MACH

A Methodology for Analysing Contracting in Health Care

B. SERDAR SAVAŞ
EUROPEAN HEALTH21 TARGET 16
MANAGING FOR QUALITY OF CARE

By the year 2010, Member States should ensure that the management of the health sector, from population-based health programmes to individual patient care at the clinical level, is oriented towards health outcomes

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

EUROPEAN HEALTH21 TARGET 17
FUNDING HEALTH SERVICES AND ALLOCATING RESOURCES

By the year 2010, Member States should have sustainable financing and resource allocation mechanisms for health care systems based on the principles of equal access, cost–effectiveness, solidarity, and optimum quality

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

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ABSTRACT

A central theme underlying the proposals for reform of health systems worldwide is the introduction of market incentives. In the United Kingdom, the experience of an internal market, with the separation of functions between purchasers and providers and the use of contracts, has been followed with interest by many governments. In countries such as Germany, separation of functions and contracting negotiations have been the norm for many decades. In the countries of central and eastern Europe and the newly independent states, the implementation of contracting is being considered in many reform proposals. This study suggests that there is a need to improve the understanding of contracting, its links with health policy, and the functions and characteristics of contracts, and proposes a methodology for analysing contracting in health care (MACH). Focusing on the context, the contracting process and on management of change for the development of contracting, the study applies the MACH to the experience of Germany and the United Kingdom. In Kyrgyzstan, where contracting mechanisms have not yet been implemented, the study uses the MACH for discussing proposals for the development of contracting. Some of the strengths and weaknesses of the MACH identified during its application are discussed, major conclusions about contracting are presented and, in the light of the lessons learnt from the application of the methodology, recommendations for the development of contracting in Kyrgyzstan are made.

Keywords

COMPARATIVE STUDY – methods
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1. Introduction

In most European countries, the health sector is an increasing concern. Health costs as a proportion of gross domestic product have tended to increase in most of the western economies. In this context, most western European countries are looking at ways to reduce the burden of social expenditure on national budgets. Social security and health are among the sectors which have been carefully scrutinized. As a result, most of the health care reform initiatives in western Europe are largely the result of a search for cost-containment.

In comparison, throughout their transition period into market economies, the former socialist states of Europe have been facing severe economic decline and budget deficits. Since all these countries have been financing their health care from the State budget, their expenditure has been directly affected. Moreover, at times of difficulty, health has become less of a priority and, in many cases, the health sector has become the key target for investment cuts.

The health system in the socialist states is the result of some 70 years of implementation of the Semashko model. These systems have achieved considerable successes, although by the 1990s they had become outdated, inefficient and ineffective. Common problems identified include the lack of a public health view, the absence of a health services management approach, shortages of medical equipment and drugs and, most important of all, a chronic shortage of knowledgeable and skilled health service managers.

In the aftermath of the end of the socialist bloc, policy-makers in the countries of central and eastern Europe (CCEE) and the newly independent states (NIS) embarked on a major process of change, trying to identify solutions to the problems associated with their socialist structure. Not surprisingly, many of these states were tempted to adopt solutions being applied in modern western countries. In the early 1990s, such solutions consisted mainly of policies to contain health care costs. Thus, perhaps unknowingly, the CCEE/NIS were adopting policies which in general

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1 The Semashko model is named after N.A. Semashko, a physician who contributed to the development of free medical care under tight central control for the entire population of the former Soviet Union.
focused on changing the behaviour of suppliers and consumers of health care through the use of financial mechanisms.

One of the most important reforms in western Europe has been the introduction of market incentives in the health sector, in the expectation that this would increase efficiency and effectiveness.

Following this example, the idea of competition in health services also appealed to CCEE/NIS. Since most of these countries were broadly moving towards market economies, it appeared logical to develop markets in the health care sector too, even though in the minds of the leaders in these countries there was still considerable confusion about such concepts as market, competition, privatization, private finance and contracting.

Although many countries have been using contracting mechanisms for some time, the implementation of the internal market idea in the United Kingdom, with a distinction being made between purchasers and providers and the development of contractual relationships, put the concept of contracting into the European health care literature. In parallel with some other western European countries, the CCEE and NIS also started to use contracting ideas in their reform proposals.

Nevertheless, the term “contracting” is commonly used without a clear understanding of its meaning and potential relevance for the development of health systems. For instance, contracting has been used as a synonym for market and sometimes as a synonym for the purchaser–provider split. Although contracts can be used in health systems based on markets with a defined split, in the pages that follow, it is shown that they can be used in other contexts too.

From the point of view of implementing reforms, it is not always clear that contracting is only a mechanism and not an end in itself. This confusion might be due to a conceptual weakness in linking contracting with health policy formulation. As a result, different players may focus on the technicalities of contracts rather than on achieving health policy goals.

Certainly it is necessary to examine the technicalities of contracting, its functions and characteristics. However, these aspects may need to be understood within the context of an overall process of change, which will influence not only technical aspects of people’s work but may also require of them cultural changes and economic sacrifices. This process of change associated with the introduction of contracting is very complex and may
not always be feasible in the short and medium term. Still, dealing with factors affecting feasibility is only a part of the task of managing change. Decision-makers will also need to provide leadership and communicate well with key players.

In this analysis, it is suggested that there is a need to improve the understanding of contracting, its links with health policy, its functions and characteristics. At the same time, there will also be benefits from a well structured review of likely obstacles to implementation and the process of managing change in countries where contracting is being implemented.

In order to address these questions, this study describes the development of an analytical methodology which can be used for both reviewing and developing contracting mechanisms. For review purposes, the methodology is mainly helpful in defining key issues to be considered when analysing and understanding contracting in any particular country. For development, the methodology provides alternative ways of developing contracting mechanisms, supported by empirical evidence from Germany and the United Kingdom.

The analytical methodology follows a logical structure which facilitates an understanding of the complex subject it tackles. Such a structure can be easily criticized and improved, without the need to rewrite the whole text. This might be an advantage for other researchers interested in adapting the approach to other specific research topics.

It is expected that, by providing an analytical methodology rather than simply discussing the issues involved in contracting, this study will make a significant contribution to the available body of knowledge on contracting.

Before the methodology for analysing contracting in health care (MACH) is described, Section 2 of this document will start with a broad discussion of health care reforms and contracting in Europe, followed by a more detailed discussion of purchaser–provider split mechanisms in competitive scenarios and then of the role of contracting in the context of purchaser–provider split and integrated systems.

Section 3 will concentrate on explaining the aim of this study and the scientific methods used, identifying the countries to be studied and the reasons why they were selected. This Section will also explain how the proposed methodology has been developed, from the literature review and interviews to the drawing up of the first draft “map of issues” and its refinement.
Sections 4, 5 and 6 will systematically apply the MACH to two selected countries, reviewing their contracting systems and providing insights into contracting and its links with other major components of the health care system. For this purpose, countries representing two distinct models have been selected: the United Kingdom (predominantly integrated and tax-financed) and Germany (more decentralized and insurance-based). Contextual factors affecting contracting (Section 4), the functions and characteristics of contracts (Section 5), as well as the process of development of contracting (Section 6) are some of the issues to be discussed in the light of the British and the German experience.

In Sections 7, 8 and 9, the MACH will be applied to a health care system where it is planned to implement contracting in the future. For this purpose, Kyrgyzstan was selected. As will be seen, Kyrgyzstan is an example of a country with a health care system based on the former Soviet model but now undergoing rapid reform. The preparations for the implementation of the reforms, the development of the national programme on health care reforms (MANAS) and the planned implementation of contracting in the future, all present an opportunity for the application of the MACH in Kyrgyzstan.

Section 10 provides some conclusions and lessons learned about contracting and the application of the MACH in the case of Germany, Kyrgyzstan and the United Kingdom. This is followed by a number of recommendations for the development of the Kyrgyz health care system. Finally, a discussion of the MACH itself, including its weaknesses and strengths, is presented.

It should be noted that the study described in this book is based on a cross-sectional analysis of the health care systems and practices in countries between 1994 and 1996. The health care systems of the relevant countries are, therefore, described in that context and some changes have taken place since then. Nevertheless, the implications of these changes for the development and principles of MACH remain marginal.
2. Health care reforms and contracting in Europe

2.1 INTRODUCTION

Section 2 begins with an examination of some of the main trends in European health care reform. This will not be a comprehensive review, but it will serve to identify some of the important issues for European policy-makers. This is followed by a discussion of two related reform mechanisms, the purchaser-provider split and competition, including expected problems and benefits.

Finally, the role of contracting, both in the purchaser-provider split and in an integrated health care system, will be discussed. This will be illustrated by examples of contracting practices in selected European countries.

2.2 MAIN REFORM TRENDS

The world is reshaping itself in the aftermath of the “cold war” era, in a new and more competitive environment. Recent demographic trends (such as aging), stronger emphasis on efficiency, calls for accountability and more attention to people’s views and choices are other influential factors. On top of this, for many countries achieving the right balance of economic performance and social protection has to be managed at the same time as the transition to a market economy.

Health and health care are affected by these changes in the socioeconomic and political environment. As a result, many governments in Europe are reviewing their health care systems and the suitability of their existing approaches to finance, organization and delivery of health care.

The roles of the State, the market and the citizens in health systems are being revisited. National policy-makers in several European countries are developing policies to review existing lines of management and organizational structures, at the same time broadening participation and the choices available to citizens and patients. In parallel, alternative sources of funding (e.g. earmarked taxes, fees or private investment capital) are being considered.

Decentralization has been seen as an effective means of stimulating improvements in health systems. This process is expected to induce a transfer
of authority or dispersal of power, in public planning, management and decision-making, from the national level to lower levels of administration. It is justified on the grounds that “it is difficult for central administration to be sufficiently close to users of services to make appropriate and sensitive responses to expressed preferences” (WHO, 1997).

Privatization is an extreme form of decentralization, since decision-making power on the supply and logistics of distribution of services is passed on to individual entrepreneurs or enterprises. Once empowered to decide on aspects such as the price, quality, quantity and availability of services they provide, entrepreneurs and enterprises may be forced to compete with each other for customers. The pressure for survival and the rewards for successful initiatives are expected to induce, among other things, greater efficiency and quality in the provision of services. At the same time, the opening up of health care systems to market initiatives is expected to attract investment capital and release the pressure on the public budget of many governments.

The development of social health insurance can also be seen as a move towards increasing the amount of resources available for the health sector. Since monetary contributions to social health insurance funds are usually based on the ability of the insured to pay and the resources are earmarked for health services, such schemes are expected to provide a transparent, stable source of funds. It is also expected that, if more than one health insurance fund exists, membership will be voluntary and competitive forces can be used to increase quality and efficiency. In some countries private health insurance schemes are also being considered.

Health care provision based on an institutional separation between the functions of provision and purchasing/commissioning of health services is being developed in several countries in an attempt to foster better allocation of the available resources for health, among other goals. The purchaser–provider split, as it is called, allows for the existence of an agent (purchaser) who purchases health care for the citizens.

In this context, contracts are increasingly being used as tools to mediate the interaction between purchasers/commissioners and providers of health care services. Contracts can define, among other things, the type of services to be provided and the volume, quality and prices of these services. The process of elaborating and negotiating contracts (known as contracting) can play a key role in priority-setting and in achieving efficient use of resources for health gain.

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2 In this book, the terms “third-party payers” and “purchasers” are used with the same meaning.
Experience in the use of such a mechanism in the late 1990s is only gradually becoming available and, as such, constitutes part of the basis for this study.

2.3 PURCHASER–PROVIDER SPLIT AND COMPETITION: ADVANTAGES

A well defined separation of functions between purchasers and providers of health services has existed in some European countries for a long time, while others have only recently introduced it. Purchasers (or third-party payers) may be a public agency (as in Sweden and the United Kingdom), a health insurer (as in Germany and the Netherlands) or even primary health care physicians (for example, general practitioner (GP) fundholders in the United Kingdom). They are responsible for purchasing health services for a defined population. Providers are those directly involved in delivering services, such as hospitals, clinics, private practices and so on.

According to Ven et al. (1994), in practice countries opt for a split depending on their existing market structure for third-party purchasers. Where third-party purchasing is carried out by one single institution (classical national health services, such as those in New Zealand, Sweden and the United Kingdom), countries seem to be opting for implementing the split. In countries where competing purchasers are established, integrated models that support a partial split of the purchaser/provider function – with limited competition – tend to be preferred (as in the Netherlands and the United States).

The main reason for splitting the purchasers and providers is to create competitive markets or “quasi-markets” (Le Grand & Bartlett, 1993) for health service provision. Governments are experimenting with competitive mechanisms in an attempt to bring to health systems some of the benefits that result from the operation of markets in other sectors of the economy. The existence of the purchaser–provider split is one of the initial steps towards the introduction of competition in health services provision. It is argued that if purchasers are separated from providers in competitive or contestable

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3 Competitive markets in health care involve purchasers seeking for good deals (in terms of quality, price, capacity to deliver, etc.) which can be offered by several providers on a regular basis. The process of public tendering involves defining the conditions to be met and the subsequent selection of the provider that can best deliver the services specified. In contrast, contestable markets in health care are based not on a formal and regular tendering process in which competition is explicit, but on the threat of purchasers switching contracts to other providers. In this case, the threat of losing a contract works as an incentive for the providers to comply with the specifications stipulated by the purchasers. Of course, for the threat to be credible, there must exist the possibility of purchasers placing contracts with other providers.
markets, the four important objectives of efficiency, flexibility, accountability and empowerment of the citizens will be achieved.

(a) Efficiency
Purchasers may be able to use their purchasing power to induce providers to offer better value for money. Providers are expected to reach higher levels of efficiency and innovation, enhance consumer choice, reduce costs and improve quality when competitive forces are in place. Ultimately, increased efficiency may help in containing health care costs. For instance, in Germany contracts have been used by insurance funds to put pressure on inefficient hospitals, which cannot count on having their contracts renewed. This has been a way of dealing with over-capacity and containing costs (NERA, 1993).

Paradoxically, it has been argued that competition in health services provision may actually reduce efficiency, since providers may dominate the market and respond in ways that have adverse effects (Light, 1991). Light also points out that efficiency can only be increased through competitive contracts if the contractors know what is efficient.

(b) Flexibility
Competitive markets or quasi-markets are expected to increase the flexibility of health care systems. In theory, flexibility can be increased in several ways: firstly, competitive or contestable markets are open to any firm capable of providing services, so new firms may enter the market offering alternative services with higher quality and/or lower costs; secondly, purchasers can choose from a multitude of providers outside their traditional locations, according to their own criteria for contracting; thirdly, providers may have incentives to differentiate between their services in order to compete, and so on.

(c) Accountability
It is expected that, faced with competition, providers will become more accountable, primarily via the contracts they negotiate with purchasers. This is mainly because, alongside a clear definition of responsibilities through contracts, there can be new arrangements whereby the performance of providers can be monitored on a more independent basis. Accountability and enforcement of contract terms becomes stronger if providers fear losing their contracts.

(d) Empowerment of citizens
Providers may be made to compete for their clients. Above all, competition for clients is expected to make the citizens the real decision-makers. Once
individuals are able to choose which provider they will patronize, they will have increased opportunities to influence and/or control the treatment they receive. This is particularly the case when consumer choice is linked with financial reward (contracts on a cost per case basis, for instance).

2.4 PURCHASER–PROVIDER SPLIT AND COMPETITION: OPPORTUNISM

There are also potential problems associated with competitive markets or quasi-markets for health services. Most of these problems arise from opportunistic behaviour. The concept of opportunism is often associated with the work of Williamson (1985). Opportunistic behaviour occurs when individuals or groups of individuals manipulate the market for their own sake, to the detriment of the common good. In the literature this kind of behaviour is always associated with competitive contexts, although one cannot say that this is the only context in which opportunistic behaviour occurs.

There are several situations in which purchasers and providers can behave in opportunistic ways. Understanding the mechanisms which influence opportunistic behaviour can prevent it and thus improve the social benefit of the free interaction between contracting parties. The following aspects can be considered.

(a) Conspiracy
This occurs when people of the same trade formally or informally agree on measures to manipulate the market, mainly in terms of prices. Adam Smith predicted that conspiracy could occur where entrepreneurs have a great deal of market power. A good example is the control of prices in some pharmaceutical markets (Maynard, 1994). However, conspiracy is not yet the most important issue facing contracting.

(b) Corporatism
This occurs when professional associations, such as those of physicians, regulate the market by imposing guidelines, rules and other measures based on debatable professional knowledge. For example, associations of physicians may lobby for legislation banning the contracting of services from doctors considered to practise alternative types of medicine, such as homeopathy.

(c) Risk selection (cream-skimming)
Both purchasers and providers may have an incentive to be selective about cases and social groups with whom they deal, resulting in discrimination
against some groups of people. Being selective basically implies choosing to deal with most profitable patients only (Robinson & Le Grand, 1994). In Germany, several mechanisms exist in order to avoid this. In the United Kingdom, financial safety mechanisms such as extra resources for expensive patients contribute to their protection. Policy-makers have an interest in contracts designed to ensure that there is no incentive to exclude high-risk or expensive patients (Roberts, 1993).

(d) Market domination
In the United Kingdom, the evolution of a competitive environment appears to have led to rather limited competition, lengthening of contractual relationships and domination by the provider side of the market. This has generally been justified on the grounds of savings in staff and economies of scale, but little consideration has been given to the potential of a single purchaser distorting the market and creating inefficiencies (Robinson & Le Grand, 1994).

(e) Self-contracting
It has been observed in the United Kingdom that in the early stages of contracting some providers set up their own private companies to contract with themselves and profit from the internal market. The government, aware of the potential danger, stopped these activities in 1993 (Robinson & Le Grand, 1995).

(f) Manipulation of episode
If contracts act as disincentives, providers may engage in upgrading patients’ treatment to procedures which are better paid. Also, lack of proper monitoring may result in providers charging for episodes which have never taken place. For instance, although a hidden practice, it has been more or less common in the past for some German doctors to spend part of their time forging forms for payment of services supposedly provided (Knox, 1993). For fundholders in the United Kingdom, the existence of perverse incentives can also lead to the manipulation of episodes, since the definition of what the fund covers is by its nature arbitrary (Fewtrell, 1994).

(g) Biased interpretation
Parties can attempt to interpret contracts in a way which betrays the spirit of the agreement. For instance, standards may be degraded and “good quality services” may be provided with fewer personnel in order to save costs.

(h) Over-treatment
Opportunistic behaviour of this category is particularly common when providers are contracted on a fee-for-service or per diem basis. By increasing
hospital stays or requesting extra consultations, providers can over-treat in order to ensure more work and extra pay for themselves (Roberts, 1993).

(i) Cross-subsidy
This is an issue particularly in the United Kingdom and it can occur:

- across services, when some services are contracted at prices below their real costs and are thus subsidized by other services which are contracted at an above-market value; the British Government has condemned this practice – during 1992 the Department of Health made it clear that it expected applications for trust status not to combine acute and community services, which aimed at avoiding a practice observed in London where a trust’s combined budgetary deficits in acute services were being tackled by taking money from community services (Ham, 1994);
- across practices, when some hospitals or other providers charge prices below costs to gain contracts in the short run and destabilize other competitors; to compensate for their losses, they may charge more for services which are contracted by purchasers from a different region (Cairns, 1993).

(j) Segmentation
In competitive scenarios, cross-subsidizing may be followed by units concentrating on services which they can supply as a monopoly, making them more profitable. As a result, services may become more centralized than would be preferable from the viewpoint of geographic accessibility of care (Maarse, 1995).

2.5 MANAGING OPPORTUNISM
Strategies for dealing with opportunism and market failure are varied. They include:

- creating mechanisms for accreditation and registration of providers: this is an attempt to guarantee some personal integrity among participants in the system – accreditation could bring professional ethics into the system, which can be a safeguard against opportunism;
- creation and development of appropriate legislation or regulation: opportunistic behaviour is more likely to occur where regulation fails to prevent it;
- development of systems for monitoring and support: although opportunism is mostly intentional, it can also happen by accident – for instance, providers may be unaware that they are cross-subsidizing simply
because they do not know how much their services cost (Paton, 1992); similarly, without systems for monitoring contracts, there will be little chance of identifying the areas where opportunism occurs and taking measures to avoid it;

- taking account of differential risks: in January 1993 Germany implemented the first phase of its risk-structure equalization, with the goal of compensating the sickness funds for the different demographic and income-related compositions of their membership and thus reduce the incentives risk selection (GAO, 1994).

Clearly, it is not realistic to expect that regulation will be able to close all the gaps that lead to opportunism. Moreover, the introduction of regulation is usually accompanied by some new opportunistic behaviour. For instance, if purchasers cover the costs of treatment above a certain figure, providers may be tempted to let patients reach this ceiling. This was observed in the fundholding scheme in the United Kingdom (Robinson & Le Grand, 1994).

In addition, regulation presupposes the availability of information. In a perfect world, information would allow the regulator to direct the use of resources towards maximization of social benefit, avoiding opportunistic behaviour. However, obtaining information is costly. Moreover, in the real world those who are regulated usually have a better knowledge of their business than the regulators. In fact, the regulated players have incentives to conceal information since they can derive profit from their information advantage (see Section 6.1.6 for information needs).

Finally, it has been accepted that where legislation is not possible, non-binding guidelines or principles can be issued to inspire the different players in the right direction. This is an important mechanism used by the self-governing bodies of the German health care system. Non-binding guidelines and principles can be applied as complementary solutions to some of the paradoxes posed by the enforcement of regulations and legislation.

2.6 TRANSACTION COSTS

As well as opportunistic behaviour, transaction costs are also considered an important potential problem associated with competitive markets or quasi-markets for health services.

A look at some of the factors which influence these costs will help to judge the expected or existing transaction costs better.
(a) **Methods of allocating resources**
Markets have higher administrative costs than non-market methods of resource allocation, as they must take into account a number of ever-changing variables and so result in greater complexity.

(b) **Complexity of the market**
Transaction costs increase with the complexity of the market. The health services market is much more complex than traditional commodity-exchange markets. This is mainly due to factors such as the higher degree of risk involved in providing health care and the stronger necessity for regulation in order to avoid profit taking precedence over health.

(c) **Opportunism**
The concept of opportunism has already been discussed above. To avoid repetition, it is sufficient to mention here that the more opportunistic the behaviour of the players, the higher the transaction costs. Inversely, the development of trust relationships or “soft contracting” between purchasers and providers reduces the need to monitor contracts so closely (Saltman & von Otter, 1992), (Howden-Chapman & Ashton, 1994).

(d) **Uncertainty**
Under very uncertain conditions purchasers and providers have their power to plan ahead curtailed. In practical terms, the greater the degree of uncertainty, the higher the transaction costs. Since the level of demand for health care is highly uncertain, both third-party payers and providers have an interest in negotiating contracts that are flexible enough to take account of the financial risks involved in their activities. However, the more a contract tries to predict and include, the more complex and expensive it becomes (Le Grand & Bartlett, 1993).

(e) **Bounded rationality**
Decision-makers, while seeking to act in a rational manner, are limited by the fact that the human capacity to formulate and solve complex problems is limited. The more limited this capacity, the higher the transaction costs. In the real world, uncertainty combined with bounded rationality can mean that the costs of contract formulation outweigh the potential benefits of contracting (Le Grand & Bartlett, 1993).

(f) **Asset specificity**
According to Williamson (1985), transaction costs and efficiency in contracts are highly influenced by the degree to which the assets required to execute the contract are specific to a particular contractual relationship. For
instance, if a provider is persuaded to invest in a new cardiology centre, it will want from purchasers some form of guarantee that this investment will not be lost. Because the provider may become tied to this particular purchaser and therefore vulnerable to future reductions in prices or activity levels, it will therefore require more sophisticated contracts that cover this vulnerable position. In the worst scenario, the provider will in fact have no incentives for investing in specific assets, regardless of the need for such investment and the expected benefit for the health status of the population.

(g) Types of contract
Different types of contract carry different levels of risk for purchasers and providers. The real challenge for those writing contracts is to balance the risks so that neither of the parties is too exposed and opportunism is avoided. This can only be achieved at a cost.

2.7 THE ROLE OF CONTRACTING
Section 2.7 presents the role of contracting from two perspectives: firstly, in market structures where competition is expected to be a significant factor; and secondly, in the context of integrated systems where planning plays a key role. These two main points will be followed by a brief description and a critique of Hurst’s theoretical framework of a contract model (Hurst 1991). Finally, examples of the role of contracting in selected countries are presented.

A number of countries have developed integrated health care systems with comprehensive planning. Why have such integrated systems become discredited and how has contracting become specifically associated with competition?

Saltman and von Otter (1992) argue that comprehensive planning, at least as practised in northern European countries and the United Kingdom, has been largely successful as a publicly accountable arrangement providing health care in a universal, cost-effective way. However, planning systems have been destabilized in the recent past as a result of several new trends and planning has become a less favoured approach to health systems management and organization.

The theory of markets for allocation of resources presupposes that to be efficient, responsive and offer choices, markets have to be competitive. In the context of the purchaser–provider split and the provision of health services, competition would imply the existence of many providers
competing for contracts offered by many purchasers. If providers’ income depends solely or mostly on contracts with purchasers, competition for contracts on the part of providers is in fact a matter of survival.

In the competitive scenario described above, contracts are the link between purchasers and providers. The content of these contracts is expected to be the result of the free interaction between different providers and purchasers who respond to changes in demand and supply conditions. Moreover, decisions about who gets the contracts are expected to depend on rational choices made by purchasers interested in maximizing the benefits they can get for the money they pay to providers.

There is, however, a second possible role for contracting in contexts where there is no market and no competition.

For Savas & Tragakes (1995), linking planning with undesirable features (e.g. centralization, inefficiency, and long hierarchical chains of command) and linking contracting and the purchaser–provider split with competition and desirable features is a misconception. They argue that contracting, in the context of national health services, is consistent with the broad functions of comprehensive planning. Contracting “does not claim to achieve anything which cannot in principle be achieved by planning ... it represents an alternative way of doing some of the things which traditionally have been accomplished by planning” (Savas & Tragakes, 1995).

These arguments open up a debate on the possible use of contracts for planning and its importance as a tool in the planning process. It can be suggested that the split in integrated systems where planning plays a strong role could be of a softer nature; that is, although a differentiation of functions should exist, the division can be between planners and providers rather than purchasers and providers. In other words, although their functions are differentiated, this approach means that the players do not have a buyer/seller relationship. Rather, it can be suggested that contracts be used as a tool to mediate the interaction between planners and providers within integrated public bodies. “In other words, contracting is regarded as the formalization of a planning and management process with the explicit commitment of contracting parties to planning and management objectives and targets” (Savas & Sheiman, 1996).

Such a management system works more or less like a role play: the players responsible for the equivalent of a purchasing function (in fact, a planning function in this case) perform needs assessment and other tasks, primarily
to define what will be required from providers. Through negotiation with the provider party, agreements are reached on the provision of the services required to address identified needs. However, the purchasers in such a model may not be really in charge of any budget and providers do not depend on the contracts to receive their income.

In many countries, particularly in the CCEE/NIS, there are perceived advantages in implementing the purchaser–provider split and contracting, as discussed above. However, the transition from a system based on the Semashko model to a fully implemented split may be too ambitious a step. Perhaps a more incrementalist approach would be a better alternative. Thus, contracts could be used in an integrated model, without the split but with an institutionalized differentiation of functions between the team in charge of planning and the providing team. The main functions of the contracts in such a model should be to plan and mediate the interaction between the staff involved in performing each of the different functions. Ultimately this approach would make the planning process easier.

