subsidies, proposed a kind of contract to the MoH in view of committing themselves to the MoH policy. The financial crisis of these hospitals made the entire sector aware that a durable solution was needed. They argue, with right as they are often the sole provider, that they are serving the same population as the MoH.

[95] Uganda Health Sector Strategic Plan 2001-2005; and The Policy for Public-Private Partnership, sub-section partnership with the FB-PNFP, Ministry of Health 2001/02

The PNFP umbrella organisations were already aware that their isolation from the system made their facilities ineffective in improving the health status of their catchment population (see RCC Mission and Policy Statement). The decision of the MoH to appoint PNFP units as HSD leader was welcomed as this represented a formal recognition as well as providing a way to become more effective. However, as in the beginning these appointments were not accompanied by the funds to perform the additional duties, hesitations quickly arose.

Thus, the need for structural funding from the national budget, equity motives, and the need for a definite commitment, from government, stimulate the PNFP providers to call for formalised relations and formal agreements. As for the PNFP their autonomy is a valuable asset because they want to retain a level of independence from the public system. The contractual arrangement fits best with all these needs.

7. Type of Contract:

The first contract arrangement, set in place, consists of two agreements: a Memorandum of Understanding between the manager of the unit and the chief district administrative officer and a Service Level Agreement covering the an annual work plan and budget. Both agreements have a time span of one year. Both are formulated in general terms but the SLA clearly strives to be a transactional contract. There are no clauses that cover the planning of activities and services, relations to other structures in the district, measurement of performance, monitoring, and mediation or arbitration. There is a clause on the possibility to ask for technical assistance from the district. A sanction clause is included but parity is askew as it only determines that the contractor can withhold payments if the unit (contractee) does not comply with reporting obligations (parity is askew).

8. Process followed:

The Ministry of Health decided to install this contractual arrangement without prior negotiation. It developed and proposed formats which the district offices were to adapt. The districts in turn mostly presented the MoU's and SLA's to the PNFP facilities or asked them to present their annual plan. With the new guidelines some negotiation now takes place.

9. Implementation:

Since the adoption of new guidelines for the preparation of annual work plans and budgets and guidelines for the use, management and accounting

of the funds, the work plans are taking the place of the SLA's. MoU's have hardly been renewed since 1998/99. A review of the experiences learns that the objectives of the subsidies are being attained[96] but that the MoU's and SLA's, are not being applied to this effect. The reasons are mostly related to: the fact that the contracts do not answer to the requirements of the co-operation, the lack of the necessary capacities and correct mandates, at local level, to negotiate and sign contracts; unclear relations between guidelines and contracts, and inadequate time spans[97].

10. Impact:
Positive outcomes can be defined. They are, however, not directly attributable to the contracts themselves, as to the subsidies and the PNFP willingness to perform in the spirit of the policies and agreements.
The Uganda representatives at the WHO Inter-Country meeting formulated the positive outcomes and challenges as follows:

- the collaboration goes beyond service delivery;
- access to services has increased and user fees decreased;
- transparency of allocations and money flow as well as efficient use of public resources has improved;
- preventive and promotive orientation and co-ordinated referral care are promoted.

Functionally the PNFP units are becoming more and more a part of the district health system and in the next phase of decentralisation (health sub-district) PNFP units are assigned the leading role.

The important challenges relate to:

- efficiency: the flexibility of the use of funds is quite limited at present, the delays / non release of funds cause great obstacles in operations and it proves difficult to quantify value for money;
- equity: physical nearness of units and non-discriminatory subsidising give rise to duplication, and the user fees of the PNFP units restricts access for the poor (in public sector units fees have been abolished in 2001);

[96] Giusti, D., Lochoro, P., Mandelli, A.: Public – Private in Health. What is its effect on the Performance of The Health Sector? Uganda Health Bulletin, MoH, April 2002.
[97] Verhallen, M.: Review of Existing Memoranda of Understanding and Service Level Agreements in Health Care in Uganda; report for UCMB, 2002 (awaiting publication)

- partnership: operationalising and institutionalising is hindered by low awareness of advantages at district level (the decentralisation policy aims at devolution), low functionality of HSD, co-ordination and information exchange difficulties, and lack of support structures.

11. Success and failure factors:

The authors are of the opinion that the following factors are key to the success so far:

- the strong need on both sides to work together to achieve mutual goals;
- the recognition of this need in the policies of both partners;
- strong national representation, certainly for the catholic church partner, with a vision towards collaboration and the capacity and mandate to negotiate;
- the expression of clear objectives to be attained with the subsidies;
- the comparability of service packages of PNFP facilities with those of public units;
- the moral commitment of the PNFP management and staff.

The difficulties can be traced to:

- lack of understanding and / or commitment of local government and church authorities and managers to national policies;
- the inconsistencies between MoH objectives and Ministry of Finance rules and regulations;
- the gap between the level of the subsidies and the output demanded: i.e. the at present the level of subsidies does not relate to responsibilities assigned as the subsidy is around 30% of the costs to provide the minimal package (the exchanges are askew);
- the lack of preparation for the implementation of the present contracts and insufficient attentions to aspects such as contract types and terms, time frames, signatory mandates, etc.

12. Future Plans:

The Ugandan participants, at the WHO meeting in Addis Ababa, indicated that the next steps planned are:

- creating a clear policy framework (the draft has been developed during last year, the guidelines have been drafted during the last months and regional workshops have started to ensure all local parties can subscribe to the policy and to adapt policy and guidelines to local needs)

- developing the tools of the partnership (refining the service level agreements and designing formal contracts)
- improving the overall efficiency of and equity in health service provision (adapting financial rules and regulations, refining the allocation criteria and increasing the levels of the subsidies).