The proposed use of contracting in integrated models discussed here conflicts with some of the theory reviewed for this study. Hurst (1992) and Ven et al. (1994) suggested a conceptual framework that distinguishes three models: the reimbursement model, the contract model and the integrated model. In the reimbursement model, providers are paid directly by the patients. The bills can then be presented to the insurer (a private company or the government) for reimbursement. In the contract model, there is a separation between third-party payers and providers of health services. Contracts are the link between the two parties and they reflect a reform strategy aimed at introducing market-style competitive incentives for providers (Saltman, 1995). In the integrated model, ownership of facilities and employment of staff are in the hands of vertically organized institutions. This implies that there is no division of functions between purchasers and providers and payment is not negotiated via contracts.

Although widely accepted, the classification above causes confusion. According to the terminology used, contracting has a role to play only in the contract model and the reader is misled into believing that contracting equals competition within the context of a purchaser–provider split.

For the purposes of this study, contracting is understood as a tool which can be used in any of the models proposed by Hurst (1992), including the integrated and the reimbursement models. In fact, it is suggested that the contract model of Hurst be referred to as the competition model.
In the light of this discussion, it is helpful to look at contracting in selected countries in Europe.

**Finland** has developed a decentralized system where municipalities have great freedom for local decision-making. Since 1993 this power has also been used to organize the provision of health services in a purchaser–provider structure in which municipalities are the main purchasers.

**Germany** has had its own version of a purchaser–provider split for more than a century. This is an insurance-based system characterized by a lack of competitive forces on the provider side, although recent changes will introduce competition between sickness funds (the purchasers). At the time of this study, two steps in the contracting process have appeared as areas to be tackled: assessing the health needs of the population and priority-setting for contracting.

**The Netherlands** has developed a mixed health insurance system based on a purchaser–provider split with competition on both the provider and the purchaser side. Crucial to the process of reforms, the Dekker Report of 1988 proposed a radical break from the traditional comprehensive planning that has guided both public and private insurance schemes. The report created a theoretical basis for the ongoing changes in insurer-provider relations, including the move towards the use of contracting as a tool. For the insurers, the transition from an administrative role to a strategic one (e.g. active purchasing) where contracts are negotiated has represented a major challenge (Maarse, 1993).

In **Portugal**, there has been an integrated National Health Service since 1979. It is responsible for both managing and providing health care services. As part of the development of its regional health policy, in 1996 the Regional Health Administration of Lisbon and the Tejo Valley initiated broad consultations aimed at the development of a differentiation of functions and the use of contracts. This is expected to transform the relationship between management, citizens and the health services (Regional Health Administration of Lisbon and the Tejo Valley, 1996).

In **Spain**, health care systems have been set up as part of an integrated national health service which is publicly financed and decentralized at the regional level in each of the 17 autonomous communities which make up the Spanish State. Parliament approves the State Budget and the available resources are then made available to the parliaments of those autonomous communities that have devolved health services. Since 1991 a new initiative
has been under way to separate purchasing and providing functions in the health system. The Ministry of Health and certain autonomous communities (in particular Catalonia) have begun a process of introducing a system of contracts between purchasers and providers (WHO, 1996). In Catalonia, the separation of the two functions is being put into practice through extension of the contracting of health care services to all centres of the public utility hospital network, irrespective of whether they are public or private.

In Sweden, health care has been both publicly provided and financed in a semi-integrated system which is strongly based on county councils as the responsible units for health care provision and management. During the 1980s, long queues for some forms of treatment and low productivity together with a general sense of powerlessness generated strong popular pressure for change. Sensitive to the problems, several county councils initiated reforms that included the creation of a separation of functions between purchasers and providers and the use of contracting mechanisms (Saltman & Otter, 1992).

Turkey has had an integrated model which is gradually changing in favour of the use of contracts within a health system with a differentiation of functions between purchasers and providers. According to plans under discussion, the third-party payers would be provincial health directorates with freedom to contract with selected hospital providers. Efforts to extend insurance coverage to previously uncovered segments of the population is also currently occupying the agenda.

In the United Kingdom, the integrated model has been used since the creation of the National Health Service (NHS) in the late 1940s. More recently, the introduction of the purchaser–provider split has been one of the central elements of the reforms. Initial appraisals reveal differing opinions about its costs and benefits.

Greece and Israel are also inclined to develop separated functions for purchasers and providers in their health care systems.

A number of CCEE/NIS are also planning or have already begun to implement changes in their health systems towards developing a model where contracts may play an important role, even if their systems remain integrated.

In Bulgaria, according to recent reform proposals, municipalities will work towards developing mechanisms to establish their role as budget-holders
responsible for contracting health services from providers. Piloting has already started, although so far no major outcomes from the project have been made public.

In the **Czech Republic**, an insurance-based system is functioning and health insurance companies are required to negotiate contracts with hospitals and physicians.

**Kazakhstan** is attempting to reform its current health care system towards implementation of an insurance-based system. The existing insurance organization will have the purchasing function.

In **Kyrgyzstan**, following the guidelines of the MANAS programme, it is envisaged that the functions of purchasers and providers will be developed, with both health authorities and primary health care groups being responsible for the purchasing function.

As can be seen, contracts are being used in many countries and they are increasingly becoming an important tool for policy-makers. In fact, the use of contracting is not limited to any type of health care system and, as noted above, does not require a competitive environment to be implemented. However, many countries are developing contracting mechanisms without a clear understanding of the characteristics, functions and challenges associated with their use. Similarly, there is little knowledge of the use of such mechanisms in different health care systems. Within this context, it is believed that research is needed, and the present study attempts to fill some of the gaps in the current knowledge base. Section 3 will define the specific aims of the study and clarify the process used to achieve these aims.
3. Aims, methods and development of the MACH

3.1 AIMS

This study aims to contribute to the existing body of knowledge about the main features of contracting and how it can be used in health care systems. This will be achieved by:

- developing an analytical methodology to:
  - help in the understanding of contracting and related concepts
  - facilitate the revision of contracting mechanisms in any country
  - assist in the development of contracting mechanisms in any country;
- applying this methodology to:
  - Germany and the United Kingdom, to test and refine it
  - Kyrgyzstan, to provide insights for the development of contracting mechanisms.

3.2 METHODS

Section 3.2 introduces the methods used in this study. Firstly, justifications are given concerning the choice of countries for empirical evidence. Secondly, the process of data collection is explained, showing how information was obtained from a review of the current literature and from interviews carried out in Germany and in the United Kingdom. Finally, the process of categorizing raw data for the development of a MACH is explained, including the role of the Expert Panel consultation and the first map of issues.

3.2.1 Selection of countries

For this study, three countries have been selected as the main focus of research: Germany, Kyrgyzstan and the United Kingdom. This choice is justified on the grounds that these three countries exemplify very distinct health systems with different approaches to contracting:

- Germany: a development of the Bismarck model, predominantly insurance-financed, with more decentralized mechanisms of planning and traditional separation of functions between purchasers and providers of health care;
• Kyrgyzstan: typical of the emerging model in central Asia, previously based on the Semashko model, which was state-funded and centrally planned in a closed economy;
• the United Kingdom: a development of the Beveridge model, predominantly tax-financed, vertically integrated in the form of a National Health Service, with formalized planning, budgeting and universal coverage.

3.2.2 Literature
The initial step was to carry out a literature review. This included reviewing articles and books dealing with contracting, either specifically or in general, in order to identify the issues which needed to be investigated and so become part of the MACH. The literature review was also used to check on new ideas, to provide follow-up on reforms being carried out in different countries and to verify information which emerged during interviews or informal discussions. The literature review has mainly concentrated on two countries with very distinct health care systems and different approaches to contracting: Germany and the United Kingdom.

The review started by using key words such as purchasing, purchaser–provider split, competition in health care and contracting. Several papers served as core material for the literature review, including Figueras (1993), Knox (1993), Le Grand & Bartlett (1993), Øvretveit (1995a, 1995b), Roberts (1993), Savas et al. (1998), Savas & Tragakes (1995), Ven (1994) and WHO Europe (1997). In addition, “grey” literature from Germany, Kyrgyzstan and the United Kingdom was used, together with drafts and publications from the WHO Regional Office for Europe.

3.2.3 Interviews
On completion of the literature review it was felt that there were gaps which could be filled through interviews. At the same time there were important aspects which, although discussed in the current literature, required further clarification.

Interviews were carried out in both Germany and the United Kingdom. For logistical reasons, the interviews carried out in the United Kingdom were restricted to Wales. This implies that some of the conclusions and problems arising from the interviews may be country-specific and therefore may not be generalized to the rest of the United Kingdom. In order to avoid unjustified generalization, the text clarifies whether or not a particular statement reflects observations from Wales. In Germany, data collection was more generic and interviews were carried out in different parts of the country.
In the case of Germany, the interviews also helped to answer questions which are not addressed in the English language literature. Finally, the interviews also helped in bringing to discussion recent reforms and plans for reforms, subjects which can take some time to be discussed in the major journals.

The interviews were semi-structured in order to allow the participants to create part of the agenda for discussion. This meant that the material originating from the interviews provided the study with extra perceptions and concerns which were not identified beforehand from the literature but have great relevance to day-to-day contracting.

The agenda for the interviews included questions designed to encourage the interviewees to talk about the contracting process in general and the role of each partner within this process. This broad agenda changed slightly, depending on the professional role of the person interviewed. More specific questions stimulated discussions in which interviewees were invited to express their views concerning the use of contracting as a tool for the implementation of national health policies. Legal aspects of contracts, the issue of competition among providers and problems with implementation of contracting were also discussed.

Key people in Germany and in the United Kingdom were selected for the interviews and a list describing their backgrounds can be found in Annex 1. The criteria used in the selection procedure reflected the following concerns:

- the interviewees should be representative of major stakeholders in the contracting process;
- they should be mainly people involved in performing activities forming the practical day-to-day work of contract negotiations and management – in other words, players rather than thinkers;
- they should have a reasonable understanding of and capacity to express themselves in English;
- they should be voluntary participants interested in having their opinions expressed in the study, in spite of no financial benefit being offered;
- they should come from geographical locations not too far apart within each country (a constraint due to the availability of time and resources for the study).

Clearly, the facts described in this study depict the reality of the situation within a specific timeframe. The interviews in Germany and the United Kingdom took place between April and May 1994, while most of the
literature review was carried out during 1995–1996. Although later articles and books were also used for updating the data collected, it is possible that specific details are now outdated. Nevertheless, the effect of any changes to the general picture does not undermine the usefulness of the methodology proposed in this study.

3.2.4 MACH: Map and panel discussion

Both the literature review and the interviews resulted in vast amounts of data. These two sets of data needed to be organized in a way which could facilitate logical manipulation. Elements of “grounded theory” (Strauss & Corbin, 1990)⁴ were selected to organize the available data from the literature review and the interviews. This particular methodology was chosen due to its systematic way of categorizing data derived from the observation of empirical phenomena.

The analysis of the interviews and the literature review resulted in what Strauss & Corbin call code notes (see page XX 99). Later, the code notes were used to create the first map⁵ of relevant issues in contracting, which represents the initial attempt to organize logically the information available at that time (Fig. 1).

The map provided a quick and logical overview of the issues which emerged from data collection. It was successfully used to form the basic framework for a panel discussion in November 1995. The objectives of this panel discussion were to test the MACH and to expose it to constructive criticism. For this purpose, a consultation on contracting mechanisms was organized and four experts were invited to participate.

The panel discussion basically consisted of exposing the map and the concepts it contained to experts from different countries and backgrounds. In order to allow for a lively and open discussion, no predetermined set of questions was provided to the participants. Instead, a broad agenda was prepared, the map of contracting was briefly explained and the participants

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⁵ There are different approaches to creating maps of logical thoughts. During this study, a methodology named cognitive mapping was reviewed. Such a methodology helps in creating “subjective and tentative systems of assertions about means and ends” (Eden & Huxham, 1988). Nevertheless, it was felt that the depth of cognitive mapping was not necessary in this study and therefore the map of issues presented here was created simply from the concepts which emerged during application of grounded theory (Strauss & Corbin, 1990).
### Descriptive analysis of contracts

#### Characteristics
<table>
<thead>
<tr>
<th>Attribute</th>
<th>Limited</th>
<th>Extensive</th>
<th>Broadly formulated</th>
<th>Detailed</th>
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<tbody>
<tr>
<td>Negotiating space</td>
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<tr>
<td>Degree of specification</td>
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<td>Degree of participation</td>
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<td>Level of negotiations</td>
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<tr>
<td>Degree of formality</td>
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<tr>
<td>Identity of interest</td>
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<td>Degree of enforcement</td>
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<tr>
<td>Scope for contracting</td>
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<tr>
<td>Flexibility for change</td>
<td>Limited</td>
<td>Extensive</td>
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<td>Accountability</td>
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<td>Scope for contracting outside</td>
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<tr>
<td>Pricing flexibility</td>
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<td>Frequency of contracting</td>
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<td>Level of information required for management</td>
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<tr>
<td>Scope for control of provision</td>
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<tr>
<td>Competitive pressures</td>
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</tbody>
</table>

#### Stakeholders in contracting
- Government
- Clinical personnel
- Associations
- Purchasers
- Citizens

#### The legal framework
- Source of laws
- No agreement
- End of contract
- Break of contract

#### Functions of contracts
- Vehicle for change
- Catalyst for planning
- Pressure mechanism
- Risk-sharing mechanism

#### Types of contract
- Block contract
- Cost and volume
- Cost per case
- Case mix
- Single item

#### Broader classifications
- Individual
- Collective
- Soft
- Hard

### Broader issues in influencing contracting
- The role of purchasers in contracting with providers
- Management of extra-contractual referrals
- Quality of purchasing
- Strategies for cost-containment
- Controlling the provision of health care
- Selective providers
- Risk-sharing between purchasers and providers

### Fig. 1. First map of relevance
Grant issues in contracting

Contracting as a process

<table>
<thead>
<tr>
<th>Major challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costing of contracts</td>
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<tr>
<td>Opportunistic behaviour</td>
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<tr>
<td>Contracting specialized services</td>
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<td>Contracting community services</td>
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<tr>
<td>Timetable for implementation</td>
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<tr>
<td>Quality measures in contracts</td>
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<tr>
<td>Freedom of choice (clinic/patient)</td>
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<tr>
<td>Unrealistic expectations</td>
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<tr>
<td>Administrative/transaction costs</td>
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<tr>
<td>Confidentiality of information</td>
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<tr>
<td>Constrained negotiations</td>
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<tr>
<td>Locked situations</td>
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<tr>
<td>Third parties’ loss</td>
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<tr>
<td>Opposition from main actors</td>
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<tr>
<td>Complexity of administration</td>
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<tr>
<td>Accountability</td>
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<tr>
<td>Human resources</td>
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<tr>
<td>Cultural change</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential benefits</th>
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</thead>
<tbody>
<tr>
<td>Increased accountability</td>
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<tr>
<td>Matching needs with provision</td>
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<tr>
<td>Better planning</td>
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<tr>
<td>Increased flexibility</td>
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<tr>
<td>Responsiveness to patients</td>
</tr>
<tr>
<td>Efficiency and quality</td>
</tr>
<tr>
<td>Responsiveness to purchasers</td>
</tr>
<tr>
<td>Reduced asymmetry</td>
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<tr>
<td>Improved integration</td>
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<tr>
<td>Increased output</td>
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</tbody>
</table>

<table>
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<tr>
<th>Prerequisites for good contracting</th>
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</thead>
<tbody>
<tr>
<td>Institutional/legal framework</td>
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<tr>
<td>Trained staff</td>
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<tr>
<td>Effective regulator</td>
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<tr>
<td>Negotiating skills (experience)</td>
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<tr>
<td>Clear objectives</td>
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<tr>
<td>Good quality information</td>
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<tr>
<td>Interest in health gain</td>
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<tr>
<td>Some balance of forces</td>
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<tr>
<td>Active buyers</td>
</tr>
<tr>
<td>Competitive bidding</td>
</tr>
<tr>
<td>Money follows patient</td>
</tr>
<tr>
<td>Monitoring of contracting</td>
</tr>
<tr>
<td>Partnership purchaser/provider</td>
</tr>
<tr>
<td>Assessment of capacity to deliver</td>
</tr>
<tr>
<td>Incentives for performance</td>
</tr>
<tr>
<td>Common contracting language</td>
</tr>
</tbody>
</table>

- Customer’s voice and exit
- Priority-setting
- Clinical freedom
- Management of service specifications
- Who should be the purchaser
- Measuring outcomes
- Competence of providers
- Controlling “innovations”
- Monitoring quality of health care delivery
- Sources of finance

- Health gain
- Equity
- Consumer choice
- Efficiency
- Effectiveness
- Responsiveness to patient’s needs
- Quality of care
- Sustainability
- Cost-containment
- Opportunity costs

Evaluation criteria

- Health gain
- Equity
- Consumer choice
- Efficiency
- Effectiveness
- Responsiveness to patient’s needs
- Quality of care
- Sustainability
- Cost-containment
- Opportunity costs
were invited to brainstorm on important issues for countries using or intending to use contracting mechanisms. This involved broadening the coverage of the most relevant issues in contracting, clarifying possible strategies for future analysis, highlighting methodological problems and solutions and generating new ideas on how contracting can be looked at.

3.3 DEVELOPMENT OF THE MACH

As a result of the panel discussion, some new issues were included in the study, some were merged and a great deal of country information was collected. Overall, the positive feedback from the participants indicated that the map contained the necessary elements for reviewing contracting in any country. Moreover, it was suggested that the issues included in the map could also be helpful in the development of contracting mechanisms.

In spite of the usefulness of the map for classifying data and assisting in the panel discussions, it was suggested that it should be simplified and its structure improved. The map was therefore streamlined and the existing concept further refined. This involved:

- defining a new logic for the presentation of the relevant issues in contracting;
- selecting aspects to be omitted due to lack of information;
- further merging of concepts and ideas under single categories according to issue;
- further data collection to complement the information available on each item selected for inclusion in the final text.

As a result, a smaller selection of issues emerged and the map evolved into a framework or what is referred to in this study as the methodology for analysing contracting in health care (MACH). With the exception of the “evaluation criteria” box, almost all the boxes from the first map were grouped under new headings or categories, namely: “Focus on the Context”, “Focus on Contracting” and “Focus on Development: Management of Change”.

The idea of developing evaluation criteria for contracting was discarded because it would represent a study of its own and would involve evaluating value judgements. Nevertheless, in order to capture the essence of the ideas contained in the evaluation criteria box from the first map, this category was restructured and reframed in the section dealing with the functions of contracts. Here, instead of referring to evaluation criteria, the ideas were redeveloped and in the final text became part of the goals that policymakers aim at when using contracts to implement health policy.
The concepts falling under the heading “Prerequisites for Good Contracting” lost their meaning once it was decided that the study should minimize value judgements. By combining the concepts originally developed for this box with the concepts in the “Major Challenges” box, the original ideas were reorganized to form a section in the final version entitled “Focus on Development: Managing Change”. It was felt that the classification “prerequisites” was too strong, since in reality no country would be able to deal with all the issues proposed in the map prior to implementing contracting. Under the new title “Focus on Development: Managing Change”, the ideas of the original work could be retained but with a less demanding tone, implying that there are lessons to be learnt and some important issues to be addressed prior to contract implementation.

As a result of the panel discussion, it also became clear that there was a degree of overlap between the concepts falling under the headings “potential benefits of contracting” and “evaluation criteria” (see map). The new organization described above dealt with this problem and enhanced the logic of the final text. A similar procedure was used in dealing with other categories in the map. For example, the box entitled “Stakeholders in Contracting” was placed in the MACH under the heading “Structure and Key Participants in the Health Care System” in the section entitled “Focus on the Context”. The change in headings is justified on the grounds that the concept “stakeholder” has a strong theoretical meaning in other sciences and therefore it could confuse the reader already familiar with the term “stakeholders’ analysis”, a particular technique not applied systematically in this study.

From the box entitled “Broader Classifications” the concepts of individual/collective and hard/soft contracting were distilled and formed the basis for defining some of the characteristics of contracts. The box entitled “Content of Contracts” did not contain any concepts as such, only a list of the topics normally found in contracts. It was felt that for the purposes of this study these topics did not require further development, although they could be helpful as a check-list of what purchasers/providers could include in their contracts. Thus, the contents of contracts are presented as a list of topics in Annex 3: Content of Contracts. The boxes entitled “Functions of Contracts”, “Characteristics” and “The Legal Framework” were further developed and remained in the MACH under their original headings. The concepts in the box entitled “Types of Contracts” were revisited and from the analysis it was concluded that the different types of contract were based on methods of payment of providers. As a result, the original concepts were incorporated in the MACH under the section “Defining payment methods”.
Finally, the concepts falling under the heading “Broader Issues Influencing Contracts” were re-positioned in different parts of the final text, in accordance with the new logic developed for the MACH. The final result is presented in Table 1 below. The regrouping of the issues in three columns involved changing the previous division based on “descriptive analysis” and

<table>
<thead>
<tr>
<th>Focus on the context</th>
<th>Focus on contracting</th>
<th>Focus on development: managing change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principles underpinning health care systems</td>
<td>Understanding the contracting process</td>
<td>— Feasibility of contracting</td>
</tr>
<tr>
<td></td>
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<td>6. Communicating the objectives and expected changes . Leadership for change 7. Communicating the objectives and expected changes . Action planning 0. Piloting</td>
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<td></td>
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<td>— Moving to the future</td>
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<td>— Dealing with key players</td>
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<td>— Managing other contextual factors</td>
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<td></td>
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<td>. Maintaining the routine work</td>
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<td></td>
<td></td>
<td>2. Culture and social values . External influences</td>
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</tbody>
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Table 1. The methodology for analysing contracting in health care (MACH)
“contracting as a process”. The new organization was felt to be more logical and helpful for the reader. In the first column, the focus is on the importance of taking into consideration contextual factors in the development of contracting. These are factors which influence contracting but are not necessarily directly related to it. The second column, entitled “Focus on Contracting”, looks at contracting itself. It helps in understanding contracts as mechanisms within health systems and explores their functions, major characteristics, potential benefits and other relevant aspects. The third column header, “Focus on Development: Managing Change”, covers points to be considered in managing the transition from an integrated system to a system where purchaser-provider functions are differentiated and contracts can be used.
4. **MACH in Germany and the United Kingdom: focus on context**

As part of the process of reviewing contracting, the MACH proposes a systematic review of the health care system of the chosen country: how the system is financed, organized and managed and how services are provided. However, since both the British and the German health care systems are well described elsewhere, Section 4 contains only basic principles and a very brief overview of those systems.

### 4.1 PRINCIPLES UNDERPINNING HEALTH CARE SYSTEMS

**United Kingdom**

Some principles have been accepted as essential for improving the living standards of the population of the United Kingdom:

- universal coverage: all citizens are entitled to the services provided by the NHS;
- comprehensiveness: the provision of all necessary health services should be guaranteed by the NHS;
- accessibility: services should be available to everyone, regardless of place of residence;
- equity: services should be provided on the basis of clinically defined need rather than ability to pay or other considerations; thus most services should be available free of charge;
- tax-based: finance for the NHS originally came only from a combination of taxes and insurance contributions; this was later supplemented by limited charges for prescriptions, dental care and eye tests.

**Germany**

The German system evolved from the model proposed by Chancellor Bismarck in 1883 and is based on the following principles:

- federalism: legislation exists at federal (Bund) and state (Land) level;
- subsidiarity: when appropriate regulations at state level are considered possible, the federal level shall restrain from legislation or confine itself to framework law;
• self-governance (*Selbstverwaltung*): purchasers and providers should operate as independent, self-managing organizations with as little interference from the government as possible;
• social partnership: employers and employees should share the costs of financing health care services;
• social solidarity: the economically stronger members of society should support the weaker members;
• pluralism: the system is based on a well organized negotiation process that involves various participants and is aimed at obtaining consensus;
• universal coverage: social insurance should be available to all legally recognized citizens.

4.2 STRUCTURE AND KEY PARTICIPANTS

*United Kingdom*
Health services are primarily provided by the state-owned (NHS, which has its origins in the Beveridge report published in 1943 (Beveridge, 1942). Since the late 1980s, the NHS has been going through a crisis of confidence. This led to a revision in the early 1990s, when central planning mechanisms were gradually replaced by an internal market\(^6\) characterized by the purchaser–provider split and strong reliance on contracting mechanisms. Through this reform process, health authorities became the main purchasers of health care, while hospitals and other units providing community services gradually became independent trusts. Some general practitioners (GPs) were also allocated budgets, becoming both purchasers and providers of services.

Under the current structure, primary health care and public health services are delivered mainly by GPs and community trusts. Secondary and tertiary services have been mostly provided by hospital trusts. These trusts are self-governing organizations.

Decisions about the allocation of resources to health districts rests with central government and is based on a capitation formula adjusted for local variables, taking into account health care needs and costs.

\(^6\) Current literature and debate use different terms to define health care markets. Ham (1994) suggests the use of “managed markets”, Glennerster & Le Grand (1995) use “quasi-markets” while Saltman & von Otter (1992) refer to “planned markets”. Although variations on the terminology are justified on the grounds of different theoretical approaches to the understanding of health markets, these are not discussed here. In this text the term “quasi-market” is adopted to indicate that it would be misleading to consider health care markets to be equivalent to other commodity markets.
The key participants in the system on the purchaser side at the time of this study were the district health authorities and the GP fundholders. The former have now been incorporated into the newly-created health authorities while the latter have since then increased their importance.

On the provider side, NHS trusts have been key players since the very beginning. They have grown in number and in the scope of the services they provide. By 1994 they were responsible for more than 90% of all hospital and community services (Robinson & Grand, 1994). GP fundholders also provide services.

Other key players include the Government – the mastermind and guardian of the whole system; the Welsh Office – now the de facto health authority and Department of Health in Wales; GPs, who are responsible for referring patients to secondary and tertiary levels of care; the private sector, where services are bought and sold to NHS trusts and GP fundholders as well as to people with private insurance and those who pay themselves; and the royal colleges, which oversee the training of specialists and the accreditation of hospital departments (see Annex 4).

**Germany**

In Germany health services are provided by autonomous parties, including statutory sickness funds, hospitals, associations of sickness fund physicians (ASFPs – in German Kassenärztliche Vereinigungen) and others. They are generally organized at two different levels: federal (Bund) and state (Land) level. Central to this system are the negotiations between the sickness funds (Krankenkassen) and both the ASFPs and the hospitals. These negotiations influence the delivery of care at all levels.

Practice-based physicians are responsible for providing ambulatory care. Secondary and tertiary care is provided by public hospitals, private voluntary hospitals and private for-profit hospitals. Services such as nursing homes for the elderly are provided outside the statutory system by voluntary organizations and local authorities. Public health services are mainly provided by local government. With isolated exceptions, there are no special terminal care facilities and most patients end their days in hospital.

Funds for the provision of health services in Germany mainly originate from the contributions paid to the sickness funds by their members and their employees. Funds are also available from taxes collected by the government (at Bund and Land levels), mainly to provide cover for the unemployed and to finance investments in infrastructure.
The allocation of resources is mostly dependent on negotiations. In the case of hospitals, costs are covered partially through contracts with sickness funds and partially through government subsidies. These subsidies normally come from the Länder, which are responsible for funding investment costs for the hospitals according to a plan prepared for each Land by its government.

In relation to the key participants, on the purchaser side, the sickness funds perform the major role, contracting with the associations of physicians, dentists, etc. On the provider side, the ASFPs are regionally organized associations responsible for negotiating with the sickness funds the total payment they will receive from the funds.