With respect to developing a more formal contractual approach, the policy formulation process has given rise to hesitations regarding its need, the conditions required, as well as the risks. The MoH first wants to study:

- the comparative performance in PNFP service provision;
- the impact of contracting on the PNFP institutions;
- transaction costs;
- required capacity to enter into and monitor contracts;
- legal implications for PNFP and Local Government.

The PNFP partners welcome this more gradual approach but do hope the further studies will not lead to a return to an administrative approach. They feel that it will be more difficult to maintain their autonomy then. They are investigating how to match more closely governments need for accountability and transparency and their own needs to operate autonomously.

ANNEX 3: CASE STUDY GUINEE CONAKRY

Introduction

Mutual Health Organisations (MHOs) have been defined as autonomous, not-for-profit, member-based organisations whose aim is to improve access to health care. They are voluntary associations based on solidarity between members. Insurance is the financial mechanism most commonly employed, but members sometimes opt for pre-payment, credit or savings arrangements. A movement of MHOs is emerging in Africa – especially in French speaking countries. In 1996-2000, a research project to study the feasibility of MHOs (PRIMA - *Projet de Recherche sur le Partage de Risque Maladie*) was carried out in the Kissidougou district, within the province of Guineé Forestière, part of rural Guinea-Conakry,

The health policy environment of the PRIMA project

The health care system of Guinea-Conakry has made significant advances since the mid-eighties. With the support of the international community, the entire public health care delivery system was revitalised, especially in the rural parts of the country. . Cost sharing was introduced for first line services through the creation of revolving funds; clinical decision-making was rationalised; health committees were created with the object of encouraging community participation in the management of the health services. In a second phase, district hospitals were rehabilitated to provide the necessary support for the health centre network. All this was done in a well-planned, nation-wide effort, which was sustained for many years. Increasing utilisation rates observed at all levels of the health system in the late eighties and early nineties were an unequivocal endorsement of this policy. The renaissance of the Guinea health system was considered to be one of the success stories of UNICEF's Bamako Initiative strategy in West Africa.

But the limitations of this centrally planned policy gradually became apparent. The top-down management and decision-making processes that may have been justified during the mid-eighties and early nineties went together with standardisation and uniformity, leading, eventually, to rigidity. There was little room left for local creativity and genuine community

participation. Increasingly, patients expressed their dissatisfaction about the quality of care in public health facilities. Complaints were voiced against the standardisation of clinical decision-making, which was perceived as excessive and not appropriate to patients' needs, and about attitudes that were regarded as unpleasant and disrespectful amongst health workers. Eventually, more and more people began to look to the private sector for alternatives. It is against this background that the PRIMA research project was designed and launched.

The local context

The Kissidougou district has about 180,000 inhabitants. Government health services are organised into a two-tier system: a network of health centres and a district hospital. With the exception of informal and traditional practitioners, there are few private health care providers. The government hospital has a virtual monopoly.

Payment for health services provided by the government is a compromise between a flat fee and fee-per-item. The fee charged for a hospital admission varies between US$10 and US$30; the fee charged for an episode of care at a health centre varies between US$1 and US$5. The rates are different for adults and children, for curative and preventive care, and depend on the nature of the problem and the type of drugs or laboratory investigations required. It is a complex system frequently abused by health workers who levy illicit payments on top of the official fee. Communities are not sufficiently organised to challenge this behaviour at present and attempts to curb overcharging have failed.

The principal source of revenue for rural households in the *Région Forestière* is arable farming. Rice, coffee and cola are harvested towards the end of the year. Part of the harvest is sold at the beginning of the dry season in December/January. Most of the traditional celebrations take place during the months of February, March and April, considerably depleting household resources. The bulk of the rice harvest is stored, either for use later or as a source of cash income when required. Reserves are at their lowest during the third quarter of the year. Hence, part of the population faces financial deprivation and encounters great difficulty in purchasing health care in the second half of the year. This often coincides with the rainy season.

The PRIMA project: the development of a Mutual Health Organisation

The PRIMA research project was set up to study whether, and under what conditions, the development of MHOs could: (i) improve financial access to health care for its members; and (ii) strengthen the position of members in seeking to improve the quality of care available to them from health care providers. The underlying hypothesis of the project was that if people organise themselves into autonomous self-managed member associations that negotiate and establish contracts with health services, this structure then becomes an effective lever for demanding and obtaining better services. PRIMA attempted to test this hypothesis in the field in an action research frame.

After an intensive period of preparation lasting more than a year, a first MHO called Maliando - meaning 'mutual aid' - was set up in 1998 in the target area of the government health centre of Yende under the supervision of a Malinese sociologist. Yende is a village in the southern part of Kissidougou district, about 50-km from the district hospital. The target population of Yende health centre consists of approximately 17,000 people scattered over two dozen small villages and hamlets within a 15-km radius. In the hamlet of Mano (about 1-km from Yende health centre), a male nurse, retired from public service, runs a legal private health care facility.

Instead of the textbook 'Minimal Package of Activities' usually defined by health professionals, the research team promoted the negotiation of a 'Consensual Package of Activities' in which community preferences were taken into account. The reasons for choosing this alternative were to ensure effective participation from the start and to link improved financial access to an improvement in perceived quality of care. This approach resulted in two important adjustments to the design. First, the range of drugs available at the health centre was significantly increased after extended debate amongst health workers. Second, although the original idea was to provide hospital care only, first line health care was included in the benefits package from the start, in response to the explicit wishes of the population. It was agreed that the insurance would cover all first line health care at the Yende government health centre, as well as emergency obstetric and surgical care for all adults along with health care for children under fifteen, at the government district hospital. A local private company provides emergency transportation to the hospital, for which Maliando pays a fixed amount. All agreements are prepared in the form of written contracts (see further annex 9). Membership

gives free access to the benefit package, except for a small co-payment per episode of illness. The annual subscription fee per individual was about US$2 in 1998, rising to about US$2.5 in 1999 and 2000. The household is the unit of subscription, which means that all members of the household have to subscribe simultaneously.

The management of the system is in the hands of local people – albeit with important technical support from the PRIMA team. The management structures that were created comprise: (i) a General Assembly, composed of delegates of the different constituent villages; (ii) an Executive Bureau which implements decisions taken by the General Assembly (within which, one person is charged with overseeing relationships with the contracted health services); and (iii) a Control Commission supervising the management of the Executive Bureau.

In 1998, the Maliando MHO covered only 8 % of the target population, i.e. 1398 out of 17275 people. In 1999, the subscription rate dropped slightly, to about 6% (1029 people). Moreover, a significant proportion of the households that had joined during the first year did not renew in the second year. In 2000, the subscription rate remained at 6-7% (1082 people) but the political turmoil, insecurity and violence in the region of *Guinée Forestière* which began in July2000 jeopardised all further research activity in the area. The PRIMA project was halted the end of 2000 but the Maliando MHO is still active.

Activity reports from 1998 and 1999 clearly indicate that the utilisation of health services by members of the insurance scheme increased dramatically. The rate of curative consultations at the Yende health centre, for example, had more than tripled, from about 0.5 new-cases per inhabitant per year to more than 1.5.

ANNEX 4: LIST OF CONDUCIVE OR OBSTRUCTIVE FACTORS

Factor	Positive Influence	Negative Influence
1. National Representation of the PNFP sector	- Policy vision and expertise; - Mandate to negotiate from owners and members - Adherence to agreements by owners and members	- Absence of policy views or expertise to develop them - Inadequate mandates to negotiate - Non-compliance with agreements made at national level.
2. Level of harmonisation of the PNFP actors	- The PNFP partners agree on key co-operation policy, strategy and implementation directions - Agreement on the long term objectives to be pursued - Common approach to pursue governmental adoption of PNFP principles for partnership	- Diversion of views and aims for the co-operation with government - Precedence to short term objectives without weighing consequences for long term objectives - Concentration on own immediate needs instead of focussing on common needs and objectives
3. Prior history of relationship	- Positive experiences / best practice examples foster new forms of co-operation; - Recognition of past failures on both sides and willingness to learn from them for the future	- Continued reminding the partner of negative experiences obstructs initiatives to renew co-operation - Unwillingness to acknowledge that each side made mistakes - Unwillingness to learn from them
4. National Health Policy of each partner	- Recognition of contribution / relation with the partner in the Policy - Definite option for co-operation - Adequate translation of the policy choices into practical guidelines - Consistency between the policy objectives and the implementation guidelines - Political acceptance of technical policy objectives	- Absence of co-operation aims in the policies of both or one partner - Absence of guidelines for implementation - Inconsistencies between the implementation guidelines - Absence of political commitment to technical policy proposals

Factor	Positive Influence	Negative Influence
5. Decentralisation Policy: - de-concentration - devolution	- Political and technical recognition of value of partner by local government and church authorities - Acceptance of central policies and guidelines by district authorities - Adequate scope for implementation decisions at district level	- Weak to insufficient political and technical recognition of partner - Non acceptance of central policies and guidelines by local government - Insufficient scope for implementation decisions
6. National and/or District organisation - interdependencies between ministries - internal division of responsibilities	- Consistency between rules and regulations of each Ministry directly involved in health care delivery - Clear assignment of responsibilities and mandates at the level which corresponds with level of commitment and decisions required	- Discrepancies between the aims of the health policy (and contracts) and the regulations of other ministries - Inequalities in responsibilities and mandates between the partner representatives
7. Recognition operational autonomy of the partner	- Acceptance of specific ethical principles of the partner - Respect of operational autonomy the partner by allowing the partner to organise its operations as fits best with overall aims and traditions - Transparent reporting and accountability guidelines - Openness on both sides regarding all resources used and results achieved	- All or nothing approaches - Obliging the partner to adopt governmental forms of organisations and modes of operation - Absence of clarity regarding reporting and accounting - Lack of openness on one or both sides on additional resources and results.
8. External pressure	- Use of technical arguments to convince the partner - Good timing - Respect and understanding for the objections - Knowledge of feasible alternative approaches to solve the obstructions	- Undue recall of financial consequences - Wrong timing - Disregard for local objections and actual obstacles - Inadequate knowledge of feasible alternative solutions

ANNEX 5: COMPARISON OF CONTRACT TYPES[98]

Factors	Classical	Neo-classical	Relational
1. Transaction	- discrete - in present terms	- less discrete - presentiation requires technical enhancement	- discreteness can only be approached - terms leave room for future planning and context changes
2. Contestability of transaction	- high	- high to medium	- medium to low
3. Measurability of exchanges	- direct - complete	- indirect - needs standards or third parties	- the exchanges are difficult to measure and / or parties do not measure them
4. Duration	- short agreement process - short time between agreement and performance - short performance period	- all periods short to midterm	- long-term, - often no finite beginning or ending of relation and performance
5. Commencement and termination	- sharp in by agreement - sharp out by clear performance	- renewed or continued contracts occur	- commencement and termination of the relation are gradual
6. Flexibility	- not required	- increased need	- high need of flexibility
7. Primary focus of planning	- substance of transaction	- substance of transaction	- structures and processes of relation - substance planning in initial period

Factors	Classical	Neo-classical	Relational
8. Planning	- complete at	- can not be completed	- limited specific planning of

[98] MacNeil I. Contracts: adjustments of long-term economic relations under classical, neo-classical and relational contract law, Northwestern University Law Review, 1978, 72:854-905. And of the same author: The many futures of contracts, Southern California Law Review, 1974, vol. 47: 691-814.