Other key players include the Federal Government, which has a major role as a regulator; the Länder governments, which make the final decisions on the planning of hospitals; hospital associations, which are responsible for setting the annual wage increases for clinicians and nurses through negotiations with their respective trade unions; the Chamber of Physicians (Ärztekammer) which defends the interests of physicians and regulates the profession; the trade unions, which also send representatives to the negotiations at federal level; insured persons and the public, who can participate in the sickness funds’ decision-making bodies through their representatives; and many other voluntary organizations and societies, through their lobbying activities (see Annex 5).

4.3 REGULATORY FRAMEWORK

Regulations governing health systems can originate from the Government, quasi-public organizations (e.g. associations), nongovernmental bodies (e.g. trade unions), commercial agencies (e.g. the Peer Review Organization), international organizations and so on. In the case of central governments, their regulatory function is exercised mainly through controls on prices, the quality and kind of services, and entry into the market.

Various institutions may engage in joint development of regulations (a pluralistic approach), or regulation may originate from central government (a centralized approach). These institutions may work at different levels (e.g. national, regional or local) and they may produce rules which can vary from the very detailed to the broadly formulated.

In the context of health services and contracting between purchasers and providers, Øvretveit (1993) considers that health markets are the most regulated of all, with state regulations mainly relating to:
managed competition, to avoid duplication or to ensure that it exists when it is required and that it conforms to the public interest;
• the worst excesses or ethically acceptable consequences of full market competition (e.g. risk selection);
• externalities, e.g. immunization, infectious disease control and other areas where individual action is ineffective.

This study proposes that the following types of state regulation should also be considered:

• benefits’ package regulation, to guarantee the minimum list of services which purchasers are obliged to contract and, if feasible, the level of quality expected;
• membership regulation, to determine whether or not the population is free to choose their insurers and how membership should work (compulsory/voluntary, etc.);
• contracting process regulation, to deal with situations where agreements are not reached, contracts are broken or have expired, services have to be provided between contracts, etc.

Finally, it is also important to consider that the monitoring function complements the regulation function. In this respect, the literature emphasizes that the role of the regulator is highly dependent on the existence of good quality information. If information is not available, the regulator will not be able to make the different players comply with the rules (Le Grand & Bartlett, 1993).

United Kingdom
The legal status of contracts within the health care system is not clear in the United Kingdom. This appears to be deliberate, in order to avoid the complexity and costs of legal battles over the fulfilment of contracts. Instead of using the courts to resolve disputes, the Government has opted for arbitration mechanisms (Mason & Morgan, 1994). The lack of legal definition was not considered a problem by most of the people interviewed in this study, although there was a consensus that an arbitration system was necessary: “Rules are being established as we go along and they have been modified, but that is OK. There is a broad structure and we follow that. But there are problems as a result, which is why the Welsh Office is still quite an important mediator” (Interviewee 21, 1994: Wales).

Due to the current structure of the health care system in the United Kingdom, understanding the legal framework for contracting involves looking
at the organizational structure of the NHS and its links with central government. This is necessary since most of the regulations originate from these institutions and are not formalized in law. In fact, the framework for contracting and dispute resolution is established by statute, and the NHS agencies are compelled to follow it (Jost et al., 1995).

In order to legislate and exercise the planning function in the health sector, the central government and its agencies use several instruments which in effect trickle down the chain of command until reaching the contractors:

- white papers and consultative papers are published by the Department of Health to indicate major directions in government policy and new strategies which government agencies are required to implement;
- executive letters provide guidance from members of the NHS Executive to health service managers on specific implementation issues and tend to include more detailed advice than the white papers;
- circulars are issued by the Department of Health on various topics; they can stipulate particular procedures or simply draw attention to some aspects related to specific points.

In order to implement national policy, the Secretary of State for Health has strong powers. He/she can effectively intervene in the HAs and NHS trusts and force them to comply with central decisions on any aspect of their work. The Department of Health also intervenes by defining priorities and setting targets for the HAs.

In contrast to Germany, major actors in the NHS are not bodies in public law and are not empowered to develop complementary legislation. The implementation of policies and legislation remains in the hands of central government. This has led to criticism in view of the inefficiencies associated with centralized, producer-oriented organizations, as previously discussed. Partly in response to this and other criticisms, changes were made through the Health Service and Community Care Act of 1990. This Act, together with other measures, created the institutional division between purchasers and providers of care and started a process of decentralization of control.

In spite of the rhetoric about decentralization, government regulation in the United Kingdom remains high on the agenda. The central government, through its agencies, currently defines:

- the general form of the contracts between purchasers and providers
- quality standards for new entrants in the internal market
• terms of access to capital markets
• rates of return on capital
• pricing rules
• regulation of entry into the internal market.

Germany
Health care in Germany is regulated and supervised by both federal and Land ministries (as well as other organizations such as the Federal Insurance Office). Due to the federalist approach, the basic laws concerning health care and its financing are set at the federal level while regulation and supervision is largely the responsibility of the sixteen Länder which constitute the Federal Republic of Germany (NERA, 1993).

The Social Code contains the social security regulations and the regulations governing the functioning of the Statutory Health Insurance system (Sozialgesetzbuch V - Gesetzliche Krankenversicherung or SGB V). The minimum benefits package to which all Germans are entitled is also defined in the SGB V. Basically, the law stipulates that all sickness fund members are entitled to receive unlimited ambulatory and hospital care.

In order to provide for the availability of unlimited care, sickness funds have to contract services from various providers. These contracts deal with different aspects of health care provision, but the major item in the negotiations is the reimbursement of providers. Decisions reached between provider and purchasing associations are always binding for their constituency. Consequently, contracts involving federal associations are binding for the whole country, whereas the deliberations of the Länder associations only result in binding agreements for their respective Land.

In compliance with German law, contracts between sickness fund associations and provider associations covering reimbursement levels have to be in place at all times (NERA, 1993). Since reimbursement is made through a points system, fee schedules for services have to be set and this involves negotiations at the federal level. If disagreement arises during negotiations, the matter must be resolved by a federal Joint Arbitration Committee. This includes representatives of the sickness funds and the associations of dentists, physicians and hospitals.

4.4 SUMMARY
In Section 4 we have focused on contracting in health care in the context of the United Kingdom and Germany. As can be seen, although both
countries have adopted similar principles and have populations of comparable size, there are many differences in the ways their health care systems have developed and function. From the organizational point of view, parties in Germany enjoy more autonomy in negotiating contracts at all levels. Also, decisions are more pluralistic and resource allocation is mostly in the hands of the contracting parties, with little influence from the central level. Nevertheless, regulation in Germany is more comprehensive and contracts are binding for the constituencies of the negotiating partners.
5. MACH in the United Kingdom and Germany: focus on contracting

5.1 UNDERSTANDING THE CONTRACTING PROCESS

United Kingdom

At the national level, deliberations are similar to those in Germany and relate mainly to defining and guaranteeing compliance with the broad principles of the health system. In contrast, no contracts are negotiated at the national level. This means that there are no national associations with rights to contract or to set up enforceable national guidelines on behalf of their members. Paradoxically, decision-making is more centralized, since the central government has strong powers to define the rules of the game. This contrasts with Germany, where the federal government cannot interfere with the rules, which are defined locally, provided they are not in breach of the constitution.

Major decisions concerning the allocation of substantial resources are made at the national level and are not negotiated with purchasers or providers. It is noticeable that contracting plays no role in budget-setting. This contrasts with Germany, where budgets are negotiated by the contracting parties at the Land level.

At district level the bulk of contracting has been carried out by health authorities and GP fundholders, the latter with an increased role as purchasers of health care over the last few years. In 1993, about 25% of the English population was covered by GP fundholders (Øvretveit, 1995a), this figure rising to about one half of the population by 1995 (Mechanic, 1995). GP fundholders are encouraged to compete for patients and to bargain with other provider units, creating competition for fundholders’ contracts (Calnan & Williams, 1995). Acting as purchasers of hospital and some primary care services, GP fundholders contract with the private sector (mainly for elective surgery) as well as the public sector. However, to date the majority of the services contracted are provided by NHS trusts and directly managed units of the NHS rather than the private sector. Fundholders can also choose to provide services themselves as opposed to contracting them out.
After the introduction of the internal market, health authorities can be seen as agents for non-fundholder GPs, contracting for accident and emergency services, general medical admissions, tertiary services and some community services. Through consultations with GPs and local consumers, they are expected to plan for purchasing and to add value to the process by adopting a broader public health perspective and increasing the responsiveness of the system to patients and to their supposed spokesperson (the GP).

In a simplified explanation, contracting from the point of view of the Welsh health authorities has involved the following stages (West Glamorgan Health Authority, 1993):

- assessment of health needs (decide priorities, balance needs/wants)
- service specifications (elaboration of the contracts)
- negotiations with providers (select providers, reach agreement on contracts)
- monitoring.

A basic contradiction exists in the model: on the one hand, health authorities have been expected to carry out formal needs assessments (often in areas with populations of around 500,000 people with a wide range of needs) as a basis for their purchasing decisions. On the other hand, GP fundholders are expected to contract for a much smaller population (approximately 10,000 patients per practice) in a bottom-up approach which is often demand-led rather than health gain-oriented.

This contradiction makes it difficult for the contracting process to achieve basic principles such as equity and to lead purchasing on the basis of a broader public health view: “With the very key role GPs are seen as having in determining health care priorities today, the issues of equity and public health in a wider context fit uneasily into the United Kingdom” (panel discussion, 1995: interview).

**Germany**

At the federal level, most of the discussions and deliberations are related to defining and guaranteeing compliance with the overall legal framework regulating the provision of health care, rather than actual contracting

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7 This item focuses on the contracting process between sickness funds and the associations of sickness fund physicians. Although many other decisions are taken at the federal level, with the participation of several other associations, these are not examined in this text for reasons of space.
negotiations. Nevertheless, the decisions at this level define the rules of the game and are therefore essential to the contracting process.

At this level, the government supervises the sickness funds, ensuring that all decisions are in accordance with the law. Also, the Ministry of Health receives proposals for changes in the legal framework. Interestingly, the government cannot veto any decision taken by the sickness funds and the associations which is not in breach of the law.

Besides proposals for changing the law, federal associations discuss proposals for the guidelines to be applied in ambulatory care. These describe how the system should operate and have the power of law for every physician. They specify, for example, that only one structure of ambulatory care should be in place and that the same services should be provided by all sickness funds. The guidelines are discussed by the Bundesausschuss, which is a special committee formed at the federal level by representatives from the sickness funds, the physicians and the Ministry of Health. The Bundesausschuss receives input from several subcommittees which deal with different types of guideline.

Once the guidelines are agreed in the Bundesausschuss, they are submitted to the Ministry of Health, which is empowered to ensure that they are in accordance with the law. The guidelines can then become effective without the approval of the Parliament. They become, in fact, “law under the law”, created and approved by the self-governing bodies of the sickness funds and the ASFPs (Interviewee 3, Germany, 1994:interview).

The federal associations also propose recommendations at the federal level. The recommendations indicate how the sickness funds and the ASFPs intend to handle different aspects of the contracting process that takes place at the state level. However, the recommendations do not have the power of law. Together with some broad guidelines, these recommendations are intended to be defined in detail at the state level. These deliberations, which are subject to changes (the Öffnung Klausel) in the contracts at the state level, constitute a compromise solution that returns power to the Länd level.

The federal level is also the arena for discussions on the benefits package and the relative scale of the points which doctors accumulate for providing these services. The final scale is valid for all sickness funds, although the monetary value of each point will only be defined at the state level, through negotiations between the sickness funds and the ASFPs.
Other, less contentious, issues discussed at the federal level include agreement on documentation, quality measures, required educational levels for the professionals involved in health care provision and other general managerial issues.

At Land level, two major types of issue are discussed: (i) the budget, both for the hospitals and the sickness fund physicians, and (ii) how to fulfil the guidelines and recommendations which the different parties have discussed and agreed at federal level (fulfilling the Öffnung Klausel). Because of the clear division between hospital and ambulatory care (primary care) in Germany, it is helpful to look at this from two different perspectives.

5.1.1 Ambulatory care
One of the most important issues for bargaining at the state level is the budget for the sickness fund physicians. As part of the process, both the sickness funds and the Land associations of sickness fund physicians send representatives to a joint committee. These representatives negotiate until a consensus is reached and a budget for the following year is fixed. An important constraint on the bargaining process is provided by the legal framework as defined at the federal level: the costs of the health care system should not increase by more than the average worker’s earnings so that the contribution rates paid by the insured are kept stable (Schulenburg, 1994). If a consensus cannot be reached, an arbitration committee is formed and a compulsory agreement enforced. Traditionally, the threat of arbitration (which may not be advantageous for either party) works as an incentive for consensus-building.

The ASFPs and the sickness funds will also contract on the form of payment which will be used to remunerate the sickness fund physicians. The different forms of payment are defined by law (SGB V) and can be combined (see section 5.1, Germany). Once the budget is calculated, the sickness funds transfer the resources to the ASFPs in each region on a quarterly basis (SGB V). The association pays each physician on a fee-for-service basis in accordance with the applicable points scale and the claims submitted by each physician.

The outcome of the negotiations is supervised by the Land authorities or, when federal associations are involved, by the federal authorities. However, as long as decisions are not in breach of the law, government authorities do not interfere in contracting matters.

The joint administrations of the sickness funds and the ASFPs also negotiate the details of the guidelines which have been broadly formulated at the
federal level. The approved proposals constitute part of the legal framework and can be enforced by law at the state level.

5.1.2 Hospital services

The major negotiation is on the prospective budget for hospitals. Individual hospitals negotiate with representatives of the regional associations of sickness funds plus a representative of the private insurers. The budget covers all running costs including staff, materials and drugs. The total amount contracted is based on data from the previous year (number of patients, bed-occupancy days, etc.). Mostly, the budget negotiation yields an all-inclusive *per diem* rate, although other forms of payment are also permitted by law (see section 5.1, Germany). Because of the negotiating skills of the parties and the different costs across several regions, the negotiated *per diem* rates can vary widely (Schulenburg, 1994). This is particularly the case with specialized hospitals, which usually have higher expenditure than general hospitals. Thus, it is common that specialized hospitals negotiate special prices in the contracting process. As with the negotiations between the ASFPs and the sickness funds, if consensus is not reached, an arbitration committee is formed. Traditionally, about 95% of the negotiations are concluded by consensus (Interviewee 5, Germany, 1994: interview).

Criticisms exist linking lack of efficiency in the hospital sector with the fact that sickness funds are obliged to contract with all hospitals which are part of the *Land* plan. Although the sickness funds may submit a request to be exempted from contracting with a hospital which they consider inefficient, the *Land* government has the final say. The traditional alternative for the sickness funds is to collect information about a particular hospital and make a case for keeping it out of the next plan. It seems irrational that sickness funds do not participate in the planning of hospitals even though they have to contract with them and bear the operating costs incurred.

Concerning the legal framework governing the contracts for hospital care, an important distinction has to be made: in contrast to the ASFPs, hospital associations are not persons of public law. As a result, the sickness funds cannot have collective contracts with hospital associations and are expected to negotiate with each hospital separately.

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8 The hospital plan indicates for each region which hospitals are allowed to operate and receive investments from the *Land*. Based on data regarding the needs of the population, location and availability of beds, the *Land* government prepares the hospital plan, which in turn determines which hospitals are to be contracted by the sickness funds.
5.2 FUNCTIONS OF CONTRACTS

5.2.1 Implementing health policy

Contracts can be used as mechanisms for introducing changes in health care delivery. These changes may be broadly defined in the national health policy or they may reflect local requests for new organizational arrangements.

The use of contracts to implement policy can contribute towards emphasizing the planning function and facilitating the definition of targets. This is mainly because when they set up contracts, purchasers often carry out needs assessment and priority-setting exercises. Contracts can be the formal mechanism linking the identification of needs and the purchasing of services to satisfy these needs. Still, realization of the potential of contracts as tools to implement health policy will depend on how they are operationalized (Figuera et al., 1993).

When used as tools for the planning function, contracts can also work as monitoring instruments since purchasers may refer to indicators specified in the contracts in order to evaluate compliance (Jones, 1995).

Because contracts usually have a predefined duration, the process of negotiating new contracts can formalize a cyclical re-evaluation of the strategic intents of both parties. Subjected to the availability of resources (staff, skills, finance), the revision of contracts can contribute to keeping plans adapted to new technological advances, demographic changes and other external factors which affect health care provision.

**United Kingdom**

Health policy is broadly determined at the national level. In the medium term, the document *Priorities and planning guidance for the NHS*, published in 1995 by the NHS Executive, sets out six priorities. These are the most important national priorities for health authorities to implement (Merry, 1996).

At the regional level in the United Kingdom, England, Scotland, Wales and Northern Ireland are expected to follow national priorities, although they may do this in different ways. In England, the *Health of the nation* document (Secretary of State for Health, 1992) provided a strategic approach to improving the overall health of the English population, setting targets for improving health in five key areas. In Wales, the Welsh Office translated the priorities into a challenge to those working in the Welsh NHS: “The NHS should aim to take the people of Wales into the 21st century with a level of health on course to compare with the best in Europe” (Welsh Office, 1989: interview). The strategic direction determined how the intent could be
secured, that is, through activities which should be focused on health gain, people-centred and resource-effective. Aims were identified for the three strands of the strategic direction. Protocols for investment in priority areas were developed, which later culminated in local strategies and contracts: “We try to make sure that we have the big picture and then we have try to develop contracting mechanisms that are capable of delivering that bigger picture.” (Interviewee 8, 1994: Wales.)

Despite the existence of arguments in favour of contracting as a mechanism with which to implement health policy and enhance the planning function (Figuera et al., 1993), it is clear that trade-offs are involved: “The biggest disadvantage is that now it is very difficult to plan health care. Strategic planning for the hospitals, for example, is extremely difficult. You have thirty GP fundholders and five health authorities, and they are all dealing with us [NHS trust directors] and they all have different views about what they want the services to be.” (Interviewee 14, 1994: Wales.)

Germany
The German Government is not involved in devising and promulgating national health policy. Therefore contracts are not used as tools for implementing and monitoring national health policy. The federalist approach means that a great many policy decisions are taken at the Land level. As a result, “There is no priority setting ... According to our constitution, the health field is primarily the responsibility of the Länder ... That means 16 health policies, sometimes 16 different health policies ... If there are special needs, then this is not evaluated, it is the decision of the physicians.” (Interviewee 6, Germany, 1994.)

Also, the legal framework, combined with a traditional approach, has resulted in sickness funds paying great attention to following the law rather than to developing strategic planning. “In Germany the SGB V says that the patient gets everything that is appropriate and necessary for his care. This means that in the first place there are the patients whose needs have to be satisfied and in the second place the system has to come up with enough money to pay for it.” (Interviewee 4, Germany, 1994.) Thus, some argue that there is no real planning to be implemented: “In Germany the public health field is like that of a developing country. It is very weak. It happens only at the community level. Health policy in Germany is health insurance policy.” (Interviewee 3, Germany, 1994.)

Despite the different approaches to health policy in both countries, this study concludes that contracts can be important mechanisms for implementing
health policy. When using such a mechanism, decision-makers will be looking mainly at matching needs to provision and increasing accountability, choice, efficiency and quality.

**Matching population needs to provision**

Contracts can be the formal link between the identification of health care needs and the purchasing of services to satisfy those needs. In theory, needs assessment is used to guide the choice of priority areas which can then be tackled through purchasing plans and the specification of services in the contracts (Jones, 1995).

Separate purchasing agencies are believed to be more careful and independent in assessing population needs and how well these needs are being met (Harrison, 1991). Also, when contracting takes place at the local level, the authorities are thought to be more sensitive to local needs and that citizens therefore have a greater chance of being heard.

In spite of these positive statements, it is recognized that it is difficult to define needs (Clark et al, 1995). Moreover, contracting cannot be based solely on needs assessment. The allocation of scarce resources for health is also guided by ethical principles. For instance, contracting expensive technology for a small village can have the merit of matching needs but is not efficient and hardly acceptable as a good investment in health.

In several countries, purchasing according to needs is still underdeveloped. Contracting, by itself, will not change this.

**United Kingdom**

The interviews carried out suggest that the introduction of contracting did not encourage the United Kingdom system to be more responsive to patients’ needs. In fact, the interviews suggest that traditional patterns of behaviour prevailed on the purchasers’ side. “My personal view is that there is no one really purchasing in line with strategic intents. It is pretty much a case of what we are doing now is what we have been doing for a long time.” (Family Health Service Authority, 1994: Wales, interview.)

“In practical terms, a purchasing authority looks first of all at what it has been told by the central government to do ... They would look second at what their provider units are screaming at them. And when they sorted those out, they would then look at... what their provider units are suggesting they might invest in new services, and if there is any money in the kitty, it is for that. ... Most purchasers are not being proactive ... They react to
suggestions that their providers are making to them. That is the way it works in practice, that is not the theory, that is how they do it.” (Panel discussion, 1995.)

**Germany**
Assessing the health needs of the population is not a routine task within sickness funds. Thus, it is difficult to relate the contracting process with increased responsiveness to needs: “Basically this [needs assessment] is not carried out by sickness funds on a routine basis. This applies to all sickness funds. They do not carry out epidemiological evaluation or any specific work on needs assessment. . . . The sickness funds’ services and financing are very much standardized by law. It is a catalogue of what the sickness funds have to pay and what they do not.” (Interviewee 2, Germany, 1994.)

Also, until recently, it appears that sickness funds were being responsive to physicians’ needs rather than population needs: “The medical society would come and say we need this and that and we would talk about it. We would say OK, bring us proven quality and we will pay for it. There was enough money to pay for everything. There was no systematic evaluation, just a small discussion.” (Interviewee 3, Germany, 1994.)

**Increasing equity**
The concept of equity is nebulous and difficult to measure (Robinson, 1994). According to WHO, equity in health implies that everyone should have a fair opportunity to attain their full health potential (Whitehead, 1990). However, in most countries differences in health exist between different social groups in the population and between different geographical areas. These differences, when unnecessary and avoidable, constitute the target for policies aimed at increasing equity.

Increasing equity often requires that priority and extra resources be given to those facing the most serious health hazards and those most deprived (Abel-Smith, 1994). Therefore, contracts can support equity by taking explicit account of these groups. For this purpose, needs assessment may be required as part of the contracting process (Savas et al., 1998).

One of the problems in implementing equity is that the principle may cause tension with other socially desirable goals of public policy. For instance, markets may be proposed as a way of promoting individual freedom, choice and competition. Yet free competition in providers’ markets may induce professionals to select groups of patients or diseases which offer the best opportunity for providers to increase their income and/or power. In
doing so, providers are in fact acting against equity. Similarly, tension exists between equity and choice, since purchasers seeking to increase choices and respond to consumers’ views may take decisions that disregard the long-term impact on equity and the health of the population concerned.

**United Kingdom**

Currently, with the key role of GPs in determining health care priorities, the issues of equity and public health in a wider context fit uneasily. In fact, equity is considered to be the Achilles heel of fundholding. “Anything that you introduce into a service by way of competition or freedom must imply that somebody else does something different. That, presumably, is inequitable, because one presumably is better than the other from a public health point of view” (Panel discussion, 1995: interview.)

In this context, some argue that the introduction of contracting mechanisms and GP fundholding in the United Kingdom has decreased equity, creating a two-tier service where provision to patients by GP fundholders differs from provision to patients by non-fundholders. To give one example, Glennerster et al. (1994) observed in their research that hospital consultants were hostile to patients coming from fundholders, mainly in the initial phase of the scheme. As fundholders started to contract with other providers, this tendency was reversed. Other commentators disagree that GP fundholding and contracting have contributed to less equity, arguing that different levels of service were already part of the NHS and therefore fundholding and contracting have only contributed to making this situation more explicit (Fewtrell, 1994).

It is also acknowledged that most GP fundholders do not perform needs assessment and do not take a public health approach to health services provision. In fact, GP fundholders are accused of setting up contracts and then referring patients to specific providers on a first come, first served basis, clearly aimed at reducing waiting lists. In doing so, fundholders are not contributing to increasing equity, since they are not diverting resources to those individuals in greatest need.

Looked at from the point of view of health authorities as purchasers, contracting has not made much difference in terms of increasing equity. Health authorities are better equipped and usually cover larger populations. In principle, this should make the task of needs assessment and purchasing for those in most need easier. However, evidence from this study shows that contracting did not contribute to increased equity (see quote above).
Germany
In general, contracts in Germany are not used as mechanisms to improve equity. In fact, this study did not find any mechanisms for identifying those facing the most serious health hazards and those most deprived in Germany. Sickness funds are expected to buy all necessary services without embarking on prioritization exercises (Interviewee 3, Germany, 1994).

However, from the point of view of the characteristics of the contracting process, the collective nature of contracts in Germany is considered an important element in guaranteeing equity. Since the agreements reached on any particular matter are binding for all sickness funds and physicians in the Land concerned, collective contracts provide a higher degree of equity in terms of the range, access and quality of the services provided (Panel discussion, 1995: interview).

Increasing accountability
Contracts are expected to help make providers of health care more accountable to purchasers for what they produce, the final quality of the services and the prices charged (Figuera et al., 1993).

In a simplified framework, accountability can be seen from two different perspectives: (i) from the point of view of the providers, who can be monitored by the purchasers – this is an issue that attracts a great deal of attention; (ii) it is also important to consider a legal framework which guarantees accountability on the part of the purchasers, who should be accountable to the population through various mechanisms.

The first perspective touches on a delicate area. This is mainly because accountability on the part of medical professionals may depend on negotiations that impinge on professional freedom. Although the debate on this topic is still raging, the bottom line appears to be that on the one hand professionalism cannot be used as a device to distance a particular group from accountability, while on the other, too much emphasis on accountability based on productivity and cost-containment achievements may lead to the marginalization of vulnerable citizens (Malek et al., 1993).

Although confirming the potential of contracting for improving accountability, the data collected in this study have shown that improvements in terms of accountability will likewise depend on: (i) the existence of mechanisms to monitor the contracts, and thus the information systems necessary for this task; (ii) management capacity to carry out the monitoring tasks;
and (iii) the existence of purchasers/commissioners with a sufficient level of legitimacy to decide on behalf of their populations.

**United Kingdom**

Trusts are accountable primarily via the contracts they negotiate with purchasers. Thus, an arrangement came about whereby the NHS began to monitor the performance of trusts (Ham, 1994). Ultimately, the systematic approach to auditing is expected to induce more accountability (Artundo et al., 1993). Early empirical evidence supports the above argument. “We are auditing more now and if the best practice turns out to be something that someone is not doing then we could remove their clinical freedom to encourage them to adopt what is the best practice” (Interviewee 12, United Kingdom, 1994).

From a different point of view, the House of Commons has warned that the very fact that public money is now going to a range of semi-autonomous trusts and quasi-autonomous organizations makes public accountability more difficult (Glennerster & Le Grand, 1995). In addition, the lack of a clear definition of the role and power of purchasers means that they have become responsible for health care and for very large sums of money but are subject to less strict rules than ordinary business people (Roberts, 1993). The lack of mechanisms to ensure accountability of health care managers in the United Kingdom is also criticized from the point of view of legitimacy. The very process of moving towards the internal market with the use of contracts has created a situation where a new breed of managers has evolved without any public form of control based on democratically elected principles (Hunter, 1995).

**Germany**

Contracts are supervised by Land authorities or the Ministry of Health, but the responsibility of the partners has an absolute priority. “We only interfere in contracting matters when contracts are in breach of the law” (Interviewee 6, Germany, 1994). In practice the ASFPs, which are physician-controlled organizations, have the legal and moral authority to review the practices of their members. The process is conducted by each ASFP and is supervised by a joint committee which includes representatives of the sickness funds and whose chairmanship alternates. Some claim that as a result “German doctors have virtually no government or payer intrusion into clinical practice” (Rodwin et al., quoted in Knox, 1993).