completeness and specificity	formalisation / signature - specific, only some contingency provisions	before formalisation	substance possible - continuous adjustment required - extensive specific planning of structures and processes may be possible
9.Sources and forms of mutual planning	- consent to price / product by seller; - short bid-asking bargaining	- some bargaining regarding price / product specifications - post commencement negotiation to finalise planning	- extensive bargaining prior to formalisation for planning purposes - mutual planning merges into ongoing relationship and 'joint creative effort' - operation of the relation is prime source for further planning - planning is extensive
10. Bindingness of planning	- planning is entirely binding	- planning is binding to lesser degree	- planning may be binding but is often characterised by a degree of tentativeness
11. Relation between contracting parties	- no relation required or wanted	- limited exchanges needed	- relation is prime instrument to achieve transaction aims
12. Future co-operation with partner	- not required or wanted	- should be possible/required	- success of the relation entirely dependent on further co-operation in both performance and further planning
13. Interest to invest beyond the transaction	- non existent - not required	- only limited interest	- material and immaterial investments in relation and substance required - assurance of continuation of relation and exchange represent an incentive to invest
14. Incidence of benefits and burdens	- shifting or each assigned to one or other party	- Id.	- undivided sharing of both benefits and burdens

Factors	Classical	Neo-classical	Relational
15. Obligations undertaken	- genuinely expressed, communicated and exchanged promises of parties - specific rules and rights and founded on the promises and monetarised or monetisable	- Id.	- relation itself develops obligations which may or may not be expressed and exchanged in promises of parties - may be external and internal to the relation - non specific and non measurable and often based on principles and internalisation
16. Transferability	- entirely transferable	- transferability may be limited	- transfer may be uneconomic and difficult to achieve
17. Number of participants	- two	- two	- two and more
18. Focus of arbitration	- protection of the exchange	- Id.	- harmonisation of the relationship to ensure continuation
19. Participants views of transaction or relation			
- recognition of transaction	- high	- high	- low or even none
- altruistic behaviour	- none expected and none occurring	- Id.	- significant expectations of occurrence
- time sense	- presentiation of the future	- Id.	- the present is viewed in terms of planning and preparing for the future
- expectations about trouble in performance or among participants	- none expected and if occurs specific rights are to govern them	- some expected reason to have recourse to standards and third parties	- possibility of trouble anticipated as normal part of relation, to be dealt with by co-operation and other restoration techniques

ANNEX 6: ASSESSMENT OF APPROPRIATENESS OF CONTRACT TYPES IN RELATION TO HEALTH SERVICE PROVISION NEEDS

Requirements	Transactional contracts	Relational Contracts
1. Multi-facetted service package	difficult	yes
2. Integrated services delivery	difficult	yes
3. Responsibility for specific population	yes	yes
4. Inclusion of relation with / participation of target population	no	yes
5. Development of structural relations with other providers	no	yes
6. Intensive communication between actors	no	yes
7. Long term relations	no	yes
8. Planning of activities	yes	yes
9. Planning of structures and processes of co-operation relation	no	yes
10. Gradual planning	no	yes
11. Large flexibility	no	yes
12. Measurability of activities / services (output)	yes	yes
13. Measurability of outcome and impact	no	yes
14. Measurability of relation	no	yes
15. Long duration	no	yes
16. Inter-linkage with other policy and implementation instruments	no	yes
17.Incentives to invest morally and materially	no	yes
18. Bindingness of exchange promises	yes	yes/no (more moral than legal)
19. Arbitration focus on harmonising relations	no	yes

ANNEX 7: EXAMPLE OF CONTRACT FROM TANZANIA

AGREEMENT FOR THE DISTRICT HOSPITAL OF .... DISTRICT

THIS AGREEMENT made the .... day of ....20.............

Between the GOVERNMENT OF THE UNITED REPUBLIC OF TANZANIA represented by the Ministry of Health (hereinafter called "the Government") on the one part, and the DIOCESE OF .... hereinafter called "the Diocese") on the other part.

WHEREAS the Diocese of .... .is the owner of a hospital which is situated at ....and is fully equiped to a total of ....beds.

AND WHEREAS the Diocese has consented to this hospital being utilized and operated as the District Hospital for the ....District in accordance with this agreement.

NOW, THEREFORE, IT IS HEREBY AGREED AS FOLLOWS :

1. This Agreement is repealing the agreement in existence relating to the hospital.
2. The Diocese shall be responsible for all future capital expenditure and development projects, including staff housing.
3. The Government shall assume full responsibility for the recurrent expenditure and other related services of the hospital.
4 The hospital shall be governed by a Board in accordance with medical ethics and the policies of the Government, as well as in harmony with the principle of the faith fostered by the Tanzania Episcopal conference or the Christian council of Tanzania.
5. The hospital will be required to provide, health services and fulfil other medical functions in respect of .... District to the same extent and will be staffed in the same manner as other comparable District Hospitals, operated and owned by the Ministry in other Districts

6. The Diocese shall retain the ownership of the hospital, and it shall be the responsibility of the Diocese to provide staff, buildings, equipment and to administer the Hospital as the Employer.

7. The Board shall consist of ten members of whom six shall be appointed by the Diocese and four shall be appointed by the Government. The Chairman of the Board will be nominated by the Diocese. All members including the chairman shall each hold office for a term of three years at the end of which they shall be eligible for reappointment for "successive periods of three years.

8. The Medical Officer in charge of the hospital shall be appointed by the Board upon nomination by the Diocese, after consultation with the Government. The Medical Officer in charge of the hospital shall be the Secretary of the Board, but shall not vote at any of its meetings.

9. The Board shall meet quarterly, with a quorum of five members, of whom at least two shall be members appointed by either part. The Board shall make its own rules regulating the procedure at its meetings.