Monitoring systems have existed for many years, but since contracts do not really limit the volume of services, these systems exist mainly to avoid
professional fraud when billing. Common abuses reported include billing for more remunerative services according to the points system or billing for services which were never provided. The 1993 Health Care Act specified more detailed monitoring procedures, including controls based on prescription limits (NERA, 1993).

**Increasing choice**

It is acknowledged that many European policy-makers are currently dealing with demanding citizens and patients who want to have a greater say in the way health and health care is provided and organized. This involves increasing choices of a logistic nature (i.e. choice of physician and hospital) as well as choices of a more clinical nature (i.e. participating in elective decisions on medical treatment) (WHO, 1997). The contract model is usually associated with increased choice of doctors, freedom of choice of providers and other forms of responsiveness (Hurst, 1992).

Although increasing choices carries a positive value, scientific justification for doing so is not as straightforward as it may seem. Le Grand & Bartlett (1993) point out that choice might be sought as an instrument for achieving other goals (e.g. increasing competition and hence efficiency). But it may also exist as an end in itself (simply because it is desirable).

If more choice is considered desirable as a means of achieving specific goals, then other means could be used instead. For instance, providers may be induced to be more efficient through the use of fixed budgets rather than through competitive forces.

Increasing choices implies increased social costs and may even imply reduced choices for others. For example, German law specifies that doctors have the option of prescribing spa treatments for their patients, so that sickness funds are denied the option of not providing such treatment, regardless of their own opinion of its efficacy.

In the literature, contracting is associated with increased choices. Hurst (1992) and others consider contracts inside a package of changes which can lead to increased choices. However, contracting *per se*, as an instrument, does not help increase choices. The contracting process allows choices to be reflected in health care provision and management. If countries do not have appropriate contexts in which choices are available and citizens can voice their preferences, contracting will not change this structure.
United Kingdom

The Government has announced its commitment to increase both choice of services and choice of providers. More choice has been justified as a means to an end (more choice leads to more competition which leads to more efficiency), as being desirable and ultimately as an individual right in itself (Le Grand & Bartlett, 1993). Yet scholars disagree on whether or not the reforms and the use of contracts have resulted in increased choice. “The contract-based reforms of the United Kingdom distinctly reduce patient options ... the overriding evidence is that patients have some logistical influence over choice of GP, considerably less over choice of hospital and very little, if any, clinical influence over proposed treatment patterns” (Saltman, 1994). This view is supported by Le Grand & Bartlett (1993).

Robinson & Le Grand (1994) show that different players have different perceptions concerning what increased choices are: when studying the effects of the reforms on patients’ choice of hospital and on choices exercised on their behalf by GPs, they found that the level of patient involvement in choice of hospital and consultant was generally low and this changed little in the first year of reforms. However, 40% of the GP fundholders reported an increase in choice due to contracting (Robinson & Grand, 1994).

Maynard (1994) explains that in the GP fundholding scheme, competition between GPs for patients was supposed to reduce waiting lists, improve services and increase efficiency in the NHS. However, GP fundholders started to form coalitions to create purchaser organizations covering over 200 000 patients in order to enhance their leverage on providers, and in so doing reduced patient choice of purchaser (Maynard, 1994).

Germany

All insured persons have free choice of physician and patients are also allowed to seek treatment directly from specialists. Moreover, since 1997 the overwhelming majority of people have enjoyed freedom of sickness fund membership. The recently granted freedom to enrol in any sickness fund has been justified on the grounds of efficiency: commentators argue that this measure was introduced so that differences in the premium paid to sickness funds would reflect differences in efficiency between these funds (NERA, 1993).

In spite of all this, it is difficult to associate an increase in choice with contracting itself. Rather, in Germany and in the United Kingdom, contracts can only reflect citizens’ choices after changes in regulations,
legislation and other social values create the proper environment for them to participate and express their preferences.

**Increasing efficiency**

Some scholars argue that the purpose of contracting is to instil efficiency into the provision of health services (Paton, 1992). The underlying logic is that in competitive or contestable markets, efficiency and quality are rewarded by new contracts, while inefficiency and lower quality lead to more punitive terms or even to the denial of a contract (Maarse, 1994).

Clearly, it would be a mistake to consider that efficiency depends only on the part of providers. Purchasing agencies need to be prepared and motivated to pursue the most efficacious service specifications and negotiate the best contracts (Maarse, 1995).

When considering potential economic gains in efficiency, policy-makers need to balance these gains against other costs, such as the costs of managing contracts. In the short term, the cost of contracting outweighs the benefits of greater efficiency and choice. Some believe that this may also be true in the long run (Øvretveit, 1993).

**United Kingdom**

For Donaldson & Mooney (1993), the split is a good step towards improving allocative efficiency. However, experience in the United Kingdom has shown that the ultimate realization of this potential depends on whether or not contracts contain purchasing decisions which are efficient. In other words, the use of contracting, rather than contracting itself, has been the factor determining whether or not efficiency has been achieved.

From the beginning of the contracting process there were concerns about the negative influence on allocative efficiency that could be caused by risk-selective GP fundholders. Since GP fundholders have an incentive to avoid treating expensive patients, their decisions may not reflect social preferences. Thus the Government has been cautious in creating measures to avoid risk selection.

It is relevant to consider that in the United Kingdom purchasers have limited influence over clinicians and therefore cannot always induce efficient behaviour. “Within contracting you can’t hold a provider accountable for improvements in the health status of the population. What we can say is that we are in your hands (the hands of the physicians) because of the referral pattern and clinical freedom.” (Interviewee 8, 1994: Wales.)
It was also observed that technical efficiency may not occur, even when competitive forces are in place. “One of the things we said to our purchasers was ‘Look, our prices for general surgery are lower than those at Singleton. Why are you buying most of your general service from Singleton? We can do more for you and save you money.’ But they won’t do it, because there are other factors that come into play. There is a need to de-invest and so on.” (Interviewee 21, United Kingdom, 1994.)

**Germany**

Efficiency in the hospital sector is one of the most debated issues. “The hospital sector in Germany does not work efficiently. There are no incentives to be efficient. They get their money whatever they do. ... The reality when dealing with inefficient hospitals is that one can seldom go so far as to close them without encountering major opposition. ... It is very difficult to close a department or a hospital. Because in these cases you are alone. Everybody else is against you, even your own members.” (Interviewee 3, Germany, 1994.) Inefficiency in German hospitals has been associated with the traditional method of hospital payment and not with the lack of competition or inactive purchasers.

At the federal level, decisions that influence allocative efficiency are to a great extent constrained by the Social Code. “In Germany the SGB V says that the patient gets everything that is appropriate and necessary for his care ... whenever there is demand, the demand is satisfied. I think we have no real benefits package, because in the end there are no limits.” (Interviewee 4, Germany, 1994.)

At the **Land** level, authorities have the power to decide which hospitals will be allowed to contract with the sickness funds. They also play an active role in investments in infrastructure and minor equipment (Interviewee 5, Germany, 1994). In theory, this should induce allocative efficiency: the investments are supposed to avoid over-capacity and attend to the needs of priority areas. However, the interviews showed that the sickness funds are not totally in favour of having to contract with hospitals which are included in the hospital plan. According to them, this determination limits their leverage for demanding more efficiency.

**Increasing quality**

Broadly defined, quality encompasses a wide range of issues: effectiveness (achieving the intended benefits of clinical intervention), acceptability and

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9 A hospital plan has to be prepared by each German **Land**. The plan determines which hospitals the sickness funds have to contract with in any particular **Land**.
humanity (to both service user and provider), equity and accessibility (availability to all), efficiency and appropriateness (tailoring services to needs) (Clark et al., 1995).

As can be seen from this definition, quality can be considered to be part of the concept of efficiency. Nevertheless, this study opts to consider quality separately from efficiency, the reason being that contracts are often associated with increases in both quality and efficiency. By considering the issues separately, one can at the same time highlight the importance of quality and reiterate its link with other concepts.

Quality is associated with competition in health care provision and the view that in competitive or contestable markets efficiency and quality will be rewarded by new contracts, while inefficiency and lower quality can lead to more punitive terms or even to the denial of contracts (Maarse, 1994) and (Bates & Brignall, 1994).

**United Kingdom**

Quality criteria are not, in general, a compulsory part of contracts. Nevertheless, quality aspects which are specified in the Patient’s Charter need to be respected and purchasers may feel the need to include quality measures in their contracts. Moreover, purchasers are aware that competitive pressures on trusts and directly managed units may encourage them to deliver cost-effective care of a certain minimum quality. Thus, by making quality an issue in the contracts, purchasers expect quality to improve or at least to remain at acceptable levels (Cairns, 1993). However, it is not an easy task to include quality in contracts and successful attempts to increase quality through contracts depend on several aspects (see Annex 6: Quality Through Contracts).

Besides a lack of information in general, another key factor in the United Kingdom is reported to be the existence of an asymmetry of knowledge between purchasers and providers. That is, purchasers of services such as health and social care have less knowledge about the quality and cost of services than the professional producers (Glennerster & Le Grand, 1995). Without clear knowledge of which quality indicators and levels of quality to expect, purchasers tend to apply a narrow view of quality, prioritizing aspects of access and convenience rather than clinical quality. “So when people talk about quality it is generally not about clinical quality, it is sort of stupid really, but that is the way it tends to develop ... because what goes into contracts are very much process issues, how long you must wait and things like that” (Interviewee 10, 1994: Wales). In fact, Ham (1994) argues
that the publication of the Patient’s Charter has ensured that quality issues in contracts will continue to be the subject of discussion, with the emphasis on accessibility and patient convenience.

**Germany**

Formalized quality control has been introduced recently. Traditionally, the Chamber of Physicians has been the main body responsible for monitoring quality of care. This task is part of the public responsibilities assigned to the Chamber by the SGB V and by the Government. The Chamber should perform this task together with the ASFPs.

In accordance with regulations, the sickness funds are also supposed to work together with the ASFPs to guarantee quality. However, in practice ASFPs do not monitor quality: “We [the ASFPs] only determine the entitlement of doctors to work. There is no quality control, either by the ASFP or by the sickness funds.” (Interviewee 2, Germany, 1994.)

In German hospitals, an internal quality assurance scheme exists. The German Hospital Association has also set up a network in which “standards are set by the scientific societies”. The hospitals send data to a network centre and they “get feedback information so that they can see how they stand in comparison to the average. If they’re doing worse than average, they can ask the centre for a consultation or for a visit by the consultants to give recommendations on how things can be improved” (Interviewee 5, Germany, 1994). However, this solution is poor, since the process of monitoring through comparison depends on each hospital’s own initiative.

### 5.2.2 Defining services

Fundamental changes in health outcomes may be achieved through the definition of services in contracts. However, in spite of contracts leaving some scope for negotiations on this matter, it is often the case that freedom to define services is limited at the macro-level by legislation, cultural factors and ethical considerations (see also negotiating space in Section 5.3.2). The experience in the countries focused on in this study highlights the differences with regard to service specifications in contracts.

**United Kingdom**

Contracts have been used to specify the service changes the authorities wish to negotiate with providers, and how and within what time frame the changes will take place. The service specifications which are agreed with providers are incorporated into contracts (NHS Management Executive, 1991).
Germany
Legislation has been widely used to define service provision, therefore contracts play a weak role in this area. Still, negotiations between the sickness funds and the ASFPs are influential since they contribute to the definition, at the federal level, of the package of services which will be provided in ambulatory care. This decision has to be followed by all sickness funds.

5.2.3 Defining volume
In order to avoid financial instability and guarantee a certain level of resources to run the facilities, contracts can fix the volume of services to be provided and define the procedure when the ceiling is reached. In general, in the United Kingdom, services delivered in excess of the agreed volume are paid for at marginal cost (Maarse, 1994).

When fixing the volume of provision, those drawing up contracts need to have information about the cost of treating different types of patient, as well as a clear picture of the needs of the population and of the monitoring systems available for following up on utilization (Cairns, 1993).

It is not uncommon that, by putting limits on the volume of services, purchasers hope to reduce costs. The crucial problem is how to deal with a patient who urgently needs treatment when the service limit has already been reached.

United Kingdom
In the NHS it is not unusual for managers to discuss the volume of services to be contracted with clinical managers in hospitals before contracting. This procedure ensures that the hospital has enough capacity to deliver the level of services specified in the contracts (Interviewee 11, 1994: Wales).

Germany
Contracts between sickness funds and hospitals define a prospective annual budget based on projected bed occupancy rates and the costs per diem. Under global budgets, if the agreed volume is exceeded, hospitals receive only 25% of the per diem rate on the excess number. In contrast, if the volume goes below the negotiated figure, the hospital receives only 75% of the per diems which were not incurred (NERA, 1993). The formula is a means of balancing the risks involved in contracts which specify volume.
5.2.4 Defining prices
In circumstances where providers of health care are paid directly by a body acting on behalf of patients, contracts can provide a means of mediating between the interests of the parties involved in relation to the price of the services which will be provided. Despite the difficulties involved in identifying appropriate prices for services, it is clear that there are powerful indicators which can both inform and misinform as to the allocation of resources (Cairns, 1993).

From the perspective of both providers of health services and purchasers, fixed prices for services in a contract carry less financial risk: managers on both sides will be able to plan their cash flow in accordance with reasonably stable prices and expected utilization of services. If contracts for health services are being negotiated in a for-profit and/or competitive environment, fixed prices may encourage minimization of costs, thereby improving technical efficiency. This is because, on the provider side, reduced costs relative to a fixed-price contract can generate extra profit.

Careful monitoring must be in place in order to avoid fixed prices and competitive incentives which can negatively influence quality. This implies that the use of contracts for fixing prices needs to be complemented with other mechanisms to sharpen the focus on overall outcome of service provision and not only on technical efficiency.

United Kingdom
The Government has ruled that prices for services should equal average costs and that trusts should break even financially. This is aimed at avoiding situations in which local monopolies use their market position to make excess profits that could destabilize the market (Maynard, 1994). Nevertheless, due to the difficulties in costing health services and in monitoring practice, it is unclear whether or not trusts are being successful in following the Government’s rule.

In the early 1990s, the Audit Commission identified weaknesses in the information and costing systems used by the NHS. This led to the setting up of the National Steering Group on Costing in 1992, with the purpose of ensuring that differences in contract prices between providers were not caused by differing costing approaches or by an inconsistent definition of the services or products being delivered. Several proposals were made, but the people interviewed expressed the view that costing in the NHS is still an art and not a science (Reeves, 1993 and Panel discussion, 1995: interview).
Germany
For ambulatory care, agreements negotiated at the state level established the monetary value of the points\(^{10}\) accumulated by the practice-based physicians who provide services. Fixing the monetary value for each point is one of the most important issues negotiated in the contracts. The monetary value of each point will indirectly define the price of the services and the overall health care costs for the agreed period of time.

For hospital care, the negotiations usually take place locally. Hospitals often negotiate individually, while several local sickness funds may negotiate jointly with each hospital. In contrast to the negotiations covering provision of ambulatory care, sickness funds do not contract by price but on the basis of an annual global budget. The total amount is usually based on projected bed occupancy rates.

5.2.5 Defining conditions
Contracts may define specific conditions to be respected in service provision; for example, the organizational quality of services, such as waiting lists, availability of beds for people accompanying the patient, or waiting time for consultation (Maarse, 1994). Specifications may also exist in relation to the facilities needed for the delivery of specific health services. For instance, a purchaser may request that a certain type of equipment should be available for his/her patients. Conditions may also be specified in terms of professional quality: e.g. the degree of qualification of practitioners and other staff providing care. Similarly, other conditions may also be required to be part of the contracts.

United Kingdom
In parallel to the development of contracting in the United Kingdom, contracts have incorporated more and more aspects related to the conditions of service provision. A summary of these conditions can be seen in Annex 3. However, little is known about whether or not providers are able to comply with the conditions specified in the contracts.

\(^{10}\) Physicians in Germany are given points for each service they provide. For example, a telephone consultation may be equivalent to 10 points. The total number of points reached by each physician is accumulated over a certain period of time. From the negotiations at the Land level, a value for each point is established and each physician’s salary is calculated on the basis of points, which are later converted into cash. The associations of sickness fund physicians distribute the final payment to each person. For example, if a doctor has accumulated 5000 points and each point has been valued in the negotiations at 2 DM, he/she will be paid 10 000 DM.
Germany
In contrast to the United Kingdom, conditions for the delivery of care are broadly defined by federal law and monitored by different players. Although the federal government leaves room for the various associations to “organize matters as they see fit” (Wasem, 1995), contracts appear to be more about following the benefit package specified by law than about negotiating new conditions at the end of every contracting cycle.

In accordance with legislative requirements (Sozialgesetzbuch V – Gesetzliche Krankenversicherung), both the Chamber of Physicians and the ASFPs are required to take measures to ensure satisfactory conditions in general and the quality of the services provided in particular. Although, in general, conditions are not defined in the contracts and are not renegotiated in every contracting cycle, there have been examples of circumstances where bargaining was necessary. In such cases, the collective nature of the negotiations has meant that specific conditions could only be accepted after a lengthy process which was somewhat more centralized than in the United Kingdom: “Specially to improve quality, we bargained for two or three years on the same theme. We have problems in defining quality, measuring quality and improving quality measurements. We (the sickness funds), physicians and hospitals have been working together but we have not found a solution in the last 2 or 3 years.” (Interviewee 3, Germany, 1994: interview)

In principle, it would be logical to consider that the definition of conditions such as quality of service provision can increase the potential advantages of using contracting mechanisms. Nevertheless, the empirical evidence shows that good standards of service provision can be achieved even when detailed conditions are not included in the contracts. However, the next logical step is surely to ascertain how contracts can be used to improve levels of service further, particularly those not meeting consumer demand.

5.2.6 Defining payment methods
Defining how the providers will be paid is one of the most important functions of contracts. Different methods of payment have advantages and disadvantages which have to be balanced against each other. The general rule appears to be that no one method of payment is always better than the others. The perceived advantages and disadvantages depend to a great extent on the overall market structure, the competitive forces in place, the institutional/legal framework and the perspective taken (e.g. from a provider or purchaser’s point of view).

A classification of contracts based on methods of payment is presented in Annex 7 as a tool to clarify commonly used terms and to stimulate
discussion of the perceived advantages and disadvantages of each type of contract. This study concluded that the current classification of types of contract used in the literature is very weak, lacking a proper framework with definitions.

Moreover, it appears that the types of contract are best understood within the specific context in which they are used. For instance, a block contract as used in the United Kingdom between individual GP fundholders and hospitals resembles a budget between a small sickness fund and a hospital in Germany. However, the collective nature of contracting in Germany and the strong institutional framework make the negotiations and outcomes very different. The sickness fund may be obliged to contract services from all hospitals in the Land’s health plan, while a GP fundholder in the United Kingdom will not be subject to such constraints.

Provider payment methods used in contracts are discussed in Annex 7, taking into account the above-mentioned limitations and using the classification of contracts found in the literature.

5.3 IMPORTANT CHARACTERISTICS OF CONTRACTS

Contracts have different characteristics, depending on the purpose and the circumstances in which they are used. As previously explained in the methodology, these characteristics can be dimensionalized. Dimensions show the range of variation in which a characteristic can be classified. This range of options and the different characteristics of contracts can then be analysed to facilitate the design of contracts and for defining the negotiation process. Below are some of the important characteristics identified in this study.

5.3.1 Level of negotiations (individual/collective)

Contracting negotiations can be carried out by representatives of associations which contract on behalf of their members. This is often referred to as collective contracting. Examples include contracts negotiated by the ASFPs and the sickness funds in Germany. Contracts between associations can determine the basis on which individual contracts will be developed or they can replace the need for any individual contracting. When collective contracts are used, questions arise concerning the extent to which individual members of the associations involved should be bound by such agreements. Moreover, it is often expected that there should be mechanisms which

11 Sickness funds are obliged to contract with hospitals which are part of the Land hospital plan.
allow for the voice of those represented to be expressed, as well as for the existence of mechanisms that guarantee accountability and responsibility.

Contracting may also take place between single institutions, such as a health authority and a hospital. These are known as individual contracts.

**United Kingdom**
The United Kingdom lacks formal associations with the power to contract on behalf of their members. Most contracts are negotiated between individual trusts and GP fundholders or health authorities. Although the health authorities contract on behalf of their populations, they do not exist as associations. Rather, they are governmental bodies that follow policy guidelines issued by central government.

However, since the implementation of the GP fundholding scheme, it has been observed that some fundholders have started forming associations or groups to purchase health care services (Glennerster & Matsaganis, 1993). This approach has come to be called locality purchasing (Glennerster et al., 1994) and is arguably the precursor of primary care groups. In some of these groups, fundholders have started to join forces on an informal basis in order to benefit from sharing contracting skills that are scarce among practices. In other cases, non-fundholders have formed groups to act together with their health authority to counterbalance the perceived advantages of fundholders. There are also examples of GPs forming groups to counter the purchasing policies of local health authorities.

The groups described above may evolve into more organized associations which may themselves one day be negotiating contracts on behalf of their members. “An early informal example in one of our regions became a formal arrangement ... under a full formal scheme, a GP commissioning executive is now charged with identifying ways in which the district’s broad contracts could be developed to meet local needs identified by local GPs.” (Glennerster et al., 1994)

Analysing the prospects of informal associations proliferating, Glennerster et al. (1994) concluded that group purchasing as it is in the United Kingdom lacks a sense of shared legal responsibility and accountability which binds these types of association elsewhere.

**Germany**
Collective contracts are a tradition. In principle, concentration of power is socially undesirable and is prevented by giving different organizations power over each other.
The insurance funds and different categories of provider form associations at both Land and federal level which carry out the bulk of negotiating and contracting. The agreements reached between sickness funds and the ASFPs on any particular matter are binding on those whom they represent. It has been argued that this type of contractual arrangement leaves very little negotiating space for the individual hospital or physician. However, collective contracts provide a higher degree of equity in terms of the range, access and quality of services and low transaction costs.

5.3.2 Negotiating space (constrained/unconstrained)

Although negotiations are central to contracting, in practice the negotiating space can be very limited. This was an important topic during the panel discussions. “One kind of limit refers to all public regulations and government interventions ... they reduce the negotiating space ... there is always a strong political pressure at the central level to take some specific measures, immediate measures” (Panel discussion, 1995).

Some of the aspects limiting the negotiation process include the following.

**Strict and comprehensive definition of services to be provided**

In reality, purchasers are often bound to contract a package of benefits. This guarantees provision of standard services to all. However, some argue that this practice locks purchasers into a conflicting situation: at the same time as they are held accountable for the success or failure of their activities, they cannot decide which services to buy with their limited resources.

**Threat of lengthy legal battles**

In some countries, purchasers must take into account that a provider who has been denied a contract may have the right go to court in order to overturn the decision. If refusing a contract may lead to costly legal battles, purchasers may prefer to contract with an inefficient provider rather than risk wasting resources in the courts. Alternatively, purchasers may consider a more collaborative approach in which evidence of inefficiency is discussed with traditional providers. Failure to deliver the expected results can be followed by an official communication to the institution responsible for arbitration. As a last resort, denial of a contract can be considered.

**Stability of the system**

Negotiating space can be constrained in order to avoid destabilization in the system. For example, in a situation in which a major contract for some form of treatment is not renewed, a provider trying to break even may be forced to increase the prices specified in its contracts with other purchasers or to
increase the prices of other services it delivers. If the funds available for purchasing are originally from the same source (a regional health authority, for example), the net result may be a loss of buying power. If this situation involves two distinct regions, the result is a transfer of resources from one region to another. Both situations can cause unwanted destabilization within the system.

**Public opinion**

Purchasers also know that a decision to refuse to contract with a particular provider may result in the closure of that particular unit. This can easily become a political process with strong repercussions in the local community or, indeed, throughout the country.

**United Kingdom**

For purchasers in the United Kingdom, the threat of facing legal battles arising out of denial of contracts is real. As a result, purchasers may not negotiate as freely as they should in theory be able to do. In a recent case, an ambulance service trust lost a £3 million contract to a private transport firm bidding in association with another trust. It has been reported that the trust sought legal advice after losing the contract and the authorities expressed concern that the loss of such a contract would increase the costs for other NHS hospitals which contract with the local ambulance trust, destabilizing the local system (Butler, 1996).

**Germany**

The insurance funds (*Krankenkassen*) have the option of not contracting with a hospital if it does not perform well. However, in practice this is a lengthy process which the funds prefer to avoid.

Decisions about which services to provide are also constrained. The health care legislation lists the health care benefits to which all Germans are entitled (NERA, 1993).

5.3.3 **Identity of interests (independent/mutual)**

The basic question is whether the contracts and the contracting process occur in circumstances where an identity of interests between purchasers and providers can be perceived and developed. The independent/mutual dimensional range indicates whether the process is perceived more as a fight for the individual’s (or association’s) interests or rather a deal among colleagues.

**United Kingdom**

The Government promoted the idea that parties should be able to understand each other as partners with common interests, rather than as
adversaries contracting on the basis of individual interests. The legal nature of the contracts (i.e. not enforceable) reflected this approach.

In Wales, the Welsh Office involved itself in identifying common ground for purchasers and providers to work together rather than individually. To some of their managers, contracts should signal the direction in which purchasing intentions are moving. Initial attempts to negotiate independently, pressing one-sided interests, were curtailed. “When the players in the negotiations come into real conflict, with each of them trying to defend their sub-goals, I cannot let them go against the goals of the whole system. So what we are trying to promote in contracting is the notion of a continuous cycle, with a statement of intent from purchasers. They should say to the providers: we are giving you notice of the direction we want to move in …” (Welsh Office, 1994: interview)

Contrary to expectations regarding competitiveness GPs in the United Kingdom developed strong links with their established providers, even after becoming fundholders. They enjoyed the freedom of choice in contracting but were keen to use contracts to support their local providers. “We want to make our local hospital the best.” (Glennerster, 1994, quoted from interview)

Germany
In each Land, the sickness funds have to negotiate the majority of the decisions with the local hospitals and the ASFPs. Legally, the negotiating partners are forced to reach agreements, although they may press hard to defend their positions. “The law forces us to cooperate. The only thing every sickness fund can decide on is how to pay the providers. The point value, lump sum system and other systems. All the other things we have to do together.” (Interviewee 3, Germany, 1994: interview)

If a disagreement arises, the matter has to be solved by a Joint Arbitration Committee which may make a decision that does not benefit either of the parties. The threat of arbitration is a strong incentive to reach a consensus. “About 95% of negotiations are concluded by consensus, 5% of the budgets are fixed by arbitration ... About 80% of the arbitration cases are decided by consensus. So there are very few cases of budgets being fixed by arbitration.” (Interviewee 5, Germany, 1994: interview)

In spite of a general willingness to cooperate, negotiations are considered to be hard. Although the partners bear a mutual responsibility, they are also keenly aware that they are negotiating from opposing sides of the table.
Thus, in contrast to the United Kingdom, the century-old division in Germany appears to have accentuated the distinction between “them” and “us”.

5.3.4 Degree of participation (pluralistic versus centralized systems)

It is possible to look at the degree of participation from the perspective of national policy-making (participation in committees which define health services) as well as participation at the level of contracting negotiations only (local contracting rounds). In either case, a pluralistic system is one where negotiations involve various partners and agreements are reached through consensus. Essentially, in pluralistic health systems the decision-making power is dispersed and policy development involves not just the government but also a number of interested groups (Dekker & Werff, 1990).

United Kingdom

Traditionally, the British health system has been considered highly organized and more centralized than the Germany system (Dekker & Werff, 1990). Policy-making is carried out by central government and policies and budgets must be submitted to Parliament for approval. At the local level, the planning process is expected to be supported by community health councils (CHCs), which were created to strengthen the consumers’ voice in policy-making. CHCs exist in every district and are funded by the regional health authorities. The members of the CHCs are drawn from voluntary organizations, local authorities and the local community. Although the work of many CHCs has been praised, there is no evidence to date that they have been able to make any real impact on health policy.

From the point of view of the staff working for the NHS, clinical professionals and other medical staff are considered to have significant influence over the direction in which services develop. This includes deciding on which patients to treat and what forms of treatment to adopt. As a result, there is no guarantee that the priorities espoused, either nationally or locally, are put into effect (Merry, 1996). At the level of contracting between purchasers and providers, the negotiations are also far from pluralistic. Contracts are often agreed between individual purchasers and individual providers with little direct influence from other groups or institutions, with the exception of the central government.

Germany

Federalism and pluralism have resulted in a multiplicity of planning, decision-making and financing bodies participating in policy-making for health.
The responsibility for developing and implementing health policy is shared by the federal government, the Land authorities, autonomous corporate parties and a variety of private interest groups. Although not all these groups participate directly in the contracting negotiations, they can voice their opinions and influence the definition of the broad policies which will subsequently have to be adhered to by contractors.

5.3.5 Degree of specification (broadly formulated/detailed)

The basic question is whether the mutual rights and duties of both parties are to be specified in detail or broadly formulated in the contracts.

On the one hand, contracts often tend to emphasize outcomes, with detailed descriptions of what is expected from both parties. However, contracts with very detailed specifications may become too complex to be monitored, resulting in “paralysis by analysis” (Hunter & Aldersdale, 1994). Worse, details can distract both parties from the real policy goals that justify contracting (Interviewee 17, 1994: Wales).

On the other hand, even if contracts contain detailed specifications which are hard to monitor, they may still be needed as a reference when a dispute arises and a purchaser decides to take the provider to court for not complying with the contract (Øvretveit, 1995a).

One approach to facilitating a definition of details is the use of standard categories of service, such as diagnostic-related groups (DRGs) and health-related groups (HRGs).

United Kingdom

In the early phase of contracting, some purchasers issued service specifications which set out principles for provision and the expected outcomes, leaving providers with the task of defining how they would provide the services. As contracting has developed, there has been a trend towards more detailed specifications. Nevertheless, many health authorities are realizing that it is pointless to have detailed contracts specifying targets which are unattainable. Thus, purchasers have taken a proactive role, discussing with the providers how to achieve improvements rather than simply demanding them in the contracts (Glennerster, 1994).

In Wales, since 1995 it has been a requirement that contracts incorporate diagnostic-related groups. One of the people interviewed, while recognizing the need for more detailed contracts, questioned the validity of this
policy. “The Welsh Office says there is a need for more detailed contracts, which I think is right ... (but) I don't understand why they feel that DRGs are better than procedures, other than when they say they want something that is uniform across Wales and that can be compared between authorities.” (Interviewee 10, United Kingdom, 1994: interview in Wales)

**Germany**

Several aspects contribute to contracts being formulated broadly rather than in detail. In practice, legislation and the process of collective negotiations at the federal level determine the services that will need to be contracted, and the specifications in the contracts concentrate on determining budgets and methods of paying providers.

### 5.3.6 Scope for contracting (broad/narrow)

In principle, purchasers should be able to play an active role in contracting and buying services from providers who can offer the best services at the lowest costs. In practice, however, purchasers may have their scope for contracting limited due to several reasons:

- **limited choice of providers**: in some cases, purchasers may not have alternative contracting options; this is often the case in remote areas served by a single hospital;
- **legislation**: legislation could force purchasers to contract certain providers; for example, in Germany the *Land* plan forces sickness funds to contract with all hospitals which are covered by the plan;
- **public pressure**: patients may not be willing to travel further to a hospital, regardless of its recognized efficiency and quality; they may also feel attached to local providers whom they consider as their own and refuse to be referred anywhere else; as a result, purchasers may be limited to contracting traditional providers;
- **freedom of referral**: doctors may have the freedom to refer patients to any provider they like; as a result, purchasers will need to contract with whichever provider the doctors refer their patients to.

Clearly, when the scope for contracting is narrow, purchasers have less power to influence their traditional providers, who may feel they are under no threat and have no reason to improve services.

**United Kingdom**

In many small towns there is little competition between providers or purchasers. This is an important factor limiting the scope for contracting. In parallel, the acceptance of the principle of clinical freedom implies that
physicians have the right to refer to any provider they want. As a result, purchasers have been forced to buy services from all hospitals in their region. Alternatively, some purchasers have engaged in discussions with their local GPs in an attempt to limit referrals to contracted providers.

**Germany**

The *Land* prepares a hospital plan defining which hospitals will be contracted. If a hospital is part of the plan, the sickness funds must contract with it. Contracts with small hospitals which are not part of the plan, such as specialist clinics and private hospitals, are also allowed.

### 5.3.7 Degree of enforcement (binding/non-binding)

Contracts are associated with the idea of legal enforcement. However, they can exist without legal enforcement. Since non-compliance can damage the continuity of the relationship, both parties may feel compelled to follow the contract even when legal sanctions are non-existent. Non-binding contracts can be an alternative way of contracting when a legal framework is not available (Mason & Morgan, 1994).

It seems that contracts should be seen not only as binding tools (in Germany), but also as tools to facilitate understanding and agreement. In fact, the emphasis on the technicalities of contracting as a binding tool can lead to deviation from the real goals behind the contracting process, as explained under Section 5.3.5 above.

**United Kingdom**

The Government has made it clear throughout the reform process that contracts were not legal documents (Ham, 1994). The 1990 Act lays down that “Whether or not an arrangement which constitutes an NHS contract, apart from this sub-section, be a contract in law, it shall not be regarded for any purpose as giving rise to contractual rights or liabilities, but if any dispute arises with respect to such an arrangement, either party may refer the matter to the Secretary of State for determination”. Non-binding contracts are in fact considered easier to implement and manage and this is one of the reasons that legally binding contracts have been discarded in the United Kingdom (Howden-Chapman, 1993).

When the scheme began, some of the people interviewed even argued that there were no real contracts in the United Kingdom. “They could never take me to court for not achieving the targets … The most accurate description of what we have is a service level agreement. A contract is enforceable by law, there are penalties, while a service level agreement is not.” (Interviewee 19,
United Kingdom, 1994: interview in Wales) In the literature, some scholars prefer to use the term understandings, rather than contracts (Maynard, 1994).

It is, however, important to recognize that contracting parties are expected to comply with contracted terms and that sanctions do exist. For example, the NHS Executive expects fundholders to manage their budgets within the allocations set by the regional health authorities. If there is continued and unjustified overspending, a fundholder may be removed from the scheme (Hodgson & Hoile, 1996).

Germany
Contracts between sickness funds and ASFPs are always binding for their constituencies. When federal associations are involved a contract applies to the whole of Germany, but when only the Land is involved a contract applies only in that Land (NERA, 1993).

Contracts are legally enforceable and regulated by public rather than private law. Nevertheless, data from interviews suggest that compliance with contracts is not dependent on the existence of enforcement. Rather, the long-term tradition of negotiations and the need for continued interaction work as mechanisms that motivate compliance.

In an effort to avoid government interference, purchasers and providers strive to reach agreements and stick to them. “If they [sickness funds and ASFPs] don’t come to a result, to an outcome, they face an arbitration system. And if they use the arbitration system, they have to obey the results of the arbitration.” (Interviewee 6, Germany, 1994: interview)

5.4 SUMMARY
Section 5 has focused on the process, functions and characteristics of contracts in Germany and the United Kingdom. Considering the contracting process, it could be observed that decision-making as it affects contracting is more centralized in the United Kingdom than in Germany. In part due to this arrangement, contracting partners in the United Kingdom are not involved in budget-setting negotiations, while in Germany this is one of the most important features of negotiations at the Land level. Similarly, regulations governing the contracting process are determined by central government in the United Kingdom, while in Germany the contracting partners play a strong role in defining such regulations. They also define a minimum benefits package, something which is not subject to negotiation in the United Kingdom.
From the point of view of the functions of contracts, it was observed that contracts can be used for implementing health policy and for defining services, volume, prices and conditions of provision as well as methods of payment. However, the use of contracts to ensure these functions varies greatly between the United Kingdom and Germany. A clear contrast exists in the use of contracts to support national planning. While in Germany this function is weak, mainly due to the federal principle which places a great deal of power in the hands of Land associations, contracting in the United Kingdom has a strong role as a mechanism to support the implementation of national health policy. The practical implication of these differences is a lack of national priority-setting in Germany.

As regards the characteristics of contracts, it is relevant to note that in Germany negotiations are of a collective nature, with distinct associations contracting on behalf of their members. Collective contracting is expected to reduce transaction costs and provide a higher degree of equity, while individual contracting as practised in the United Kingdom is expected to address local needs better. However, the degree of public participation in national committees and local contracting rounds is considered low in the United Kingdom, which means that “local needs” may only reflect providers’ perceptions of “localized needs”. In contrast, Germany has a more pluralist system, with many organizations participating in national and regional negotiations. This diversity contributes to a more independent identification of interests and, as a result, associations press hard on behalf of their members’ interests during the contracting negotiations.
6. MACH in the United Kingdom and Germany: focus on development and managing change

Walt & Gilson (1994) argue that too often health policy implementation focuses on the content of the reforms, neglecting the players involved, the context of implementation and especially the processes contingent upon developing and implementing change. This study has so far identified most of the content of one particular mechanism implemented during the reform process, as well as the different players and contexts within which this mechanism is being used in different countries. This last part of the methodology attempts to shed light on the process of change and to identify some of the crucial factors that may affect the feasibility of reform initiatives aimed at introducing contracting in any one country.

Once feasibility has been considered, managers may be involved in addressing tasks which can facilitate the development of contracts. Communicating a shared vision, planning for action, building support among key players and managing other contextual factors are some of the topics which have been identified and are discussed here.

6.1 FEASIBILITY OF CONTRACTING

The following sub-items deal with some of the issues which have been identified as influencing the feasibility of contracting, in light of the British and the German experience.

6.1.1 Health policy

As previously discussed, contracts can be used for translating health policy into reality. Clearly, contracting should be understood as a tool rather than an end in itself. Thus, when considering the use of contracting, the main question is whether such a tool can contribute to the achievement of health policy goals and work in line with the policy principles adopted in the country.

The empirical data analysed in this study show that it may be necessary to have a framework of goals or health policy guidelines when implementing
contracting mechanisms. A clear understanding of the health policy by the different participants in the system before contracting is developed can facilitate the process of implementation. As argued by Øvretveit (1995a), unless they define goals and principles, decision-makers may be dominated by providers’ concerns and the short-term technicalities of contracting.

Ideally, policy goals could be made clear at the level of overall objectives (e.g. long life) as well as in terms of the principles associated with these goals (e.g. equity, basis in primary health care) (Normand, 1994). According to WHO, experience shows that at all levels, a clear strategy for the implementation of policy is necessary (WHO, 1993).

United Kingdom
Some of the people interviewed in this study expressed their concern about the need for clear policies that could be understood by all players. It was felt that contracting in the United Kingdom was being developed without clear objectives, becoming an end in itself. “When the internal market began, people started to develop the art of contracting as an end in itself ... The hard lesson that we are learning is that you have to be clear, if you are moving into an internal market situation, about what it is you want to achieve. You have to be clear about the purpose, otherwise it is a lot of effort for no good reason.” (Interviewee 8, United Kingdom, 1994: interview in Wales]

Øvretveit (1995a) argues that the future of the NHS depends on commissioners keeping a sense of the public health view behind contracting, defining a clear strategy for commissioning and conveying this strategy to the others. This is more important than a health care service strategy or plans for contracting providers.

Germany
As previously observed, health policy in Germany is decentralized and more importance is given to guaranteeing provision than to defining contracting strategies.

A comparison of Germany with the United Kingdom can lead to the conclusion that although a clear health policy may be important in some circumstances (as in the case of the United Kingdom), in other instances traditional values, affordability, the existence of a solid legislative basis and other factors may diminish the importance of national health policy-making.
6.1.2 Differentiation of functions (planning/purchasing and provision)

Contracting requires a differentiation of functions between purchasers and providers of health services. This institutional division has been discussed in Sections 2.3 and 2.4.

In Section 2.7, this study proposed that contracts can also be used as a tool for planning in systems where a real purchasing function does not exist. In these cases, the differentiation of functions occurs between planners and providers: a group or unit is formed inside an integrated system and has functions similar to those of a purchasing agency. What makes this group different from real purchasers is that it does not have a real budget in its hands and therefore it cannot buy services. It can, however, influence provision through its planning function which can be supported by the delegation of power from central government to the planners. A differentiation of functions between planners and providers may be particularly useful during a transition phase from an integrated model to the contract model.

Whether a purchaser–provider or a planner–provider differentiation exists, it has been observed that the behaviour of health care providers and purchasers/planners will critically depend on the environment within which they operate. Therefore the differentiation of functions in itself cannot be considered a magic solution.

An important factor, if purchasers/planners are not actively engaged in their functions, is that in itself the differentiation does not ensure the expected benefits of contracting. In turn, active purchasing/planning may imply the existence of incentives for the purchasers/planners to contract in the best interests of the population they represent.

6.1.3 Affordability

Although contracting is expected to generate efficiency gains, it also poses major challenges in terms of transaction costs. These are understood as the “ongoing costs of designing, negotiating, monitoring and enforcing contracts” (Howden-Chapman & Ashton, 1994). In principle, transaction costs are inherent to any economic activity.

From the point of view of policy-makers interested in implementing the purchaser/provider split and contracting, the basic question to be answered is: are the transaction costs of contracting affordable? Clearly, with the implementation of contracting, costs will come first and efficiency gains, if any, will come afterwards. In other words, the introduction of contracting
may depend on extra resources being available to meet the initial costs (see Section 2.4(i) for transaction costs).

**United Kingdom**
The introduction of market-based reforms has been associated with the fastest increase in NHS spending since the 1960s (Glennerster, 1994). In particular, fundholding has meant that fundholders have taken on new staff to handle the input of individualized data and to manage the contracting process (Glennerster & Matsaganis, 1993).

**Germany**
Funding for the German system comes from one of the largest economies in the world. As previously noted, contributions from employed workers remain the major source of funds for payment of health care costs. As a result, affordability in the long run is closely linked to the level of income of the members of the sickness funds. Countries willing to implement a system similar to the German one should take into consideration that affordability in insurance-based systems depends to some extent on the wealth of workers and employers.

**6.1.4 Human resources (skills)**
If contracting is only in the initial phase of implementation, it is certain that human resources with specific managerial skills will be needed. Alternatively, existing personnel may be trained in new functions. However, this may cause problems, since staff may feel that the new skills should not be part of their professional background.

**United Kingdom**
A major challenge in the contracting process has been considered to be the lack of expertise in dealing with contracts. This shortcoming was stressed by Robinson & Le Grand (1994). The same concern was expressed by one of the participants interviewed. “The other aspect, particularly in this kind of change, is the need for skills. I would say that a lot of the difficulties in the United Kingdom are due to the actual lack of skills that are necessary for the contracting system to work ... Even now there are not the right skills in the right places to make it work.” (Participant 1, United Kingdom, panel discussion, 1995)

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12 Although the fundholding scheme is a specific arrangement for contracting, it is still worth looking at the implications of the scheme in terms of its costs.

13 According to Knox (1993), the sickness funds were responsible for approximately 46% of all health care costs in Germany in 1992.
The lack of expertise has caused some confusion among doctors in GP fundholding practices. They were suddenly expected to be managers as well as physicians and many did not believe it was right to train medical professionals to become contract managers. “I feel that I am a GP and I don’t have the necessary skills to do it ... I have got this feeling, ... that I didn’t spend several years training to become a budget manager rather than patient manager ... With the fundholding I am not at all clear what the role of the GP is in terms of the overall managing of money and whether it is an appropriate role for a doctor to have.” (Calnan & Williams, 1995)

Skills for alliance-building have also been considered important. The emphasis is on developing the capacity to work together with new partners, networking and influencing rather than directing and political awareness (Hunter, 1995).

**Germany**

Contract negotiations are part of a historical process and the evidence of this study suggests that problems with human resource skills are not a major topic on the agenda. Nevertheless, as the new reform measures start to become effective, it is expected that major players in the negotiating process will need some knowledge and skills in areas that they currently do not practise. These include needs assessment for purchasing and evidence-based purchasing.

In recent years, the adoption of capped budgets for hospitals, for instance, has meant that the sickness funds are being forced to increase their capacity to evaluate services purchased. “There was no systematic evaluation, just a small discussion. But under the system of capped budgets, it became a problem. There is not enough money. So now we need an evaluation programme, especially in the field of drugs.” (Interviewee 3, Germany, 1994: interview)

### 6.1.5 Regulation and legislation

“The framework of rules and competition in a particular market is the main factor affecting purchasers’ ability to purchase for health gain.” (Øvretveit, 1993)

The regulatory framework and contracting in the countries which form the focus of this book have already been discussed. Here it is sufficient to recount that regulation and legislation are essential for the establishment of contracting mechanisms.
In some countries the split creates a health market, which can be more or less competitive. This market has been recognized as having some peculiarities of demand and supply which make it practically unique in terms of lacking mechanisms for self-regulation. Many believe that, if left unregulated, the free interaction of the parties will lead to waste and other undesirable consequences (Abel-Smith, 1994) (Øvretveit, 1995b).

Where competition incentives have been introduced commentators have noticed that the need for regulation by central government has increased (Saltman, 1995). Regulations and legislation can help to prevent opportunistic behaviour, as previously discussed. Whether governments should play a strong role as regulators or should restrict themselves to creating laws and enforcing them is a controversial question. Different countries take different approaches, depending on factors such as the local culture, the overall power structure of the country, etc.

**United Kingdom**

A strong regulatory role by the Government is clear in the United Kingdom, despite the rhetoric of market forces. “The NHS Management Executive continued to exercise detailed supervision of the operation of the reforms during 1991. The result was less a market in which a multitude of transactions took place ... than a command and control bureaucracy of the kind that has been dismantled across central and eastern Europe” (Ham, 1994).

Nevertheless, data from the interviews show that many believe in the Government’s role as mediator and regulator. “You have to be clear ... what the rules of the game of the internal market are. Issues of regulation, fair purchasing, fair contracting. You need to have those, plus the purpose and the rules before you can develop a satisfactory contracting system.” (Interviewee 8, 1994: Wales)

“I feel there has to be an element of regulation ... I think, in a purely competitive situation the larger hospitals would swallow the smaller ones, very rapidly. I also think that if you have only competition, any strategic plan would go out of the window, because everybody would be trying to strike short-term deals.” (Interviewee 11, 1994: Wales)

Overall, discrepancies in opinion concentrate on the degree of interference of government regulation in the contracting process. It would be fair to conclude that in the United Kingdom key players expect a clear regulatory framework but little interference from the Government in the day-to-day running of the system.
Germany
Health care regulation and supervision is exerted by federal and Land ministries and by organizations such as the Federal Insurance Office. Regulation and supervision of the provision of health care is largely the responsibility of the Ländere (NERA, 1993).

Some scholars consider that the German State assumes a strong role in relation to the negotiation process (Maarse, 1994). However, this is not the view expressed in the interviews. “We do not interfere in contracting matters. Only if the contracts are in breach of the law. But there is such a broad margin for contracting that normally we observe what is contracted with interest, but we do not interfere.” (Interviewee 6, Ministry of Health, Germany, 1994)

In principle, the German Government is limited in its regulatory functions by the principle of self-governance, which delegates responsibility of self-regulation to sickness funds and the ASFPs. Also, the regulatory powers of the federal government and the Ländere governments are differentiated, in accordance with the principle of subsidiarity. But in practice, the health care system appears to be highly regulated and to depend on these regulations to work effectively. In contrast to the United Kingdom, the German Government develops regulations through more pluralist channels. However, it may also make use of informal forms of pressure to shape a tight framework for contracting. “I know of individual cases at state level where the ministry has said: ‘In this region I need a department with 60 beds and nobody wants to have it.’ Then the government puts pressure on a certain hospital owner. ‘I will give you no money if you do not accept my planning.’” (Interviewee 5, Germany, 1994)

It would be fair to say that in comparison with the United Kingdom, the key players in Germany seem to accept a somewhat higher degree of regulation, as long as it comes through the traditional chain of regulatory power.

6.1.6 Availability of information
Availability of information for decision-making is essential during the design, implementation and evaluation of policy (Schieber, 1995:368). Some argue that information is in fact a precondition for purchasing for health gain (Øvretveit, 1993).

For the negotiating partners, information is critical when deciding where to place contracts, what type of contract to use and at what cost, what level of service to contract, what priorities to address, how well targets are being achieved, etc.
On the one hand, the lack of information or the availability of incorrect data for contracting is often associated with opportunistic behaviour. On the other hand, empirical evidence shows that too much emphasis on data induces opportunism. “The danger of having a commercial-type relationship, where payment is based on information on the services provided, is that everybody is going to massage the data ... if you put weight on data, you get biased data. Then not only you as purchaser end up paying more than you should because this data is coming from your providers, but you don’t even know what is happening any more.” (Interviewee 17, 1994: Wales)

From the literature review, the panel discussion and the interviews, some basic categories of informational need have been identified as essential.

(a) Health status and health needs
The concept of health gain is directly related to the health status of the population. In order to contract for health gain (a common goal of health policy), information must be available on the health status of the population (mortality, morbidity, living conditions, etc). Once the health status is known, the players responsible can work on addressing health needs and take decisions on how best to allocate available resources to address priority areas (Øvretveit, 1993).

(b) Health services activities
If purchasers are to pay for services provided to patients, some form of reliable information system must be in place to verify the level of activity and the nature of the services provided. Ideally, if activity data could be collected nationally in an agreed format with standardized codes, this information could also be useful for other statistical purposes, increasing the overall social benefit for the same cost (Participant 1, United Kingdom, 1994).

(c) Confidentiality
The major problem concerning information on health services appears to be in dealing with the question of confidentiality and the reluctance of medical professionals to record precise information (Boaden, 1994).

(d) Health services outcomes
Information on outcomes is essential for quality assurance and technical and allocative efficiency gains. However, for countries with competitive health care markets, it is believed that competition will only produce efficiency gains when good information about quality and outcomes is available. In this context, purchasers of health care are in a relatively weak
position compared with providers. This is because information on outcomes is mostly in the hands of providers (Glennerster et al., 1994). Purchasers may assume that this information will be made available for evaluation, but in practice this is not always the case (Robinson & Le Grand, 1994).

It is also noted that there is a danger that the complexity of some information systems can become overwhelming, with too much emphasis on detailed information (Hunter & Aldersdale, 1994). As a result, such systems can increase transaction costs, making contracting more expensive than alternative methods of command and control.

(e) Costs
Information on the cost of the services to be provided can be essential for the contracting process. This is particularly the case in countries where purchasers have to negotiate the price of specific services to be contracted. Information on costs may be less relevant when prices are fixed by a central institution.

(f) Soft information
This includes information on aspects which influence the contracting process but cannot be measured directly, including the attitude of partners in negotiations, hidden agendas, etc.

**United Kingdom**
Robinson & Le Grand (1994) concluded in their research that the lack of information for contracting was a major area of difficulty. Those interviewed reported a lack of data about the services being provided, doubts about the accuracy of available data, poor information on health needs, costs and activity, etc.

Information on costs is of major concern. The principles of contracting in the NHS are built around formal notions of costs, where the price of services provided must equal costs. However, it has been observed that in reality, providers’ prices vary enormously (Clark et al., 1995) and in most cases providers do not know how much their services cost (Paton, 1992).

After criticism by the Audit Commission of the weakness of information and costing systems, a National Steering Group on Costing was set up in 1992. This focused on ensuring that inconsistent definitions of prices, services delivered and costing techniques were avoided (Reeves, 1993). There is, however, little information available on the progress resulting from this initiative.
Germany
Information on health status and health needs was identified as being a problem for the sickness funds. “The data is very bad ... This is the case not only for BKK but for all sickness funds. They do not have epidemiological evaluation, nor do they do any specific work on needs assessment. BKK has special statistics for hospitalization, case data and what was done ... It is retrospective data.” (Interviewee 2, Germany, 1994: interview)

6.2 MOVING TOWARDS THE FUTURE
6.2.1 Communicating the objectives and expected changes
Often the use of contracting mechanisms will be part of a broader set of changes in the health system. These changes can cause anxiety and opposition. If clear and reliable information on the proposals is not made public, there is a greater chance that rumours will start and vocal opposition will grow due to misleading information. Barnes (1995) shows that opposition often takes the form of protests against reductions in quantity or quality of service, or both. However, managers can prepare themselves to address such questions honestly and make explicit statements about the expected impact of the proposed changes. Informed publicity can be given through television and radio broadcasts, newspapers, conferences, seminars, etc. with clear information on the potential benefits of the change for key participants.

It is accepted that public debate and information partly depends on whether the leading authorities have a strong political mandate to carry out the changes. Also, the public must be willing to participate. In some countries, the process may be only symbolic, an attempt to push through changes without too much opposition. Nevertheless, such an approach may stall the implementation of such changes at a later stage (WHO, 1997).

United Kingdom
Supporting the need for a clear definition of goals and communication, Øvretveit (1995a) argues that the future of the NHS and its contracting system is linked to the task of developing a shared sense of purpose and conveying this understanding to others, not least the public.

The need for clarification was also an issue during the panel discussion. “I think that a lot of the confusion goes back to health policy and being clear about what the system is trying to achieve and what the contract is trying to achieve within that system. Almost at the top of this there is a need to sort of have a
clarification discussion about contracts, what they are, what people expect them to achieve.” (Participant 1, United Kingdom, panel discussion, 1995)

**Germany**

After the Reform Act of 1993, sickness funds appeared to be increasing their capacity to communicate with the public in general. AOK, the largest sickness fund in Germany, explained that people would be hired to deal directly with communications and public affairs. The goal was to communicate the changes and the policies of AOK to the staff and “to establish a good relationship with the public in terms of public opinion ... We are looking at the competitive environment post-1995 ... we will be planning the campaigning for 1996 and informing those insured through us, especially those who may be intending to leave us.” (AOK, 1994:interview)

### 6.2.2 Leadership for change

Leadership, as understood here, is about the ability to involve key participants in the formulation of a vision which they can identify with, internalize and feel ownership of (Cleland, 1994). Ultimately, the existence of a broad sense of ownership will make it easier for the development of strategic alliances and the implementation of contracting mechanisms.

Leadership is also instrumental in establishing a balance of power between different players and facilitating the pursuit of common interests. If there is a lack of leadership, a variety of groups may seek to push the reform agenda towards the implementation of changes most acceptable to themselves. Moreover, it has been observed that when acknowledged leaders accept innovation, others tend to follow (WHO, 1997).

**United Kingdom**

A lack of leadership and unclear definition of roles at the beginning of the reform process were considered negative influences, which led to players moving in different directions and dispersing forces (Ham, 1994).