10. (1) The Board may delegate its authority in respect of the day to day running of the hospital to the Medical Officer in charge who shall be assisted by a Management committee whose members shall be as follows:

(i) The Medical Officer in charge who shall be the Chairman of the Committee;
(ii) The Hospital Secretary;
(iii) The Hospital Nursing Officer in charge;
(iv) The representative of the Training centres attached to the hospital.

(2) There shall be an Advisory-Committee to advise the Management committee whose members shall be as follows :

(i) The medical officer in charge, who shall be the chairman of the committee;
(ii) The Hospital Secretary;
(iii) The Hospital Nursing Officer In - Charge;
(iv) The representative, one each, of the Training Centres attached to the Hospital;
(v) Representative of Chama Cha Mapinduzi at the hospital;
(vi) The District Medical Officer;
(viii) The representative of Medical practitioners working at the Hospital

11. Former staff employed by the Hospital shall remain to be employees of the Diocese.
12. The Diocese shall be responsible for staffing the hospital and the Government may be requested to attach such additional staff as may be required.
13. The salary, leave privileges and personal emoluments of the employees of the hospital shall be the same as those applicable to civil servants in Tanzania.
14. The discipline of staff including those attached by the Government shall be maintained by the Board in accordance with the provisions of the schedule hereto.
15. Subject to the provisions of clauses 16 and 17 the Government will be responsible for providing funds required for running the hospital and operating other approved services including funds for minor maintenance and repairs of equipment and buildings.. The funds will be paid quarterly in advance to the hospital.
16. The Board of Governors shall be required to prepare estimates of expenditure, in respect of each financial year, and submit them for approval by Government at a time required and specified by the Ministry.
17. The following types of recurrent expenditure shall not normally be accepted as a charge against funds provided under Clause 13:

    (a) International travel expenses for employees of the hospital for travelling on first appointment, leave and termination of employment.
18. The charging of fees for in-patient and out-patient services provided at the hospital and related premises will be in accordance with the directives of the Ministry.
19. The Board of Governors will keep and maintain its accounts of expenditure in the form and details required by the Government and these will be subject to audit by an auditor or auditors approved by the Government.
20. As soon as possible after the end of each government financial year, the Board will submit to the Ministry an audited account of expenditure incurred for the running of the hospital during the previous financial year.

21. Supplies intended for use in and through the hospital will be exempted from duties and taxation to the same extent as supplies to the Government Hospitals.

22. This agreement does not cover the running of any training school attached to the hospital unless specifically approved by the Ministry in Writing.

23. Any extension or improvement- of the hospital and its related services which will entail substantial additional recurrent expenditure, will be subject to the prior approval of the Ministry.

24. Amendments to this agreement may be undertaken by mutual consent.

25. This agreement shall come into force upon signature by both parties and may be terminated by either party after giving at least one year's notice or earlier by mutual agreement.

SCHEDULE

MAINTENANCE OF DISCIPLINE

1. In this Schedule, unless the context requires otherwise- disciplinary authority" means. -

   (a) In relation to a senior officer, the Board of Governors;

   (b) in relation to a junior officer, the Management Committee;

"Disciplinary offence "or Offence" means any act, omission, misconduct, failure of any kind, however known, by or on the part of an officer, which in the opinion of the disciplinary authority warrants action being taken against the officer, and includes a contravention of any condition which forms part of his contract of employment;
"Officer" means any member of the staff of the hospital and includes an officer on attachment by the Government;
"The principal secretary" means the Principal Secretary to the Ministry of Health.

2. The power vested in the Board of Governors as disciplinary authority over the staff of the hospital categorized as junior staff may, by writing

under the hand of the Chairman, be delegated to the Management Committee. The Board shall retain its power, to control the discipline of all the other staff of the hospital.

3. A disciplinary authority shall make such investigations as it thinks proper into all allegations made or referred to it if it proposes or is requested to exercise its disciplinary powers. If it considers that there is substance in the allegations, it shall inform the officer of the allegations and afford him an opportunity or exculpating himself and making representation against any penalty which may be awarded.

4. (1) The following penalties may be awarded against any officer by disciplinary authority:

(a) Dismissal;
(b) Termination of appointment;
(c) Reduction in grade;
(d) Reduction in salary not below the entry point of the salary scale at which he is then appointed;
(e) Stoppage of increment;
(f) Withholding of increment;
(g) Recovery of the costs or part of the cost of any loss or breakage caused by his default or negligence;
(h) Written reprimand.

(2) The penalties prescribed in paragraph (a), (b) and (c) shall not be awarded except where the disciplinary authority is satisfied that the offence involves acts or omissions of serious misconduct or gross inefficiency.

(3) Nothing in this schedule shall preclude any Head of Department from issuing a reprimand for or a warning for unsatisfactory work to any officer.

5. (1) Whereas in the opinion of any disciplinary authority any act or conduct alleged against an officer is, if substantiated, likely to lead to the officer's dismissal, the disciplinary authority may interdict the officer on half salary pending the determination of the matter.

(2) Where an officer is charged with a criminal offence, a disciplinary authority may interdict the officer on half salary pending the determination of the matter by the Court and of any subsequent disciplinary action by the disciplinary authority.

6. (1) Where a penalty involving dismissal, termination of appointment, reduction in rank or in salary is contemplated upon an officer attached to

the Government, the Board of Governors should consult the principal secretary before the final decision is made.

For all other penalties imposed on such officers the Board should forward a report to the Principal Secretary for his records.

(2) In case of grave misconduct on the part of an officer attached to the Ministry of Health the Medical Officer in charge will suspend the officer concerned immediately pending consultations with the Principal Secretary.