Leadership in defining clear roles for purchasers and providers in the United Kingdom is a particularly difficult task, not only because of the history of the NHS (an integrated model until recently) but also because of experiments such as the GP fundholding scheme. In this particular case, there have been misunderstandings concerning the roles of the trusts and their target populations. The simple question still being debated is whether the trusts’ clients are the patients, the GP fundholders or both (in which case some conflicts of interests may occur) (Participant 1, United Kingdom, panel discussion, 1995).
Germany
Although health policy is more decentralized and central leadership is not so strong, the different players are aware of their roles and press hard for their interests. “Everyone knows their role in the system and they fight in their role. We have a very institutional approach.” (Interviewee 3, Germany, 1994: interview)

In fact, the heterogeneity and multiplicity of participants in the decision-making process contribute to a higher degree of power balance among key players. In order to exert some form of leadership and guide the bargaining process, the Ministry of Health convenes periodic meetings in a national forum (Konzertierte Aktion – Concerted Action) (NERA, 1993).

6.2.3 Planning for action
Ideally, planning for action should involve planning all the tasks needed for the proposed changes to take place (Barnes, 1995). Here, master plans can be useful tools. These are documents which outline the proposed changes in the health care system, taking a broad view of its main components such as management and organization, finance and health delivery. Through the establishment of links between the different components of the health care system, master plans attempt to address some of the numerous implications of even small changes (Savas & Ustunel, 1996).

The broad approach of a master plan covers most aspects of the health care system. However, some scholars believe that it is also necessary to carry out a multisectoral impact analysis. This type of analysis attempts to understand the impact of the proposed changes on other sectors of the economy and society in general. It is a complex task, perhaps more appropriate when the scope of the reforms is very large, for example during the implementation of macroeconomic structural adjustment plans (Peabody, 1996).

Some of the areas covered by action plans include:14

- accountability and responsibility for implementation – who shares responsibility for implementing the plan?
- management structure for implementation – how is the whole process to be managed?
- analysis of resources – what resources (financial, human, technical) are required? Sources of funding?
- stages of implementation – when will the various steps or stages affecting implementation begin? How will it continue?

14 This is based on WHO, 1997.
The planning exercise will also have to deal with timing for implementation (WHO, 1997). That is, planning should take into consideration the context, evaluating whether or not the circumstances are favourable for implementing changes. Ansoff & McDonnell (1990) suggest that spreading the changes over a reasonable time frame can be helpful. In particular, if planning takes into account that the least contentious changes should come first, confidence can be built as the process of implementation progresses, with more controversial changes being introduced at a later stage.

Clearly, the timing aspect in action planning will depend on the overall pace of implementation of the reform. Here a debate exists between those who defend the big bang approach and those who believe in the incrementalist approach. Cleland (1994) defends the view that for change to be irreversible, it must be introduced in progressive stages. Vienonen (1993) argues that size, ethnicity and history matter in choosing which approach to follow. Thus: “In smaller, ethnically and historically homogeneous countries, a big bang, if well prepared and planned, may be a feasible solution”. WHO emphasizes that the structure of government, political will, the state of the economy, popular support and the degree of support of other key stakeholders are the main criteria to consider: “A swift reform, with top-down imposition of a grand plan such as in the United Kingdom, New Zealand or the Czech Republic, has been effective in bringing about changes in the short term.” (WHO, 1997.)

The process of adjusting the plans during the process of implementation appears to be important. Essentially, plans should allow for some flexibility, since the people involved will invariably need to deal with the unexpected. According to Vienonen (1995), for this revision to take place, evaluation and monitoring must be part of the plan of action.

The functions linked to the action plan (coordination, evaluation, monitoring, etc.) can be carried out by special units created for this purpose or they can be delegated to the existing administrative infrastructure. Savas & Ustunel (1996) suggest that the creation of policy, planning and coordination units inside ministries of health can be beneficial in the process of reform in the central Asian republics: such units are arguably necessary due to their similarity to the traditional command and control bureaucracy that until recently existed in these countries.

**United Kingdom**

The Welsh experience confirms an approach based on developing action plans and establishing specific units in charge of the functions related to
planning: “They had a group called the Welsh Planning Forum and they were given the task of linking contracts into areas that would improve the health of the population.” (Interviewee 20, 1994: Wales)

Germany
In general, the process of reform implementation has taken an incrementalist approach, without action plans or master plans. This reflects the structure of the German health care system, based on regionalized institutions and a strong legal framework. In this context, most of the reforms throughout the last decades have concentrated on “amending the existing legislation without changing the structure of the health system” (NERA, 1993).

6.2.4 Piloting
Piloting is often associated with an incrementalist approach to the implementation of reform. It involves applying planned changes to a sample context and evaluating the results. Often piloting takes place in specific regions or units which can be monitored with ease.

WHO (1997) suggests that a pilot experiment in a local setting is perhaps an effective mechanism for providing evidence prior to the implementation of reforms. This argument is supported by Vienonen (1995) who believes that in pilot projects, adverse effects can be corrected and innovation can be pursued. However, it is acknowledged that political urgency (i.e. the need to show action to win votes) does not always allow for true evaluation of pilot projects. Cleland (1994) explains that piloting gives the opportunity for the people involved to adjust gradually to new and more complex models.

Despite the rationale discussed above, in practice decision-makers might not carry out pilot experiments because of the fear of losing political support. Pilot experiments may be taken as a sign that the proposed measures have unresolved problems or that there is uncertainty about implementation.

United Kingdom
The implementation of the reforms which led to the development of contracting did not result from any systematic evaluation of pilot experiments. In fact, the reforms have been classified as a big bang (Klein, 1995). It is difficult to evaluate whether the results could have been better if more time had been devoted to developing the new contract model in a controlled trial. As pointed out by several commentators (Malek et al., 1993; Glennerster & Le Grand, 1995), the reforms were not necessarily based on
a rational approach and the political impact sought by the British Government at the time could have been diminished by pilot experiments. Ultimately, because of the big bang approach, the players had to learn by doing. This alternative may not be viable in countries where extra resources to correct mistakes and redirect players are more scarce.

More recently, in 1994, piloting was used in England and Scotland for the development of total purchasing\textsuperscript{15} in the GP fundholding scheme. Four pioneer total purchasing pilot schemes were established in four NHS regions as the first wave of national pilot projects. They were followed in April 1995 by 53 total purchasing pilot schemes in England and Scotland. A third wave began purchasing in April 1997.

On a preliminary assessment of the pilot projects, the King’s Fund reported that the exercise contributed to a more clear characterization of total purchasing in practice. As a result, the identification of policy and operational issues could help the development of the second wave of pilot schemes (Mays et al., 1997).

\textit{Germany}
This study has not identified evidence of pilot experiments in Germany prior to the implementation of health care reforms.

6.3 DEALING WITH KEY PLAYERS
The key players in the United Kingdom and Germany have been identified in the previous sections. Here it is sufficient to emphasize the importance of community participation and outline some strategies for dealing with stakeholders and implementation.

Although human capacity is the most fundamental aspect in implementing the necessary changes for contracting, community participation is not always taken into account in the process of managing change. Clearly, the involvement and thus support of key people, including the community affected, might be essential for the success of any plan: “… people support what they help to create” (Cleland, 1994).

\textsuperscript{15} Under the total purchasing scheme, GPs or groups of practices were delegated a budget by their local health authorities to purchase an extensive range of hospital and community services, including some services which had previously been outside the standard fundholding scheme.
Indeed, authors reviewed in this study defend the proposition that the successful implementation of policies depends on involving the community, both during the process of planning local services as well as in their administration and implementation (Abel-Smith, 1994).

One of the major obstacles to community participation is culture: for instance, in the central Asian republics, community participation in the reform process is expected to be low, mainly due to deep-rooted attitudes in society which repel public involvement in policy-making. This makes it difficult for reforms to reach the degree of transparency and participation which would otherwise be expected (Savas & Ustunel, 1996).

Community participation can also be a hindrance, particularly when it takes the form of lobbying. Although favourable to community participation, WHO (1997) argues that reforms have been easier to introduce in countries where fewer interest groups participate in decision-making. Apparently, less pressure from lobby groups facilitates the implementation of reform mechanisms, particularly during a period of transition.

Several strategies for dealing with the implementation of reforms and the involvement of key players have been identified in this study. As regards support for reform implementation in a local setting, Barnes (1995) suggests that planners can benefit from drawing up a diagram of the key players and their commitment to the proposed changes. This scale of commitment may be used to identify and convert people or institutions otherwise considered likely to oppose the reforms. For example:

- no commitment: likely to oppose the change
- let it happen: will not oppose the change but will not actively support it
- help it happen: will help, if resources are provided
- make it happen: must be actively involved and willing to lead.

Barnes explains that careful consideration should be given to those who are crucial to successful implementation (last row). WHO (1997) expands on the idea and suggests the use of the “accordion” method for effecting change (Ansoff & Donnell, 1990). This method recommends strategies for building both consensus and implementation.

Political alliances or networks which can support the process of change have been considered important. Such alliances are also relevant in the initial phase of the reforms, to gather enough critical mass to allow for
consensus-building. In turn, consensus-building is about generating positive support and creating an understanding of the need for and impact of the changes. If consensus is reached among some of the important key players, the chances of implementing the reform successfully are higher.

When building consensus, it has been suggested that key players opposing changes be excluded from the process. If this is not possible, ways of influencing their behaviour should be identified (WHO, 1997). This involves using indirect incentives for those who are supportive, or direct incentives in the form of payments or side-bargains to opponents. However, those resisting change should not be penalized, as this may increase their opposition.

WHO suggests that during implementation, all key players should take part in the process, regardless of their commitment. The assumption is that as long as there is dialogue and some form of participation from the opposition, implementation will move ahead.

Successful implementation can also be achieved through strategies which put two influential players negotiating with each other on an equal level. “One contributory factor in the success of the New Zealand and United Kingdom Governments was their creation of a situation whereby one set of players (managers) perceived for themselves particular advantages in supporting the changes in terms of enhanced prestige and influence, such that they chose to discount the concerns of the other players.” (WHO, 1997)

**United Kingdom**
The pace of and success in the implementation of government policies is highly dependent on medical professionals, the media and other strong lobby groups staying on the government’s side. From the outset, the Government realized that securing the commitment of GPs was important. This was achieved through a communication strategy and bribery in the form of financial inducements, at least for the early waves of fundholders (Glennerster et al., 1994).

Where the community was concerned, it was argued that decisions about the provision of services in the United Kingdom are in some cases highly political and dependent on public opinion. “In pragmatic terms, having key people on either side to influence other people can be more relevant than any scientific evidence.” (Participant 1, United Kingdom: panel discussion, 1995)
**Germany**

A framework of countervailing forces has developed over the years whereby the considerable power of some key players is checked by the power of other players. In practice, the use of such a framework means that any changes in the system involve a lengthy process in which many players can influence the implementation but no single player can easily steer the whole process. In such a context, strategic alliances and efforts in consensus-building appear to be essential for successful implementation.

### 6.4 MANAGING OTHER CONTEXTUAL FACTORS

#### 6.4.1 Maintaining the routine work

The implementation of contracting may catalyse a great deal of support among the staff involved. Inevitably, even where such support exists, implementing changes in health systems is not an easy task and normally requires extra personnel and additional resources. Also, staff may be required to take on new tasks on top of their current responsibilities. In such cases, “there can be a perceived status differential, with routine work being seen as less important than the change project” (Barnes, 1995).

Certainly, most of the services performed by medical professionals cannot be postponed while staff are involved in meetings or other activities related to the implementation of change. Consequently, it is suggested that managers provide some forms of incentive and encouragement for those who keep the normal services running (Barnes, 1995).

#### 6.4.2 Cultural and social values

The process of change will require that managers be sensitive to cultural and social values. This includes understanding the general social and economic framework of the country and the underlying principles (WHO, 1997).

This study has identified the importance of being aware that there can be different cultures in a single country. Different ethnic, religious and even professional groups can find certain changes unacceptable, even when these changes are in their own interests. In the case of contracting, some of the participants in the panel discussion believe that the cultural milieu can dilute the impact of proposed changes, incorporating new mechanisms into traditional systems in such a way that nothing really changes.

In implementing reforms and contracting as an instrument, the inertia of the existing culture should be broken through the development of
consensus\textsuperscript{16} on the need for change. “I think we all agree: contracting is not a goal in itself but it is an instrument, a tool for coordinating activities … But if you want to bring about change you need much more. And here perhaps culture comes in … the most important thing is to try to change the culture, the mentality … if there is no cultural change the system will absorb contracting and at the end of the day nothing has changed.” (Participant 3, The Netherlands: panel discussion, 1995)

**United Kingdom**

It has been reported that the implementation of contracting mechanisms requires skilful managers and people willing to accept the cultural changes this brings about. They will need to take up the challenge of orchestrating all the appropriate skills within practices, in a way that leads the players to perform a successful contracting process. This will require managers to secure changes in behaviour as demanded by the new working environment (Boaden, 1994).

Implementation of changes can be influenced by pre-existing values at the same time as new mechanisms will be inducing cultural change. “If you look at West Glamorgan alone, there were some GPs in Swansea that had no access to X-rays and they have been asking the hospitals for years to let them have access to X-rays. When they became fundholders they changed hospitals. That made the local hospitals think again and now they have access to X-rays in their local hospitals. So there has been a big change in culture … I have to admit I have spoken to more people from the hospitals in the last year than I have spoken to in the last 30 years.” (Interviewee 7, 1994: Wales)

**Germany**

Analysts involved in proposing reforms to the German system have been careful in dealing with changes which affect cultural values, in particular the existing normative framework (NERA, 1993).

Knox (1993) illustrates the importance and power of traditional arrangements in Germany: Bismarck, the Iron Chancellor, could not get his way against the entrenched interests in the prevailing context of the unified Germany of the early 1880s and as a result had to discard his preferred idea of a tax-supported system for the insurance-based system.

\textsuperscript{16} See section 6.3.
6.4.3 External influences
Implementing changes also requires managing and understanding the exogenous factors affecting the process. One of the main influences identified is the adoption of external models as a result of ideological influences, followed by the acceptance of the necessity to change towards systems used in countries considered more advanced.

WHO recognizes that “one key influence is the transference of reform models and ideas across national boundaries” (WHO, 1997). This influence affects both the formulation and the implementation of reforms. Examples include the adoption of the NHS model in countries such as Greece, Italy, Portugal and Spain, where the influence of the British NHS is apparent.

While learning from international experience can be beneficial, concern exists when models are imported without a clear understanding of the prerequisites and implications of implementation in a totally different environment. “Transference of ideas, not skills, will add to the problems of implementation.” (WHO, 1997)

6.5 SUMMARY
Section 6 has focused on the development of contracting and the management of the process of change necessary in implementing contracting mechanisms. Firstly, issues which have been identified as influencing feasibility have been discussed. It is argued that successful implementation of contracting mechanisms is affected by the existence and the acceptance of a national health policy. In addition, transaction costs have been considered as one of the major challenges for contracting. This is evidenced in the United Kingdom, where reforms were followed by one of the highest levels of spending in recent years. The extra cash was used in part to hire and train the human resources necessary to run the contracting process. However, the lack of skilled people to carry out contracting negotiations and the non-availability of information for decision-making were major constraints which negatively affected feasibility.

Secondly, the management of change has been discussed from the point of view of communication and leadership. It is argued that a lot of the confusion in the United Kingdom was caused by lack of leadership and poor communication of objectives and changes.

Thirdly, action planning and piloting for management of change has been discussed. It is observed that action plans or master plans contribute to
keeping the reform process to a timetable for implementation, spreading changes over a reasonable time frame when necessary. In planning action, the creation of policy planning and coordination agencies and the use of pilot experiments are suggested.

Fourthly, the study has discussed the importance of taking into consideration community participation and the involvement and support of other key players, and looked at strategies to deal with the involvement of key players. Empirical evidence shows that in the United Kingdom public opinion appeared to have a great influence on the implementation of reforms, while in Germany a framework of institutionalized countervailing forces called for more attention to consensus-building and the formation of strategic alliances with different players.

Finally, it is observed that routine work can be negatively affected by the implementation of contracting mechanisms. Also, from the interviews in the United Kingdom it is observed that contracting mechanisms have brought far-reaching changes in the expectations of both the general public and the staff of the NHS. To some extent, new expectations and the willingness to change were influenced by external factors. It is acknowledged that the transference of reform ideas and models across national boundaries, without a clear understanding of the prerequisites and implications of implementation, could lead to frustration and add to the problems of implementation.
7. MACH in Kyrgyzstan: focus on context

In Section 7, the first stage of the MACH is applied to Kyrgyzstan. As the focus here is on content, the section is essentially a descriptive one.

7.1 PRINCIPLES UNDERPINNING THE KYRGYZ HEALTH CARE SYSTEM

As stated earlier, the Government of Kyrgyzstan has been developing a national health policy. The policy goals or principles set out in its policy document are:

- health gain: improving the health status of individuals and the population as a whole through health care interventions, which implies adding years and quality to life;
- efficiency: choices in health care should be made in such a way that the maximum total benefit from the resources available to a community is obtained;
- equity: health services should be available according to need rather than ability to pay, and the total costs of provision should be distributed according to individual ability to pay;
- quality of care: health care should be high quality with respect to the input of resources, the process of provision and the outcomes.

7.2 STRUCTURE AND KEY PARTICIPANTS

Kyrgyzstan has a population of approximately 4.5 million. At present the Ministry of Health is completely responsible for the organization and management of the health care system. On the finance side, health services are almost totally financed through taxation.

Health services are delivered at local level through feldsher/midwifery stations (FAPs) serving populations of 500–2000. These offer consultations on health problems and preventive services. Feldshers can also prescribe medicines for some common diseases. In rural areas there are also polyclinics.

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17 General information on Kyrgyzstan can be found in Annex 8 and further information on the Kyrgyz health care system in Annex 9.
serving populations of around 9000 and rural hospitals serving populations of 20 000–25 000. Each rayon (district) has a central hospital, and each oblast (region) has an oblast hospital and specialized oblast centres, e.g. tuberculosis dispensary, dermatology and venereal disease dispensary, sanitary-epidemiological stations and a centre for AIDS. In the cities polyclinics function as primary care facilities and also provide specialist outpatient services. At national level there are hospitals, specialized research institutes and other medical institutes in the capital, Bishkek, which serve the whole country and act as final referral point. Control of communicable diseases and some environmental services are organized according to the traditional sanitary-epidemiological services (SES) model. Community care has not developed significantly. Mental health services are organized by the Chief Psychiatrist in the Department of Curative and Preventive Services in the Ministry of Health. There are also separate psychiatry and narcology facilities in every rayon.

The organization described above is changing rapidly. In parallel with many other reforms taking place in various sectors of Kyrgyz society, health reforms are also on the agenda. The proposed reforms have been developed with the assistance of international organizations and are outlined in the document MANAS – National Programme of Health Care Reforms (1996) (Ministry of Health, 1996). Under the current structure, some key participants have been identified and are described below.

**Parliament** has the authority to develop and adopt laws concerning the health of the population, determine strategies, approve plans and programmes of action aimed at health protection and improvement, and ensure financial support for health services. Since 1994, Parliament has consisted of two chambers: the Legislative Assembly, with 25 permanent elected members to represent the interests of the whole population, and the Assembly of People’s Representatives, with 70 members, which meets only intermittently and represents regional interests.

The **Cabinet of Ministers** is responsible for debating proposed legislation and plans. It has a department in charge of the social sector, which includes the health sector. As explained above, a substantial volume of legislation can also be enacted by the Cabinet.

The **Ministry of Health** has been accorded a supervisory and policy-making role under the People’s Health Protection Act. This implies undertaking all responsibilities and functions that were formerly carried out in Moscow. The Ministry counts on the support of a decision-making board
called *Kollegya*, consisting of the Deputy Ministers, the Dean of the Medical Institute and the heads of the Bishkek and Osh Health Departments. Although it is at a lower level than the Cabinet of Ministers, all policy-making processes in the Ministry of Health are finalized at the *Kollegya*.

The **Ministry of Finance** deals with financial planning at the national level and approval of *oblast* budgets, including recommending how the *oblast* budgets should be allocated to various sectors.

The **State Commission on Foreign Investment and Economic Assistance** (*Goskominvest*) develops and coordinates public investment policies and plans, including those for the health sector. It also coordinates the activities of international and bilateral donor organizations in the country.

The **MANAS National Team** was established in early 1996, with the task of supporting the implementation of the MANAS National Programme on Health Care Reforms. The group is headed by a Programme Coordinator and comprises 25 central level professionals and seven regional level professionals, one from each *oblast*. The group was also assisted by a Programme Coordination Secretariat comprising an adviser, a strategy consultant, a resident technical adviser and an administrative assistant.

*Oblast health administrations* (*OHAs*) are responsible for implementing the constitutional rights of citizens to health care and administering the health services. They develop health programmes, prepare local budgets, ensure the implementation of programmes and provision of health services within their *oblasts* and provide in-service training for health personnel.

### 7.3 REGULATORY FRAMEWORK

Following independence, in 1992 the Government enacted three basic laws in recognition of the urgent need for reform and regulation of health care:

- People’s Health Protection Act of the Kyrgyz Republic
- Medical Insurance Law
- Sanitation Law of the Kyrgyz Republic.

(a) **People’s Health Protection Act of The Kyrgyz Republic**

This Act, approved on 2 July 1992, determines the general legal framework for health protection and the roles and responsibilities of different state bodies in health protection. The Act defines the roles of the different bodies as follows:
• Parliament develops and adopts legislation concerning the health of the population; determines the strategy and approves plans and programmes of action aimed at health protection and improvement; and ensures financial support for health services;
• the Ministry of Health supervises the activities of all health-related institutions, including training and research institutions and coordination of their activities, and approves normative and methodological documents concerning health;
• local state administrations ensure the realization of the constitutional rights of citizens for the protection of their health and the management of health services; develop health programmes, prepare local budgets, ensure the implementation of programmes and the provision of health services within the oblast, and provide in-service training for health personnel as a step towards updating and ensuring public education;
• public associations, employers and other officials have responsibilities in health protection such as public education on health and occupational safety.

Part II of the law expresses citizens’ basic rights regarding health protection in the following terms:

• free use of national health protection establishments
• equal access to defined basic preventive and curative health services
• free choice of physician
• access to the nearest source of emergency care irrespective of what kind of facility it is
• the right to social insurance in case of complete or partial loss of health and work capacity
• the right of access to information concerning their health and the health of their children.

The Government is responsible for taking the measures necessary to protect the health of the population and for guaranteeing sources of finance.

Further regulations have been issued, based on the law, on the following issues:

• measures to improve the health protection of the population
• the right of health workers to free privatized housing
• the Republican Health Fund.

(b) Medical Insurance Law
The law provides a basis for financing the health care system through medical health insurance, both compulsory and voluntary. It is anticipated
that compulsory medical insurance will be administered by health cash desks established at oblast level. Although not yet defined by the Government, premiums are to be paid monthly by employers for each employee and by local administrative bodies and the State for government employees, pensioners, the unemployed and students. Voluntary medical insurance is to be provided by private insurance companies.

Medical insurance is to be controlled and monitored by independent medical commissions to be established by the local administrations. The scheme is to be supervised by the Ministry of Health.

(c) Sanitation Law
This law refers to Article 35 of the Constitution and aims at ensuring the right of citizens to sanitation and environmental health safety. This responsibility is given to the Department of Sanitation and Epidemiology in the Ministry of Health. This is a significant difference from the former Soviet system, where health and sanitation issues were covered by different ministries.

A substantial volume of legislation can be enacted by the Cabinet of Ministers without the need for parliamentary approval. The Cabinet has a significant role in the health sector due to its intersectoral nature.

Although current regulations entitle all citizens of Kyrgyzstan to a comprehensive package of services, diminishing resources have forced a reassessment of the benefits package. This revision is expected to rationalize service provision without compromising the prioritized health problems of the country.

7.4 SUMMARY
Section 7 has focused on addressing contextual factors relevant to the Kyrgyz health care system. The current health care system of Kyrgyzstan has some features which are also common to the British system, namely a tax-based financing system, regional administrations integrated into a national health system and centralized decision-making in the hands of the government. However, it is clear that the context in Kyrgyzstan is very different from the contexts in Germany and the United Kingdom. From a demographic point of view, Kyrgyzstan has a much smaller and younger population than those two countries. In fact, in terms of its population the whole country could be compared to a large region/Land of the United Kingdom or Germany. Thus, it can be argued that it may not require an organizational structure
with so many layers (central, oblast, rayon, etc.). Since the country has only recently acquired full independence from the former Soviet Union, this structure may change when the entire social, economic and political system is reorganized. So far, the transition period has resulted in continuous economic decline throughout the 1990s. The basic laws have only recently being approved and more legislation needs to be developed in the future. Also, community participation in decisions affecting the health care system is still at an early stage and channels for citizens to express their views and for guaranteeing accountability will need to be developed.
8. MACH in Kyrgyzstan: focus on contracting

8.1 UNDERSTANDING THE CONTRACTING PROCESS

As mentioned in Section 7.1 and Annex 9, it is envisaged that in the long term the health care system of Kyrgyzstan will be insurance-based, with purchasers and providers in charge of negotiating service provision contracts. Considering that professional organizations and other associations representing diverse interests are not traditional in Kyrgyzstan, these contracts will probably have an individual character.

Currently, the health care system of Kyrgyzstan is considered to be too centralized. Most decisions on health service provision and organization, including staffing levels, are in the hands of central government. However, once the purchaser–provider split is implemented the system is expected to become more decentralized, with purchasers and providers having a good degree of freedom to negotiate contracts for service provision. However, decisions concerning new investments are expected to remain centralized and not to become part of the contracting negotiations. This strategy follows the German approach and is intended mainly to avoid over-capacity and guarantee allocative efficiency.

The introduction of social insurance would be gradual and followed by an increase in the share made up by insurance premiums of the total amount of resources available for health care. Health funds would be established at oblast level and the oblasts would be responsible for allocating resources for service provision. Part of these resources are expected to be allocated to primary health care facilities. Urban facilities would receive a certain amount based on the number of patients enrolled in their lists, while rural facilities would receive allocations per catchment area. Both urban and rural facilities would be responsible for contracting secondary and tertiary care for their patients.

As well as primary health care facilities, OHAs would also enter into contracts with providers, with the Ministry of Health giving general guidance on purchasing priorities and exercising specific powers to purchase training and research services. When contracting primary health care services, OHAs would be able to consider:
• contracts with existing polyclinics
• contracts with small groups of practices
• contracts with individual private practitioners.

Primary health care would be provided by FAPs and by primary health care centres in rural areas, with the latter responsible for monitoring the former. In urban areas, primary health care groups would be responsible for providing first level curative care and preventive services. When necessary, primary health care centres and primary health care groups would refer patients to the hospitals with which they have contracted.

Inpatient care would be provided by the autonomous public hospitals and existing private hospitals. They would admit patients on the basis of their contracts with primary health care providers.

Tertiary care would be provided by _oblast_ hospitals and national institutions. The national institutions would have contracts with the _OHA s_ and would receive teaching increments from the national budget.

The new contracting process described here implies that nominal ownership of hospital facilities will remain with the Ministry of Health, _rayon_ or _oblast_ as at present, but managerial autonomy would be granted to hospital managers who would decide on staff levels, purchases of drugs and equipment, and priority investments for the maintenance of facilities, etc. These decisions would be taken in accordance with agreed contracts and prospective deals. Similar autonomy would be granted to primary health care facilities. The contracting process in the long term is illustrated in Fig. 2.

### 8.2 FUNCTIONS OF CONTRACTS

#### 8.2.1 Implementing health policy

The health policy principles adopted by the Government have been clearly defined. In the following pages, the study concentrates on discussing each of these principles and how they can be implemented in Kyrgyzstan. The reader should keep in mind that contracting has not yet been implemented in Kyrgyzstan. Therefore, in this Section the MACH is used as a framework for the author’s comments/proposals for the further development of contracting.

**Matching population needs to provision**

At national level, measures will need to be taken to evaluate the health status of the population (epidemiological situation) continuously and to develop
strategies for the implementation and dissemination of policies at oblast level. According to current plans described in the MANAS programme, information on priority needs and health status will be provided by a general directorate which has yet to be created (the General Directorate of Disease Prevention and Health Promotion).

Although the decentralization brought about by contracting is likely to bring a greater improvement in health, the lack of involvement of the
Ministry of Health in the allocation of resources may result in contracts which do not contribute to achieving the targets determined at national level. To avoid this, the Ministry of Health should develop mechanisms to determine the geographical distribution of resources to the oblasts, as well as for approving the oblast budgets and ensuring that the funds are spent in line with the identified needs of the population.

It is also envisaged that OHAs will need to be reorganized so as to carry out their new activities better. One way that this could be done is through the establishment of a department responsible for purchasing. The tasks for such a department could include:

- translating health plans and strategies into contracts to be agreed with providers
- negotiating with each provider the terms of the contract
- ensuring that the contracts reflect the needs of the population.

In addition, efforts should be concentrated on developing close relationships between the OHAs and the primary health care groups and hospitals. This will facilitate the development of contracts with service specifications that reflect predefined priority areas at national level.

**Increasing equity**

Contracting *per se* cannot address equity issues in Kyrgyzstan. However, contracting can support equity through needs assessments and the allocation of resources in accordance with the identified needs. This is because, through needs assessment, purchasers/planners can identify vulnerable and disadvantaged groups or communities that need to be addressed under the contracts entered into by the OHAs and primary health care groups. It is expected that an increase in resources for under-served communities would result in a speedy improvement in the health status of the population in these particular communities. At the same time, the flow of resources would have an impact on the health care infrastructure, contributing to the development of local provider organizations.

If current financing mechanisms remain unchanged, it is fair to conclude that contracts would not contribute to bringing about equal access to equal needs in Kyrgyzstan. However, current proposals such as the development of social insurance can have a positive impact on the accessibility of health services.

Equity is also related to the utilization of health services. People with equal needs may not be able to use the available services equally. This may be due
to geographical barriers to accessibility, but it may also be the result of cultural factors. Once more, financial arrangements and countrywide provision of services (geographical accessibility) will have a strong influence on the level of utilization.

In primary health care settings, contracts can foster higher rates of utilization of services, particularly if they determine that certain services should be provided at home by health care personnel. The provision of door-to-door services can have a substantial impact, particularly in relation to mother and child health.

**Increasing accountability**

Contracting processes require some form of accountability: injecting more accountability into the current system is a concern for Kyrgyzstan. Within the MANAS programme, it is suggested that a specific department be established in the Ministry of Health with the mandate to:

- establish standards of good practice in purchasing and contracting
- advise on quality assessment, quality assurance and quality management in contracts
- license private insurance companies.

However, the findings of this study suggest that accountability will develop in the system when purchasers start to refuse contracts with some providers due to failures to fulfil contract requirements.

**Increasing choice**

In the medium term, the strategies proposed for Kyrgyzstan focus on prioritization and rationalization, thus increased choice for patients is not a central issue. According to the proposals in the 1996 MANAS Programme, it is expected that more emphasis will be placed on other areas in the long term, including improving patient satisfaction. Whether this will mean more choice is unclear from the available literature. Nevertheless, it is certain that factors such as the difficulty of gaining access to various geographic locations, the lack of a democratic tradition and the existence of inappropriate legislation are obstacles to be tackled. The use of contracts *per se* will not be enough to improve choice for the population.

**Increasing efficiency**

According to the MANAS Programme, treatment protocols and other aspects related to standards in service provision are to be established by the Department of Purchasing and Performance Evaluation at national level
and are expected to become the norm for all contracts. If high standards of service outcomes are specified in contracts, technical efficiency is expected to increase.

In the medium term, it is envisaged that hospitals will receive global budgets from central government. Hospital managers will need to reallocate funds across budget lines and be accountable for efficient management of the budget. In the long term, it is expected that hospitals will be paid on a cost-per-case basis. As a result, hospital managers are expected to increase efficiency in an attempt to reduce costs and generate surplus from the amount paid per case.

The MANAS Programme also proposes that in the medium term primary health care facilities will continue to receive allocations based on the current itemized budget. In the long term, rural primary health care facilities will receive per capita allocations based on their catchment areas. Urban primary health care facilities will receive per capita allocations depending on the number of patients registered on their lists. Both rural and urban primary health care facilities are expected to use their budgets to provide primary health care services and to contract secondary and tertiary care for their populations. The combination of a budget ceiling with contracting is expected to foster technical efficiency on the provider side, because providers will probably be requested in the contracts to be more productive without receiving extra budgets.

Increasing efficiency will require incentives/sanctions which can encourage key players to achieve predefined targets (including quality standards) with the minimum use of resources. Nevertheless, the introduction (or threat of introduction) of competition in the near future would only have a limited impact on efficiency. According to current proposals, hospitals, for instance, are not expected to compete for contracts from the OHA. Similarly, rural primary health care facilities will not be competing for registered patients. Some level of competition (or threat of competition) for registered patients may occur among urban primary health care facilities. Contracting in this case may put pressure on providers to achieve higher levels of technical efficiency.

Despite the relatively low level of competitive pressure, efficiency gains are expected to be made due to:

• the definition of service provision in contracts which would be based on treatment protocols developed to reflect the best available knowledge;
• the implementation of budget ceilings.
**Increasing quality**

The contracting process can contribute to the development of quality standards. It is expected that these standards would later become an integral part of the negotiated contracts.

Under the proposed organizational structure, the national Department of Purchasing and Performance Evaluation would be in charge of advising on the quality issues to be adopted in contracts. This task would be supported at *oblast* level by the Department of Purchasing, which would also be responsible for monitoring the standards set in the contracts.

Monitoring, a crucial function for improving quality of care, is associated with contracting. A major step towards improving quality of care through contracting is to establish information systems that provide feedback on the outcomes of the care given to patients. This is discussed in more detail in Section 9.1.6.

### 8.2.2 Defining services

Kyrgyzstan has chosen to define at national level the priority services to be made available through public financing. These services constitute what has been called the benefits package; the definition of such a package is a means of putting the priority-setting exercise into operation. Besides broadly defining the priority services, the package also specifies the extent to which they should be subsidized.

It is expected that all the services in the benefits package will be ensured by contracts. However, the implications of this study suggest that OHA and PHC facilities would have a reasonable degree of freedom in specifying these services. Since treatment protocols in Kyrgyzstan are outdated, flexibility in the definition of services would allow the OHAs to change these protocols through contracts. At the same time, flexibility in defining services would help OHAs and primary health care facilities to address local priorities. Ultimately, the specification of service provision based on treatment protocols developed in accordance with the best available knowledge would help in improving health and quality of care. Clearly, some clinical freedom would need to be relinquished in the process if current practices are shown to be outdated. This may be a difficult reform issue that the Government will need to deal with.

### 8.2.3 Defining volume

According to current proposals, both the OHAs and primary health care groups will operate contracts with broadly defined volumes, similar to the
block contracts used in the United Kingdom. These will mainly contain definitions in terms of curative and diagnostic care.

In contrast to Germany and the United Kingdom, it is proposed that contracts should also include volumes of certain preventive services, such as monitoring pregnant women and the growth of infants and children, and the provision of immunization services. This is justified by the fact that these services are considered essential to achieving the policy goals previously discussed.

Defining volumes of preventive services will require data on the frequency of home visits by medical professionals and on the visits of patients to health care facilities. Here, information systems with historical data will be needed, a responsibility that rests with the OHAs. If this kind of information is not available, the implementation of such proposals will be affected.

The implications of this study are that it will be very difficult for primary health care groups contracting hospital services to define the volumes of care in the contracts, even in the long term. This is because these groups will be caring for small populations (maximum around 10 000 patients) and will therefore need to contract very few unpredictable cases of hospital treatment per year.

One approach is for primary health care groups to join up and specify aggregate volumes in their contracts. These contracts could involve all the primary health care groups providing for the hospital needs for the entire population of a specific oblast. This would strengthen the groups’ bargaining power in their negotiations with hospitals as well as facilitating the specification of contracted volumes.

8.2.4 Defining prices
Partly for historical reasons, the definition of prices in contracts remains one of the greatest challenges of all in Kyrgyzstan.

Under the former health system based on the Semashko model, hospitals received itemized budgets to cover all their expenses. Managers and clinical professionals alike were insensitive to prices and costs. Little was known about the cost of any service provided and there was no reason to develop costing mechanisms. As a result, there is still a lack of information on the cost of services and interested parties find it difficult to define prices in contracts.

This study suggests two ways to tackle the problem.
1. Parties can start contracting on the basis of approximate prices. In due course, through trial and error coupled with the necessity to balance the books, partners would arrive at acceptable prices. On the one hand, this approach would be the simplest way forward, requiring little in the way of resources. On the other hand, it entails high risks, mainly when prices are set too high or too low for one of the parties. Moreover, price differentials between different providers may give the wrong information to contractors, who may shift contracts to “efficient” providers which are in fact under-priced and may be about to go bankrupt.

2. Costs can be estimated by carrying out a national survey. This would involve selecting a varied sample of health units from different oblasts (urban or rural primary health care facilities, hospitals, etc.) and different geographical locations within oblasts. A careful procedure would also require that the sample randomly takes into account units that care for populations of different sizes. Once most costs are determined, the information could be made available to all contracting parties. Partners would then be better able to define starting prices, which could be reviewed in every contracting cycle.

In the organizational structure proposed by the MANAS Programme, such a task could rest with the Department of Financial Analysis and Resource Allocation. Nevertheless, it is envisaged that Kyrgyzstan may require some international support in developing its costing and pricing mechanisms.

8.2.5 Defining conditions
Treatment procedures are defined by protocols in Kyrgyzstan. However, there are no specifications concerning the conditions related to service provision. Overall the system is provider-oriented and gives little consideration to improving conditions such as waiting times and other issues related to the quality of treatment received. It is expected that contracts could change the current situation. The implications of this study are that incorporation of consumer opinion directly into contracts, or the development of standards for service provision, would be important steps towards changing the current provider-oriented mentality. This will require more participation from the community in the contracting process.

8.2.6 Defining payment methods
Under current arrangements, health facilities are funded from central government through line budgets, with payments based on historical data on utilization. This method is, to a certain extent, a reflection of the payment methods used when Kyrgyzstan was part of the Soviet Union.
According to Government plans, in the long term payments will be more decentralized. Primary health care facilities will assume fundholding functions and will pay for secondary and tertiary care from their own budgets.

This study indicates that the proposed change offers considerable challenges. In terms of information technology, the current facilities are not equipped to manage the extra transactions involved in fundholding. As noted above in the case of the United Kingdom, information technology was necessary to manage the extra workload generated by fundholding.

Concerning human resources, it is also evident that in the short to medium term the expertise and skills necessary for managing fundholding are not well developed. Moreover, in the medium to long term the availability of training institutions in Kyrgyzstan is also limited.

In the light of the knowledge accumulated in this study and the above limitations, the decision to pay providers through a fundholding scheme similar to the British one is dubious. In fact, it may be argued that primary health care facilities in Kyrgyzstan should not have a fundholding function.

However, the Government appears to be decided and is likely to go ahead. Under these circumstances, it is suggested that a phased approach should be adopted as outlined below.

In a first phase, primary health care facilities would not have fundholding functions. Instead, rural facilities would continue to be paid through line budgets. However, a higher level of autonomy would be introduced, allowing these facilities to transfer resources between different lines. The total budget allocated to the rural facilities would also include resources for payment of the FAPs.

By contrast, urban primary health care facilities would be paid according to a predefined catchment area for which they are responsible. Since these facilities are new, this method of payment would not conflict with traditional practice.

During the first phase, hospitals would be paid by the OHAs from global budgets. In order to increase the managerial autonomy of hospitals, global budgets would be used instead of itemized line budgets. The total amount of these budgets could be calculated using historical data.

National institutions would receive global budgets directly from the Ministry of Health during the first phase covering all aspects related to the
provision of tertiary care. For research activities, these institutions would be required to present specific proposals to be financed on an individual basis.

The first phase would last for about 3–4 years, giving the key participants time to prepare themselves for the next phase.

During the second phase, rural primary health care facilities would be paid relative to their catchment area. In contrast, urban facilities would start to be paid per patient on their lists. Both groups of facilities would be required to contract secondary and tertiary care for their populations. Incentives would also be paid to encourage health promotion and disease prevention.

Hospitals would be paid per case, with services grouped into distinct case categories similar to the Fallpauschalle method used in Germany. It is expected that this system would give providers incentives to contain costs. However, it would require management and accounting information systems, the establishment of monitoring and auditing functions, systems of coding and reimbursement, etc.

Similarly, national institutions would receive funds from the OHAs through case-based contracts with the oblasts, as well as through teaching increments from the national budget.

**8.3 IMPORTANT CHARACTERISTICS OF CONTRACTS**

**8.3.1 Level of negotiations**

According to the proposals in the MANAS Programme, OHAs in Kyrgyzstan will contract individual primary health care facilities which will in turn contract hospitals. Such an arrangement resembles the fundholding scheme in the United Kingdom.

The implications of this study are that primary health care facilities should amalgamate to form associations which would improve their bargaining power, reduce the costs of contracting, and facilitate dissemination of information on prices, quality indicators, etc.

Assuming the existence of favourable legislation, primary health care associations would also have more flexibility in choosing different methods for paying hospitals. For example, instead of contracting on a case basis, the associations may decide to set up block contracts for emergency services. This may shift some of the risks involved to the providers and at the same time reduce the transaction costs of contracting.
8.3.2 Negotiating space

One of the strongest factors limiting the negotiating space of contracting parties is the availability of financial resources. From the purchasers’ point of view, the limited resources available for health care imply a weaker position in comparison with providers.

Negotiations will also be limited due to the current epidemiological situation. Certain health priority areas (mother and child health, infectious diseases, etc.) will need to be addressed immediately, so that purchasers will not have the freedom to contract services other than those which are given priority.

From the point of view of legislation, some negotiating space may also be lost due to the definition, at national level, of a benefits package. However, as previously mentioned, it is expected that these benefits will be broadly defined, leaving some scope for the parties to negotiate.

8.3.3 Identity of interests

In contrast to Germany, the partners in Kyrgyzstan have worked together towards a common goal for many decades. This is partly an inheritance from the socialist era, when the rhetoric of “workers working for the benefit of themselves” was commonly accepted.

Although in the long term purchasers and providers will be developing differentiated functions, in Kyrgyzstan there is a great potential for both parties to maintain closer links and develop a softer relationship. With the implementation of contracts, the unifying principles of the socialist era can be preserved and gain more content. The implications of this study are that the OHAs should have an important role to play in clarifying common goals and the mutual benefits of nurturing a close relationship. In particular, OHAs can play a crucial role in developing a public health perspective among contractors. This perspective is often lost when several small purchasers are required to buy services that only address local needs.

8.3.4 Degree of participation

The developments in Kyrgyzstan discussed in this study indicate that the proposed health care system will generally allow more popular participation, although it is expected that strong elements of centralization will remain in place.

Clearly, it will take some time to develop the transition from a closed to a participatory system. This study suggests that a sudden change is not advisable, since it may result in chaotic interactions.
From the perspective of public participation at national policy-making level, decisions will to a great extent remain centralized. Similarly, at the oblast level there is no evidence that new forms of public participation will be developed.

At the local level, the development of primary health care facilities can help the creation of new channels of public participation. As the link between patients and the majority of services available, these facilities are in a strategic position to defend the interests of the population they represent. In turn, it is suggested by this study that the establishment of community councils in each primary health care setting would favour increased community participation. Such councils would consist of representatives of the facilities and of their users. They should allow users to express their expectations of primary health care as well as hospital services. If properly run, the councils’ experience in the long term could also help in reducing the current bias towards the development of a highly bureaucratic system.

If they are established, such councils would need to develop strong forms of democratic participation which could avoid manipulation of information by the primary health care facilities (e.g. complaints may be filtered before reaching the authorities in charge). Also, it is not certain whether the population would be willing to participate actively in the councils.

8.3.5 Degree of specification
The degree of specification in the contracts is a controversial issue. On the one hand, a step by step approach suggests that to begin with contracts should be broadly formulated and then evolve gradually into more detailed contracts. This approach has been adopted in the United Kingdom.

On the other hand, this study stresses that the current Kyrgyz health care system contains several inefficiencies, some of which can be tackled via contracts. For instance, contracts can be excellent tools with which to change some of the treatment protocols currently in use. By specifying in the contracts certain techniques for treatment and diagnosis, purchasers can speed up the introduction of those contemporary medical protocols which have proved more efficient.

Clearly, the use of well defined treatment protocols in contracts may require a high level of detail. Also, the specification of these protocols in the contracts does not imply that providers will be able to make them available. These are important aspects which need to be taken into account.
If the introduction of new treatment protocols is feasible, it is expected that this might provoke a shift in the focus of health care provision. The current health care system is strongly input-oriented, i.e. the emphasis is on determining the number of beds available, the number of doctors and nurses on duty, etc. The introduction of treatment protocols in the contracts would shift the emphasis to the process of provision (i.e. how things should be done). This is a step in the right direction, although the ultimate goal would be to have a more outcome-oriented health care system.

As previously discussed, this study supports the development of a close identity of interests between purchasers and providers in Kyrgyzstan. An important aspect would be the way in which the contracting partners and the medical professionals would view the introduction of contract specifications that included treatment protocols. Ideally, such protocols should neither undermine the relationship between the contracting parties nor be taken as a threat to the medical professionals. Here purchasers have an important role to play by developing protocols together with providers and discussing them with clinical personnel and other medical staff who may be affected. This would increase the likelihood of the specifications being followed (see Section 9.3).

### 8.3.6 Scope for contracting

At present there is a clear limitation in Kyrgyzstan in the number of eligible providers of hospital services, especially outside the capital city. Under these circumstances and following an approach similar to that applied in Germany, the MANAS Programme proposes that primary health care facilities will be required to contract with certain hospitals which are considered to be essential. As stated above, this measure is mainly aimed at ensuring that local hospitals continue to exist in remote areas and that over-capacity is avoided in areas of high population density.

It is not envisaged that this scenario will change drastically in the long term. The number of hospitals in remote areas is not expected to increase owing to the lack of resources for investment in both the public and private sectors. Paradoxically, however, the Government will need to deal with over-capacity in some areas. Rationalization, which has already been started, often means the closing down of some rural hospitals.

The rural hospitals are seriously under-equipped, poorly staffed and under-utilized units for inpatient care. Aware of this situation, the Ministry of Health is currently attempting to close them or to transfer their resources to rural primary health care facilities. Obviously the process of rationalization
is facing political and professional resistance. As a result, it is expected that some rural hospitals will survive and be available for contracting in the future.

Under these circumstances, this study recommends that purchasers should be able to select rural hospitals according to criteria based on policy goals rather than on legal ramifications.

8.3.7 Degree of enforcement
The expectations created by the implementation of contracting in Kyrgyzstan are linked to the policy goals previously discussed (health gain, equity, etc.). In this context, and taking into account the knowledge accumulated in this study, it is hard to argue in favour of legally binding contracts.

First of all, such an approach would damage the efforts towards building up a common identity of interests between the partners. Partners could easily start to take very cautious measures to protect their position vis-à-vis their contracts in an attempt to avoid being accused of non-compliance by the other side). Resources would be wasted in drawing up very detailed contracts aimed at guarding positions rather than dealing with predefined policy goals.

As was seen in the United Kingdom, the development of an “us” and “them” relationship can easily undermine efforts to reach common goals. This is a problem, particularly at the beginning of contracting when the participants’ roles are not very clear and can easily be misunderstood.

Legally binding contracts would also have negative financial implications for Kyrgyzstan. Besides the need to create legislation regulating these contracts, resources would be required to enforce them. This includes extra expenses for courts, judges, etc.

8.4 SUMMARY
Section 8 has focused on the contracting process and the functions and characteristics of contracts in Kyrgyzstan. Since contracting has not yet been implemented in Kyrgyzstan, the concepts developed in the MACH were used in this Section to make conjectures about future developments.

Decision-making which will affect contracting tends to be rather centralized in Kyrgyzstan, a feature also observed in the United Kingdom but not in Germany. However, the implementation of an insurance system and the
purchaser–provider split is expected to contribute to the decentralization process in Kyrgyzstan. However, the Ministry of Health is expected to retain powers to provide general guidance on purchasing priorities. In contrast to Germany, contracting partners in Kyrgyzstan will not be involved in budget-setting negotiations, since budget allocations will be based on catchment area populations or lists of patients. Also unlike Germany, it is not expected that contracting partners will play a strong role in defining contracting regulations. The contracting process envisaged for Kyrgyzstan seems to be appropriate, although the adoption of a regionally based health insurance system in a country with such a small population may be questioned.

As regards the functions of contracts, it is expected that contracts will play an important role in implementing health policy goals in Kyrgyzstan. For this purpose, the involvement of the Ministry of Health in the contracting process to ensure that funds are spent in line with predefined policies was defended. This involvement would resemble the approach in the United Kingdom, where the Secretary of State for Health has a strong role in determining priorities. The exercise of priority-setting and rationalization through contracts appears appropriate to Kyrgyzstan, where resources are scarce and the prioritization process can be developed at an early stage of reform implementation.

From the point of view of the characteristics of contracts, in Kyrgyzstan negotiations will be of an individual nature, resembling the fundholding scheme in the United Kingdom. However, it is expected and recommended that primary health care facilities group together and develop joint purchasing contracts. Negotiation of these contracts is expected to be somewhat constrained, since Kyrgyzstan is to develop its own benefits package. The participation of the public in decision-making in general is also expected to be constrained. In contrast to the United Kingdom and Germany, the population in Kyrgyzstan is not used to expressing its opinions. Another clear limitation worth mentioning is the scope of contracting. With a smaller population than the United Kingdom or Germany, the number of providers in Kyrgyzstan is also smaller. Outside Bishkek there is only a limited number of institutions that purchasers will be able to contract with for hospital services.
9. MACH in Kyrgyzstan: focus on development and managing change

9.1 FEASIBILITY OF CONTRACTING

9.1.1 Health policy
In 1993 Kyrgyzstan established a commission for developing its national health policy (the State Programme for a Healthy Nation) and in 1994 the final document was approved by the Government.

The document emphasized the importance of an intersectoral approach during implementation and very clearly adhered to WHO’s health for all approach. In brief, the State Programme:

- outlined the principles on which health policy implementation should be based
- specified priority areas to be tackled
- identified targets related to the priority areas
- defined the agencies responsible for implementing the policy measures
- set time frames for their implementation
- defined the sources of funding.

In essence, the Government has a developed broad national policy and identified specific health care reform strategies, and is now implementing these strategies. From the point of view of the experience accumulated in this study, all activities follow a proper logic and interact with each other. Thus, although some aspects of the content of the national policy or the MANAS Programme may be controversial, the country has a health policy to follow and this was established prior to the implementation of contracting mechanisms.

9.1.2 Differentiation of functions
In the long term, the strategy adopted by Kyrgyzstan specifies that structural changes will be introduced which will separate finance and the provision of health care. Nevertheless, this does not imply that new funding methods (e.g. an insurance model) will need to be implemented. In fact, it is believed that it would be better to introduce the purchaser–provider split
by giving providers and planning units a higher degree of autonomy while retaining traditional sources of funding (MANAS Health Programme, 1996).

At the *oblast* level, a Department of Purchasing is expected to be created. Its terms of reference would include the negotiation of contracts with providers. In parallel, primary health care units would also be given autonomy to negotiate contracts with hospitals.

According to the MANAS Programme, primary health care facilities will become fundholders, suggesting that the health care system in Kyrgyzstan will have a clear differentiation of functions.

### 9.1.3 Affordability

The funding of health services is constrained by the low income of the population. In addition, due to the difficulties being experienced during the transition period, health services have a relatively low priority in the overall process of policy-making.

Despite this, the Government has developed an ambitious plan to move from an integrated health care system to, ultimately, health insurance with contracts negotiated between purchasers and providers. Clearly, the introduction of a health insurance model will be of no value in mobilizing resources for health services if these resources are not available. Similarly, the use of contracts in a purchaser–provider split will not generate extra resources. Both aspects need to be taken into account in the development of the health system.

In order to understand the question of affordability in Kyrgyzstan, it is important to distinguish between preparations for and the implementation of contracting.

In the preparatory phase, those who will be in charge of contracting will need to be trained. Since the necessary expertise is not available in the country, training will require international input. The costs of developing training material, training trainers, running the training programme, etc. will be considerable. Currently the country is working with international agencies to obtain loans to restructure its health system. It is expected that the training of Kyrgyz personnel for contracting will also require international financial resources.

Once contracting is implemented, a considerable number of additional functions will also require extra human resources (see Section 9.1.4).
The additional resources for the preparatory and implementation phases would be required at two different levels corresponding to the levels at which contracting is to take place (i.e. oblast and rural/urban primary health care unit). This implies that each primary health care unit will need to develop all the functions associated with budgeting, book-keeping, contract management, etc. As a result, scarce resources would be directed to administrative functions rather than to health activities.

Clearly, if contracting were only to take place between OHAs and providers, the costs for both phases (preparatory and after implementation) would be much lower, making the implementation of contracts more affordable.

9.1.4 Human resources

The health care system has been administered by physicians for decades. All senior staff in the Ministry of Health, OHAs, hospitals and several other institutions are medical doctors with no special education in health services management. There are no public health specialists with a broad view of health services. Neither are there epidemiologists, as the term is understood in western societies. The sanitary epidemiologists have received only limited training in environmental and hygiene issues. Similarly, the vast majority of “health economists” in Kyrgyzstan are in fact accountants, not capable of developing a cost analysis of health service provision or of performing other functions normally associated with health economists.

In this context, it is evident that there are no human resources able to work as purchasers and carry out needs assessments, determine service provision and costing, develop economic evaluations, etc. Contracting will require human resources with experience in public health, epidemiology, statistics, health economics, financial management and planning, costing, accounting, information systems and technology, evaluation and quality assessment. Moreover, communication and negotiating skills will also be needed.

The development of these skills and knowledge will require an institutional approach which may take several years to establish. However, once better skilled human resources are in place, they can be deployed either to perform tasks related to contracting or any other tasks required in the health care system.

9.1.5 Regulation and legislation

Kyrgyzstan has inherited the highly normative character of the former Soviet health care system under which laws, regulations, directives and other legal mechanisms determined standards, processes and actions.
In the current transition period, the pace of change is undermining the capacity of the system to produce legislation. In the health sector, the lack of legislation is creating serious threats to the implementation of reforms. This is especially noticeable in the development of private health services and private health insurance and the implementation of contracting mechanisms.

As previously discussed, contracting requires a strong legal framework to define the rules. In Kyrgyzstan the lack of legislation, especially concerning the role of fundholding primary health care units vis à vis hospitals and OHAs, can affect the feasibility of contracting.

9.1.6 Availability of information

During the Soviet period, all health data collected were transferred to Moscow and all decision-making power was located there. A well established routine of data collection provided information on morbidity and vital statistics from peripheral units at rayon, oblast and republic level for onward transmission. Limited information was also collected on personnel and equipment. Almost all data processing was done by hand, resulting in delays and some data corruption. Quality control mechanisms existed, but the practice of data review was prone to abuse. Because of the punitive style of the Soviet administration, there was a tradition of reporting what superiors wanted to hear rather than facts. The data collection system served centralized planning and maintenance needs, but it was not used to support management initiatives at the local level.