(3) If upon receipt of the report of the disciplinary authority the Principal Secretary confirms the decision to impose the penalty of dismissal, termination of appointment, reduction in rank or in salary, then such penalty shall take effect accordingly. Should such a penalty be unacceptable to the Government, the attachment of the officer shall lapse and the officer shall be returned to the Ministry of Health forthwith.

7. (1) Where a penalty of :

a) Dismissal

b) Termination of appointment

c) Reduction in grade

d) Reduction in salary, is imposed upon an officer by the hospital management committee he may appeal to the Board of Governors whose decision shall be final; provided that in the case of officer attached to the Govern-ment, such decision shall be subject to the terms of paragraph 6 of this schedule.

(2) Any appeal made under sub-paragraph (1) of this paragraph shall set forth the ground of appeal in writing and shall be forwarded to the Board of Governors within thirty days of decision against which the officer is appealing.

In witness whereof the parties hereto have set their respective hands and seals the day and year first above written.

SIGNED AND DELIVERED by the Ministry of Health for and — Signature......... .

Name ....

on behalf of the GOVERNMENT OF THE UNITED REPUBLIC OF TANZANIA

Designation ....

IN THE PRESENCE OF

Signature ....
Name ....
Designation ....
Postal Address ..

SIGNED FOR AND ON BEHALF OF THE

Signature............
Name ....
Designation ....

IN PRESENCE OF

Signature ....
Name ....
Designation ....
Postal Address ..

ANNEX 8: EXAMPLE OF CONTRACT FROM UGANDA

MEMORANDUM OF UNDERSTANDING BETWEEN
THE .... DISTRICT LOCAL GOVERNMENT
AND THE ....HEALTH UNIT FOR THE USE OF FUNDS OF THE ....GRANT FOR THE FINANCIAL YEAR ....
FOR THE DELIVERY OF HEALTH SERVICES WITHIN THE DISTRICT OF ....

This memorandum is made on the .... day of .... 20 ......

between

(on the one part)

The .... District Local Government represented by the Chief Administrative Officer, POBox .... , (hereinafter referred to as 'the district'), and

(on the other part)

The .... Health Unit within the District of ...., represented by .... , (hereinafter referred to as 'the health unit')

INTRODUCTION

1.1 WHEREAS the District, wish to improve the quality of life of the people of ....district.

1.2 WHEREAS the District, in order to achieve the above objective will provide funds to the Health Unit in the form of .... Grant (hereafter referred to as "the Grant"), the specific objectives of which are set out in the District Guidelines on The Utilisation and Management of Grants for the Delivery of Health Services (hereafter referred to as "the Guidelines").

1.3 WHEREAS District has examined the Health Unit Annual Workplan for the Grant, which forms

Annex 1 to this Memorandum of Understanding (hereafter referred to as “the Workplan").

1.4 WHEREAS District confirms that the Workplan has been prepared in correspondence with Guidelines.
adequately addresses the objectives of the Grant as set out in the Guidelines and the needs of the District, is realistic and achievable, is in line with Government of Uganda Policy and within the budget ceilings provided by the District

1.5 WHEREAS District agrees to provide funds for the implementation of activities identified in the Workplan,

1.6 WHEREAS District has attempted to ensure that the budget ceilings provided accurately project the level of Funding that will be available to the Health Unit in the Financial Year .... Government of Uganda Budget

AND

1.7 WHEREAS the Health Unit has developed the Workplan in accordance with the Guidelines, and with Government Policy, and the Health Unit has ensured that the Workplan addresses the needs of the District

1.8 WHEREAS the Health Unit agrees only to implement the activities in the Workplan using the funds provided by the District.

NOW THEREFORE IT IS AGREED HEREIN AS FOLLOWS

2. RESPONSIBILITIES OF THE HEALTH UNIT

2.1 The Health Unit will make every reasonable effort to implement all the activities set out in the Workplan,

2.2 The Health Unit will implement Workplan, plan and report on the use of funds, in accordance with the Guidelines,

2.3 The Health Unit will submit a quarterly Progress report, Cumulative Progress Report and Budget Request to District by the end of the first week after the close of the quarter to qualify for release of funds for that quarter, to enable the District to conform to the regulations as specified in the Guidelines,

2.4 If the Health Unit encounters problems in the implementation of the Workplan. It will seek technical assistance from the District or any other party in a position to provide the necessary support. On receipt of technical assistance, the Health Unit will act on this assistance, and make efforts to overcome any problems in implementation. If the Health Unit does not act on technical advice from District, it must gives reasons for the same,

2.5 The Health Unit will not alter the Workplan before getting written approval from the District

2.6 Functioning as Health Sub-District Headquarter Unit (delete if not applicable)

The Health Unit will provide the following services:

(a) support supervision of all the health units in the Health Sub-District;

(b) providing services of district priority including surgical services;

(c) providing out-reach services (district priority areas) to the population in the Health Sub-District:

(d) purchasing drugs for the Health Unit;

(e) purchasing drugs for the lower level health units in the Health Sub-district

(f) disease surveillance;

(g) collection, compiling and analysis of health data of the Health Sub-District:

(h) preparing monthly Health Sub-District reports and submitting them to the District Director of Health;

(i) shall be supervised by the District Director of Health; and

(j) shall prepare activity reports on the completion of an activity

3. RESPONSIBILITIES OF DISTRICT

3.1 The District will fund the implementation of activities identified in the Workplan and the implementation of any other activities resulting from changes in the Workplan, provided that the Health Unit has followed the procedure for altering the Workplan set out under clauses 2.4 and 2.5 of this Memorandum of Understanding and has acquired the approval of the District,

3.2 provided that the District has received the required reports on time, as set out in the Guidelines, the District will ensure that release of funds is made on time,

3.3 the District will not release funds if the required reports set out in clause 2.3 are not received.

3.4 the District will analyse all Activity reports (if applicable), progress reports and Budget Requests submitted by the Health Unit, each Budget Request will be considered on its own merit and if the funds released are below the Budget Request, the District will give reasons for the same in writing to the Health Unit.

3.5 The District Government will monitor the activities of the Health Unit, and provide the Health Unit with technical advice on the basis of observations from the monitoring

3.6 the District will provide technical assistance for the preparation of the Workplan for the next Financial year.

3.7 Changes to the Workplan

3.7.1 the District will consider each request for authority to make changes to the Workplan on its own merit.

3.7.2 If the District does not find proposed changes in a workplan acceptable, it must give reasons for the same, and suggest viable alternatives to the Health Unit

4. VALIDITY OF LETTER OF UNDERSTANDING

4.1 This Memorandum of Understanding is valid from the date of signing such time as the District has both received the Verified Cumulative Annual Report for the Grant and any unspent funds returned to the District in accordance with the Grant Guidelines.

4.2 Any modifications to this Memorandum of Understanding shall be by mutual agreement of both parties

SIGNED for and on behalf of the Health Unit ....

IN THE PRESENCE OF ....

SIGNED for and on behalf of the Health District ....

IN THE PRESENCE OF ....

ANNEX 9: EXAMPLE OF CONTRACT FROM GUINEA-CONAKRY

COPY OF THE PARTNERSHIP CONVENTION ESTABLISHED BETWEEN *MALIANDO* AND THE KISSIDOUGOU HOSPITAL

CONVENTION DE PARTENARIAT

ENTRE

D'UNE PART: La Mutuelle de santé : **MALIANDO**
de l'aire de santé de: **Yendé-Millimou**
représenté par son Président:

M. Moriba KOMANO

ET

D'AUTRE PART: l'Etablissement de soins:
Hôpital Préfectoral de Kissidougou
représenté par son Directeur:

Dr. Sékou Ditinn CISSE

Préambule

- Où que l'Homme réside
- Qu'il soit riche ou pauvre
- Sans distinction de sexe ;
- Sans considération de son appartenance ethnique et religieuse,

La Santé est son bien le plus précieux et aussi, l'un de ses droits fondamentaux. L'on a coutume de dire à juste titre que « la santé a un coût». Ainsi, de par le monde, les systèmes de santé tendent à organiser les soins en véritable *« **marché**»* ou dans la pratique :

- Les établissements de soins, qu'ils soient publics ou privés, sont des prestataires ou ***«vendeurs »*** de soins de santé, qu'ils produisent en supportant des charges de production conséquentes ;
- Les ménages sont des consommateurs et véritables ***« clients »*** de ces établissements de soins, devant acheter les services aux tarifs fixés par lesdits établissements.

Cependant, il apparaît aussi que, même si la « santé s'achète et se vend » son marché n'est pas celui de n'importe quelle marchandise. C'est celui du Bien sans lequel le bien-être de l'Homme et son développement général seraient quasiment compromis.

De ce fait, il est admis que le secteur de la santé fait partie de ceux pour lesquels l'Etat ne saurait être absent en tant qu'acteur. Et l'administration sanitaire qui le représente tend à se positionner vers un rôle régulateur du système à travers des politiques nationales de santé, cela avec des tâches d'orientation des programmes sanitaires vers des soins de qualité, d'animation et d'appuis techniques divers aux autres acteurs.

Ainsi donc, les signataires du présent document déclarent prendre acte du fait que chaque catégorie d'acteurs est indispensable dans l'entreprise de promotion d'une « santé sans exclusion » mais qu'aucune des catégories ne saurait à elle seule faire aboutir cette

entreprise. Ils prennent aussi acte de la nécessité d'un minimum d'organisation partenariale pour que le collectif des acteurs parviennent ensemble à rendre disponibles des soins de santé de qualité et accessibles même aux couches les plus démunies de la population.

Puisse donc les présents accords constituer une base solide pour un partenariat fructueux entre producteurs et consommateurs de soins, dans le respect des orientations nationales ! Et que, de ce partenariat ressorte comme principal produit la vraie « Santé pour Tous » support de tout développement économique et social

Amen !

LES DEUX PARTIES CONVIENNENT DE CE QUI SUIT:

Article l Partant du préambule qui précède et des constats qui suivent, la présente convention est établie entre les deux parties pour servir de base à un partenariat devant favoriser la production et la consommation optimale de soins de santé reconnus de qualité selon des critères communs.

I. DES CONSTATS FAITS PAR LES DEUX PARTIES:

Article 2 La Mutuelle **Maliando** et la **Direction de l'Hôpital Préfectoral de Kissidougou** s'accordent sur les constats suivants:

1) du côté de Maliando:

a) L'impérieux devoir pour elle, d'évoluer vers la finalité de son organisation qui est de «promouvoir par toutes stratégies adéquates et dans le respect de la légalité, l'accès de l'intégralité de la population de l'aire du Centre de Santé à un Paquet Minimum de services de santé » de qualité ;

b) La nécessité d'au moins avoir un équilibre structurel de son budget annuel ;

2) du côté de l'hôpital préfectoral :

a) L'impérieux devoir pour lui, d'accomplir la mission qui lui est définie dans le cadre de la politique nationale de santé, à savoir

«l'amélioration de l'état sanitaire des populations à faibles revenus, en assurant la couverture sanitaire de la sous-préfecture ;

b) L'impératif de recouvrer la plus grande partie des charges de production des soins auprès des usagers jusqu'au moins, à l'équilibre budgétaire cela, du fait que l'Etat ne peut plus assurer à lui seul toutes ces charges ;

c) Le devoir de promouvoir l'équité dans l'accès aux soins pour l'ensemble des usagers.

Article 3 Les parties concluent de ce qui précède, une convergence de leurs finalités, à savoir : assurer l'accessibilité effective de la population concernée, à une gamme des services de santé de qualité, en relation avec la pathologie locale ;

Il s'agira maintenant pour elles, de collaborer franchement en vue d'évoluer de façon soutenue vers cette finalité commune.

II. DE L'ENGAGEMENT DES PARTIES:

1. De l'Hôpital Préfectoral de Kissidougou

Article 4 L'Hôpital Préfectoral s'engage à œuvrer de façon continue à prendre en charge les pathologies définies par les 2 parties dans les points **a, b** et **c** de l'article **2** du Contrat de Prestations de services ;

Article 5 L'Hôpital Préfectoral s'engage aussi à assurer en son sein, toutes conditions nécessaires et possibles, en vue d'améliorer l'accessibilité socioculturelle de l'établissement aux usagers (notamment à travers la qualité de l'accueil et l'information de ces usagers) ;

2. De la Mutuelle Maliando

Article 6 La Mutuelle s'engage dans le cadre de ce partenariat avec l'Hôpital Préfectoral, de participer à la promotion de conditions de consommation optimale des services rendus disponibles par l'hôpital préfectoral :

a) En assurant l'acquisition des servies au bénéfice de ses adhérents, au moins aux coûts recouvrables de ces services ;

b) En améliorant l'organisation de la solidarité entre couches favorisées et couches défavorisées de la population, afin de prévenir, au niveau de l'hôpital préfectoral, les difficultés de recouvrement de coûts pouvant subvenir du fait de la prise en charge d'indigents ;

c) En participant très activement à l'information de ses adhérents, en particulier sur les soins disponibles au niveau de l'hôpital préfectoral et leurs conditions de consommation, et, en général sur les éléments essentiels de la politique nationale de santé.

Article 7 La Mutuelle s'engage aussi à participer dans la mesure de ses capacités budgétaires et partenariales aux efforts généraux d'équipement de l'hôpital préfectoral et de motivation de son personnel ;

3. Dispositions communes. Les parties conviennent que :

Article 8 Les dispositions de la présente Convention seront concrétisées chaque année à travers un Contrat Particulier de Prestation de Service, entre l'Hôpital Préfectoral et la Mutuelle, précisant :

- les risques qui seront couverts par la Mutuelle -pour ses adhérents au titre de l'année ;
- les tarifs par risque ou groupe de risques et les conditions de leur règlement à l'Hôpital Préfectoral;
- les projets d'équipement de l'Hôpital Préfectoral, si possible, ayant reçu un engagement de participation de la Mutuelle ;
- le programme commun d'information et d'action vers les collectivités cibles de la Mutuelle.

Article 9 De même, en fin de chaque année, les contrats exécutés seront évalués par les deux parties, sur la base de critères et d'indicateurs adoptés en commun

Seront prises en compte aussi dans cette évaluation :

- Les réactions des adhérents de la Mutuelle, recueillies sur les supports placés à cet effet au niveau de chaque UNEM de la Mutuelle.
- Les réactions du personnel de l'Hôpital Préfectoral recueillies sur les supports placés à cet effet au niveau de chaque service.

Article 10 Afin d'améliorer l'information et d'instaurer une pratique de transparence entre les deux parties, elles conviennent aussi des principes partenariaux suivants :

a) L'Hôpital Préfectoral s'engage à convier la Mutuelle à la séance de synthèse de chaque monitorage semestriel de l'établissement ;

b) Réciproquement, la Mutuelle s'engage à convier l'Hôpital Préfectoral et sa Direction aux séances de l'Assemblée Générale qui dresse les bilans annuels de l'organisation.

Article 11 Les parties prennent acte que dans le cadre de la présente convention, la DPS (Direction Préfectorale de la Santé, incluant aussi la Direction des Micoréalisations) a pour rôle :

- l'orientation des parties à travers la politique nationale de santé ;
- l'apport d'appuis techniques divers (information, conseil, formations...) ;
- la promotion d'évaluations communes des programmes ;
- la médiation entre les parties en cas de litige après intervention de la CRD.

III. DE LA DUREE ET DES CONDITIONS DE MODIFICATION DE LA PRESENTE CONVENTION

Article 12 La présente Convention régira le partenariat entre les parties pour une durée renouvelable de trois ans.

Article 13 Elle peut être périodiquement revue, à la demande bien motivée d'une des parties ou des deux parties. Ces modifications seront validées en début de chaque année, avant le renouvellement du Contrat Particulier de Prestations de Services.

Article 14 En cas de constat du non-respect des clauses de la présente Convention par l'une des parties, l'autre devra d'abord lui adresser un « rappel à l'ordre » avant de saisir si nécessaire la DPS qui est retenue comme médiateur.

Si suite à la médiation de la DPS aucune amélioration significative n'est intervenue, la partie lésée peut se retirer de la Convention en le notifiant par écrit à l'autre. Ce qui annulera l'ensemble de ses engagements envers l'autre.

Article 15 En cas de rupture des relations de convention entre les parties, la partie fautive reste tenu d'achever ses obligations définies dans leur contrat de l'année en cours, sauf désistement de l'autre partie.

A cet effet la DPS adressera une liste des actions à achever obligatoirement ainsi que les acquis stratégiques devant être sauvegarder. De plein droit, il mettra en demeure la (ou les) partie (s) concernée (s) de s'exécuter.

Article 16 Les deux parties déclarent être en accord avec l'ensemble des dispositions de la présente Convention qui est établie en trois (3) exemplaires originaux. En conséquence, elles y apposent leurs signatures pour servir et valoir ce que de droit.

La présente convention prend effet à partir du 20 juillet 1998 pour une période de trois (3) ans.