The extent to which this malign tradition is affecting the reliability of current Kyrgyz data is uncertain. It is clear that most essential information is not available in the current structure. In particular, there is a lack of information on health status, health needs, health service activities and outcomes and costs of health service provision.

Clearly, Kyrgyzstan needs modern data collection methods, information technology to process the data and skilled human resources to maximize information systems. The greatest challenge is to develop a system which is capable of converting health statistics (raw data) into health information (processed data).

A first step would be to develop national health indicators. These would be the key element for successful needs assessments, policy development, monitoring and evaluation of health services. A definition of national health indicators would also help to send the right message to purchasers, defining
what they should be measuring in their contracts, and to providers to allow them to have a clear understanding of what was expected of them. In turn, purchasers should be allowed to assess how successfully a provider meets the contract specifications.

9.2 MOVING TO THE FUTURE

9.2.1 Communicating the objectives and expected changes

Kyrgyzstan is facing changes throughout society. In practice, change is now part of daily life.

During the initial post-independence period, change symbolized the coming of a new era capable of delivering all the goods and services available in western societies. The social momentum of high and unrealistic expectations was shattered within two or three years, when the realities of economic decline started to become apparent. The euphoria of independence was then replaced by the nostalgic feeling that in the past everyone had a job or every patient had access to the drugs he or she needed. In retrospect, people did not understand the process on which they had embarked and their high expectations culminated in tremendous disappointment. For political and ideological reasons, the public was misinformed about the reality.

There are reasons to believe that the hardship of the past has helped the public to see the transition process in a more realistic way. They now understand that it is painful, albeit not impossible.

In the health sector, the Government has carried out serious appraisals in close collaboration with international agencies. These were used to clarify the current situation, the goals to be achieved and the means to achieve them, resulting in the preparation of the MANAS National Health Care Programme with its proposals for gradual reform of the sector. Not surprisingly, the disclosure of the MANAS Programme caused public expectations to run high once more.

Thousands of copies of the Programme were made and distributed to all health care institutions before a clear communication strategy had been developed or a political analysis of the key players made. The expectation was that health professionals would read, understand and support the process of reform. This haphazard approach to communication is likely to bring problems in the future.
It is suggested that the Government should use all available means of communication (television, radio, newspapers, etc.) to target opinion leaders and the general public. Through these channels, the Government would explain the objectives of the reforms, the expected changes, the process of change and the possible problems. This communication exercise would help people to develop realistic expectations and realize that such a transition can be painful.

9.2.2 Leadership for change

Leadership of the health sector reform process in Kyrgyzstan has been assigned to a small group of people, the MANAS national team, whose members were selected by the Government from both the central administration and the oblasts to prepare and implement the health care reforms. They were the main target for the initial efforts to build capacity, which focused on locally developing a skilled workforce capable of dealing with the main components of the MANAS Programme. For this purpose, various training programmes were organized, including courses on project management, the English language, computer skills and several issues related to health care systems (payment mechanisms to providers, national drug policies, etc.)

The MANAS team has been working closely with the Ministry of Health, academia, Parliament and international organizations. The collective nature of the team’s leadership (46 people in 1996) has created a strong image for the Programme inside the country. Moreover, the stable conditions created for the work of the team have created a favourable environment for guaranteeing the continuity of the Programme.

Since the reform process will involve the adoption of new legislation in several areas, it is suggested that in the future the team focuses its efforts on working more closely with Parliament.

For the specific development of contracting, it would be beneficial to identify some individuals from the team who could become the champions of contracting. Through their leadership, similar champions could be identified at different administrative levels, enabling a critical mass to be formed and carry out the reforms.

9.2.3 Plan of action

Clearly, Kyrgyzstan has adopted a planned approach to health care reforms. From the development of the State Programme for a Healthy Nation to the development of the MANAS Programme, policy formulation and the
definition of the necessary tasks to achieve policy goals have been carefully considered.

However, it cannot be expected that implementation of the plans will happen exactly as described in the official documents. Political pressure, economic conditions and technical capacity can induce changes throughout the implementation phase. Nevertheless, the existence of a plan of action clearly indicates the direction of the reform process, the links between the different components of the health care system and the timing/schedule of the planned actions. As a tool for serving these purposes, the MANAS Programme represents a good example of a comprehensive, rational planning exercise.

In spite of its merits, it is suggested that the MANAS Programme needs to be more detailed in order to facilitate the implementation of contracting. In particular, accountability and responsibility for implementation will need to be made more specific and sources of finance more clearly identified in order to guarantee that implementation will be feasible. In turn, this will involve the calculation of estimated costs for the different stages of implementation.

### 9.2.4 Piloting

The MANAS Programme envisages that a piloting period is necessary prior to the introduction of fundamental changes in the health care system during the transition phase (medium to long term). But the piloting exercise is not detailed in the document.

This study suggests that piloting should involve all parties which may in the future participate in contracting. Moreover, as far as possible, the contracting exercise should test the whole contracting process and not only a part of it.

Prior to piloting, evaluation criteria will need to be developed. These would be used to assess the results of the exercise to determine:

- whether to propose revisions to the original plans prior to implementation
- whether implementation should continue
- whether key people are prepared to carry out their new tasks.

### 9.3 DEALING WITH KEY PLAYERS

Kyrgyzstan has perhaps the most developed democracy in central Asia. There are several political parties and free elections were held recently with a high voluntary turnout of voters.
However, Kyrgyzstan’s democratic processes are far from the norms of modern western societies, especially in relation to public participation. In fact, society continues to be dominated by the hierarchical command and control system of the former Soviet Union. There are no democratic pressure groups, professional organizations have yet to be established and public means of communication are state controlled. In this context, tribal identity is still the strongest social factor uniting different individuals. Due to family roots, a geographical sense of belonging and brotherhood, individuals from the same region value solidarity and help each other. Informal wise men may exist in some villages and they may even send representatives to discuss village matters in more formal decision-making settings.

In spite of such traditional forms of organization and power structures, the participation and impact of local leaders on the reform process is very limited. Political or bureaucratic power remains the determinant factor in decision-making: the key players in the formal structures in the health sector are Parliament, the Cabinet of Ministers, the Ministry of Health, the Ministry of Finance, the OHAs, the Goskominvest and the MANAS National Team.

This study suggests that in the context described here, the MANAS team should develop specific strategies to deal with all the key players. In particular, Parliamentarians should become more involved in the preparation of the reforms. They would need to be given thorough and timely briefings about the reform process or they could find it difficult to approve the Government’s proposals.

The Cabinet of Ministers, through its Department of Social Policies, is also participating in the decision-making process for reform implementation. An effective strategy to gain support from the Cabinet would be to have a representative of the Department of Social Policies on the MANAS team. This would create a link to open up opportunities for the logic behind the solutions developed by the MANAS team to be made known within the Cabinet.

Dealing with personnel from the Ministry of Health is a great challenge for the reform process. Faced with changes, most of the people from the Ministry have been taking a very conservative position, defending themselves from the reform process which they tend to consider as a threat to their positions. Here it is suggested that the MANAS team should concentrate its efforts on explaining that there are various opportunities for the workforce to acquire the new skills and knowledge to fulfil their new tasks.
This approach is also suggested for people from the local health administrations.

As regards the Ministry of Finance, it is important to note that due to the reforms it will lose its control over resource allocation and payment of providers. From the Ministry’s point of view, this may cause total health expenditure to increase.

The Ministry of Finance has already demonstrated a preference for the privatization of health services as a means of reducing the public costs of health care provision and to release public funds for other investments. However, the Ministry could benefit from advice pointing to the fact that privatization of health care financing is bound to increase the proportion of resources spent on health (in GNP terms) in an inequitable way. Clearly a crucial task would be to ensure that the Ministry is informed about these threats and about other areas where efficiency gains can be ensured. It should also become more acquainted with the increases in efficiency which can arise from the reform proposals contained in the MANAS Programme.

_Goskominvest_ is the main player involved in high-level fund-raising activities. It currently deals with the World Bank, the Asian Development Bank and other institutions which are providing resources for reforms in the health sector. Traditionally, _Goskominvest_ has borrowed specifically for medical equipment and pharmaceuticals, since it believes the human capacity of the country is sufficient to carry out the reform process. However, as previously discussed, the basic skills are not available. It is therefore suggested that the MANAS team should work closer with the _Goskominvest_ group, briefing its members on the financial needs for increasing the capacity of Kyrgyzstan’s human resources and the need sometimes to support the work of international experts in the reform process.

Although the most important players have been discussed here, other groups and/or institutions may also support or threaten the reform implementation. It is therefore suggested that the MANAS team engage in developing a more detailed political analysis of these players and specific strategies to gain and sustain support for the approved Programme.

### 9.4 MANAGING OTHER CONTEXTUAL FACTORS

#### 9.4.1  Maintaining the routine work

The implementation of reforms and contracting will generate extra work. As a result, existing staff will probably need to deal with new tasks at the
same time as they will have to cope with the day-to-day running of the health care system.

At the national level, the MANAS team is currently in charge of most of the new activities, which relieves the pressure on other professionals working at this level. This helps to ensure that routine work is carried out.

At the oblast level, keeping up with routine work will be challenging. It is suggested that careful planning should clarify which staff will be involved and the amount of time to be dedicated to reform implementation. However, it may be unrealistic to prepare plans at central level allocating time frames and tasks to oblast staff. This study proposes that broad frameworks should be prepared by the MANAS team which would subsequently be detailed individually in collaboration with each individual oblast. The oblasts would then negotiate individual working plans with other institutions at oblast level. This flexible approach would result in greater involvement of local people in planning while guaranteeing the continuation of routine work.

9.4.2 Cultural and social values

The reform process will need to take into account the strong elements left over from the former socialist system. New mechanisms being introduced in the current health system, especially contracting and the purchaser–provider split, are often associated with competition and the transformation of health to a “private goods” item to be sold on the market like any other goods. Although incorrect, such associations are inevitable in the current phase of social transition. As a result, there is a tendency towards polarization: on the one hand, some people will avoid the implementation of far-reaching changes, fearing that they threaten their socialist values. For these people, the reforms represent nothing more than the “marketization” of the health care system. On the other hand, the champions of market reforms will promote health care reforms and their achievements as their personal success. Both sides, using the reforms for political gain, can hamper the development of a national debate of a technical nature.

In order to ensure that discussions on contracting and health care reforms do not become too political, the technical aspects of contracting should be made available to the public. In particular, evidence should clarify that the use of contracting mechanisms does not necessarily imply the transformation of health into a “private goods” item.

It is also relevant to note that balances of power will change through the process of reform. Traditional sources of power common to some socialist
systems will be particularly affected. In particular, technical knowledge and skills will become more important in the struggle for power. Especially when considering the implementation of contracting, it is envisaged that more power and decision-making capacity will be transferred to regional administrations. Under these circumstances, it is expected that some individuals will attempt to monopolize the sources of knowledge and skills for their own benefit. If not avoided, such actions will slow down or even block the process of reform implementation.

9.4.3 External influences

Prior to independence, Kyrgyzstan had very limited contact with cultures outside the Soviet Union. Within this environment, people were led to believe that their health care system was superior and the rest of the world should learn from their experience.

After independence, due to increased communications and international contact, a different reality was unveiled. This was followed by a period of admiration of and mystification by western health care systems. Ideas were developed to adopt the German insurance model, the British general practitioner system, American health maintenance organizations and so on. After a while, relations with the international community became institutionalized. In the health sector, WHO, the World Bank, the United Nations Development Programme and the United Nations Children’s Fund were the prominent international organizations. Among bilateral donors, agencies from Denmark (Danida), Germany (German Agency for Technical Cooperation – GTZ), Switzerland (Swiss Federal Office), Turkey (Turkish International Cooperation Agency), the United Kingdom (Know-How Fund) and the United States (USAID) were also active.

WHO has tried to assist Kyrgyzstan develop a health policy based on the European health for all strategy and provided important support to the MANAS Programme. This has involved financial and technical support to capacity-building activities aimed at developing human resources in the MANAS team. The MANAS Programme reflects the policies advocated by WHO, especially the focus on health improvement with gains in equity and efficiency.

The World Bank, after carrying out a survey on the burden of disease, opted for creating pressure towards the development of a minimum benefits package to cover the most cost-effective services (according to the disability-adjusted life year approach).
USAID has been very active in defending the introduction of competitive elements in the health care system, putting forward in particular the concept of primary health care budget-holding as the way to go.

GTZ from Germany has concentrated efforts on helping the Government to establish a health insurance scheme.

In general the external influence and assistance has had a positive impact on many aspects of the reform process. New ideas have been discussed and different points of view debated in a spontaneous policy forum where participants could learn a great deal from each other. However, the abundance of organizations and different views has also created a great deal of confusion and at times led to decisions of debatable value in improving the Kyrgyz health care system. Moreover, it is known that international and bilateral organizations do not always work in accordance with the needs of recipient countries. Other factors such as the political, ideological and economic interests of the donors play a strong role in defining the path these agencies feel that Kyrgyzstan should follow.

Throughout this process, the MANAS team has sought to become the focal point for coordinating external assistance and for developing a proper forum for the different agencies to discuss their proposals for support. This approach could prevent duplication of effort and increase the synergy of actions. To some extent the effort has been successful, but more emphasis on coordination will be required and the MANAS team has a crucial role to play in strengthening this function in the future.

9.5 SUMMARY

Section 9 has focused on the development of contracting and the management of the process of change necessary for the implementation of contracting mechanisms in Kyrgyzstan. Firstly, it has argued that the development of the State Programme for a Healthy Nation has the potential to guide key players in the successful implementation of contracting mechanisms. Kyrgyzstan is clearly moving towards the development of different functions for purchasers and providers, in a model that resembles the British purchaser–provider split. However, questions remain concerning the transaction costs which will be generated by the implementation of contracting mechanisms. This is a major concern for Kyrgyzstan, a country which has limited resources available compared to Germany or the United Kingdom. Similarly, the human resources for carrying out activities necessary throughout the contracting process are not available. Thus, it is
recommended that an institutional approach be adopted for human resource development. This would be paralleled by the development of renewed data collection methods, the adoption of modern information systems and the development of national health indicators to be used by purchasers during the contracting process. Clearly, all these activities require resources not available in the country and the Government will need to rely on expertise and financial support from the international community.

Secondly, management of change has been discussed from the point of view of communication and leadership. The Government could benefit from using all available means of communication (mainly television, radio and newspapers) to inform opinion leaders and the public in general about the proposed reforms. In order to avoid the leadership vacuum observed in the United Kingdom, the leading role of the MANAS team was considered to be important. Specific activities could include the identification of champions at different administrative levels to support the reform process led by the MANAS team. The team would also benefit from working more closely with Parliament, involving itself in the process of preparing new legislation.

Thirdly, the existence of planning for action to manage change and piloting has been discussed. The MANAS Programme represents a good example of a comprehensive plan for reform implementation. Here, in contrast to Germany or the United Kingdom, Kyrgyzstan has an opportunity to plan its health care system at a time when transition and change are both expected and accepted by the population in general. Nevertheless, current plans need to be more detailed, making clearer how accountability, responsibility and sources of finance will be guaranteed. The use of piloting exercises may help in clarifying some of the grey areas and better preparing those in charge of planning and implementation.

Fourthly, the importance of taking into consideration community participation and the involvement and support of key players has been discussed. It is clear from the study that the channels for community participation in the Kyrgyz health care system are not well developed. Moreover, solutions adopted in Germany (pluralism) or the United Kingdom (local councils) seem alien in the Kyrgyz context, where political or bureaucratic power remains the determinant factor for decision-making.

Finally, it is acknowledged that after independence Kyrgyzstan has been increasingly exposed to international influence. This has resulted in the transference of reform ideas and models which are not always appropriate
to the Kyrgyz context. In addition, the abundance of organizations with different views working in Kyrgyzstan has at times caused confusion and led to questionable decisions. In order to deal with the lack of coordination and prevent duplication of the work of foreign organizations in Kyrgyzstan, it is suggested that the MANAS team should play a stronger coordinating role in the future.
10. Conclusions, recommendations and discussion

This study has aimed at creating a methodology for analysing contracting in health care (MACH) with a dual objective: to allow interested parties to review and to develop contracting mechanisms. As regards the first, the MACH has been used to review contracting mechanisms in two countries, Germany and the United Kingdom, chosen on the basis of predefined and discussed criteria. As regards the implementation of contracting mechanisms, the study has applied the MACH to a country where contracting mechanisms are undergoing development. After careful consideration, Kyrgyzstan was selected for this purpose.

In the following pages, the conclusions of this study will be presented. This will be followed by sections on recommendations for Kyrgyzstan, on the strengths and weaknesses of the MACH approach, and on its future development.

10.1 CONCLUSIONS

Many conclusions could be drawn from this study. Only some of the more significant ones are presented here.

1. Contracting does not require the existence of a purchaser–provider split or competition to be implemented.

As observed in Section 2, governments are experimenting with competitive mechanisms in an attempt to bring to health systems some of the benefits that result from the operation of markets elsewhere in the economy. In this context, contracting is often associated with the introduction of competition in health systems. However, it can be concluded from this study that, if a country decides to develop contracting mechanisms, competition is not necessarily a precondition. In fact, as long as a differentiation of functions exist, contracting is possible without competition. This implies that contracts can exist in integrated systems. (Savas & Tragakes, 1995.)

Contracts in integrated systems can work as a formalization of and mechanism for the planning function. This formalization is expected to be based
on the contracts negotiated between the planner and the providers (Savas & Sheiman, 1996). Although part of the literature refers to a contracting model which presupposes the existence of the purchaser–provider split, this study has shown this to be a misconception. The competition, as it has been known, is in fact a purchaser–provider model. The change in the terminology is suggested as a means of avoiding confusion.

2. Contracting with an institutionalized differentiation of functions can be used in an integrated model as part of an incremental approach towards full implementation of the split.

Supposing that a country decides to use contracting, the implementation of the purchaser–provider split will depend on many different factors such as affordability, availability of information for purchasing and monitoring, and development of human resources. In an integrated model (especially in former socialist countries), contracting without a formal purchaser–provider split can be an initial step towards the development of the split and competition. In these cases, contracting could be used mainly as a planning tool in the management process. If countries take on this incremental approach, they may be able to learn the rules of the game as well as develop human resources and overall capacity prior to implementing the split.

In the United Kingdom, for example, during the introduction of the purchaser–provider split district health authorities used contracting not only with hospitals that had achieved trust status, but also to guide the services of those institutions still under their direct management. This process presented a valuable opportunity for health authorities to prepare for the full split of the provider–purchaser functions. However, it is difficult to claim that this was the case.

3. Where there is an overall health policy, contracting should be linked to it and an integrated part of a country’s health care system.

Although it is logical that contracting should contribute to health policy, in practice this does not happen regularly. In Germany, contracting is not linked to health policy goals and there is no intention to use contracts for this purpose. In this study, such an approach has been shown to contrast with the British experience, where contracts are intended to be used for achieving predefined health policy goals.

Because contracts can have different functions and characteristics, they can be applied in very different contexts. As discussed in Sections 5.2 and 5.3,
these functions and characteristics will need to be developed in accordance with the overall health care system. This would help policy-makers to reach predefined health policy goals.

Clearly, if a country decides to consider using contracting mechanisms to implement health policy, the definition of its health policy goals should come first. This approach emphasizes the need to consider contracting in the intended policy context.

4. **Contracting needs to be considered as part of the overall management of change.**

The lessons learned from the German and British experiences imply that if contracting is to be developed, policy-makers should consider this mechanism as simply another part of the health care reform process. Therefore strategies should not be developed just for contracting, but as part of an overall management of change process.

By understanding contracting as one of the components in the dynamic process of change, policy-makers will be encouraged to focus more on the implementation than the content of contracts. Although both aspects are important, it appears that policy implementation tends to be biased in content, neglecting the process of change. As discussed by Walt & Gilson (1994) and observed in the United Kingdom and Germany, the actors are the most important element of the change process. Any change in health care systems would require the involvement of all related parties; this would be particularly crucial in pluralistic systems, such as in Germany.

From the point of view of the expectations created by the reform process, once contracting is understood as being part of a broader process of change it becomes clearer that the implementation of contracting is not a purely technical problem. It may also require changes in culture (such as the involvement of the community in decision-making processes). After the German Reform Act of 1993, the largest sickness fund, AOK, developed a communication strategy in order to convey policies to the general public. (Although this, in fact, was not intended to involve citizens in the decision-making process, but rather to influence general public opinion.)

5. **Before embarking on contracting, it is important to consider the factors which affect feasibility.**

Here, the main concern is affordability. Clearly, contracting is more expensive than command and control management. This is because in the day-to-day
running of contracting, there are more transactions than in a command and control system. The costs of such transactions can be substantial and can affect feasibility. In addition, even if gains in efficiency are achieved with contracting, costs come first and gains later. The experience of the United Kingdom showed that the fastest increase in NHS spending since the 1960s was following these internal market reforms (Glennerster et al., 1994).

Affordability is not the only determinant of feasibility. This study has emphasized the need to consider other managerial and organizational factors when a country decides to use contracting mechanisms.

As has been observed in the United Kingdom, the lack of skilled and knowledgeable human resources has been a constant concern (see 6.1.4). As well as skills, incentives for retraining may also need to be made accessible through the transition period. If differences in incentives or other factors cause a situation where contracting partners have great differentials in terms of knowledge and skills, this asymmetry may cause opportunistic behaviour that compromises the benefits of contracting.

One of these factors, the clear understanding and implementation of a differentiation of functions between providers and purchasers/planners, is certainly essential. It will form the basis for contractual negotiations. The differentiation of functions may be accompanied by changes in the overall legal framework. The need for more or less complex legal frameworks varies in the countries studied. While Germany opted for a strong and detailed framework of laws, the United Kingdom favoured the development of a looser framework where contracts are not legally enforceable. Nevertheless, in both examples specific legislation has been required to make contracting work.

Feasibility will be affected by the lack of information for purchasing. This is particularly the case where competition exists but it is also influential in non-competitive contexts. The lack of information or incorrect data can influence the decision-making process, facilitate opportunistic behaviour and, as a result, critically affect the achievement of the benefits expected from contracting.

6. **Contracts do not need to be binding and enforceable by law to be effective.**

In contradiction to the experience of Germany, in the United Kingdom it has been observed that even when contracts are not binding or enforceable
by law, they can still be respected and followed. The crucial aspect seems to be the maintenance of a close identity of interests between the contracting parties with a minimum of legislation. In other words, when contracting parties negotiate they should keep in mind that they have common goals to be achieved through the contracts. If there is a common understanding of this, the parties will tend to respect the contracts not because of fear of legal prosecution but because non-compliance would hamper the achievement of the common objectives.

Goodwill may not always be enough and some legislation may be needed. However, the emphasis on contracting should not be on building a legalistic system where the courts replace the negotiating table. If the contracting parties can discuss their differences rather than use legal arbitration, the costs and the stress of the system are expected to be much lower. Moreover, it is evident from this study that an emphasis on legal aspects can increase transaction costs, including during the preparation of the contract, since parties fearing legal suits may require more resources for preparing detailed contracts to cover all foreseeable misunderstandings (see 5.3.7).

Based on the German experience, it is concluded that the existence of some negative incentives can induce contracting parties to negotiate rather than arbitrate. These negative incentives include the possibility of the courts ruling as they wish rather than necessarily supporting one side or the other. In such cases, the simple threat of an agreement which may be unfavourable to both parties may force a negotiated consensus. Similarly, a lengthy and expensive arbitration system can also work in favour of negotiation.

7. Public participation in the contracting process can be strengthened.

Responsiveness to the public’s views of and satisfaction with health care services is one of the objectives of health policy in many countries. Nevertheless, this study identified a lack of effective mechanisms whereby people can influence the provision of services. Neither the United Kingdom nor Germany have adequate mechanisms for the public to be involved in the decision-making process.

In the future, as the public becomes more informed and demanding, this might become an issue of greater concern. Signs pointing in this direction are abundant: the Patient’s Charter in the United Kingdom is an example. In the European context, the adoption of the Ljubljana Charter on Reforming Health Care (The Ljubljana Charter, 1996) in 1996 by nearly 50 countries clearly indicated that health care reforms should be
centred on people, ensuring that the citizen’s voice and choice decisively influence the way in which health services are designed and operate.

Contracting can play a role in increasing public participation in health service provision. This can happen, for instance, through fostering mechanisms in the contracts that guarantee that patients can choose their providers and decide on alternative forms of treatment. Citizens can also be asked to participate in local or regional health boards which decide on contracts, as in the case of the Finnish municipalities; or where local community councils exist they can be strengthened by electing members rather than appointing them, as in the United Kingdom. Other approaches could include the creation of citizens’ juries on contracting of controversial services (homeopathy, for example).

However, contracting is only an instrument for implementing policy. If the implementation of contracting is not followed by the development of policies which promote the development of channels for citizens to express their views, participation will not be increased. Moreover, even when channels for participation are developed, cultural factors may prevent the public from taking part in decision-making committees and boards. Ultimately, lack of interest from the public means that citizens’ preferences are not reflected in the contracts, even when purchasers are willing to make the system more responsive.

8. Contracting for small populations makes it difficult for needs assessment and priority-setting to be carried out.

It could be observed that in the United Kingdom these difficulties are in great part a result of the fundholding scheme and it has been suggested that fundholding general practitioners should act jointly for purchasing purposes. This move would create better conditions for the general practitioners to keep a public health view and develop better purchasing strategies.

9. In developing countries contracting will offer few benefits unless the overall capacity of the system is increased.

Contracting does not improve health care systems directly. If a country decides to use contracting mechanisms, investment will be required to increase the capacity of the system before contracting can bring any of its expected benefits.

For the people involved, the use of contracting mechanisms in the context of an integrated health care system represents a major change. The new
organizational structure challenges them with new roles and functions, and their management capacity to deal with such challenges needs to be increased. Institutional capacity will also need to be developed. Legislation will need to be revised and new laws developed. Infrastructure capacity also has to be built for information systems to deal with the more complex interactions associated with contracting. The lack of capacity to collect and process information was a major problem during the initial phase of reform implementation in the United Kingdom.

10.2 RECOMMENDATIONS FOR KYRGYZSTAN

1. Functions should be differentiated and contracts introduced.

As already explained, the differentiation of functions and the use of contracts in integrated models can work as a mere formalization of the planning function. The establishment of the planning function inside OHAs and the use of contracting mechanisms could increase the potential for health gain, efficiency and effectiveness of the Kyrgyz health care system. The use of contracting mechanisms in the context of a health policy which has already been formulated can help professionals to develop planning skills which were not necessary when planning was carried out in Moscow.

2. Contracting with an institutionalized differentiation of functions and without competition can be used as part of an incremental approach towards full implementation of the purchaser–provider split.

If so desired, it is suggested that contracting should initially be implemented in the structure of the current integrated system. The new arrangement would not include competition. Such an arrangement could be modified in the future to include competitive mechanisms, should the need arise. This approach can contribute to alleviating some of the complex and costly transactions which are inherent to competitive contracting. Owing to the social and economic difficulties which are currently affecting Kyrgyzstan, it is concluded that it may be more appropriate to take this incremental approach to contracting rather than try to implement the purchaser–provider split from the outset.

3. Before embarking on contracting, current proposals which may adversely affect feasibility should be reviewed.

One aspect to consider is the proposed implementation of contracting at two levels: oblast and the rural/urban primary health care unit. Contracting
at both levels is likely to increase transaction costs considerably without any clear advantage for the population.

As regards the organizational structure, the small size of the population may make it advantageous to reduce the number of administrative levels. It should be possible to carry out activities such as needs assessment and coordination of primary health care facilities at oblast level. By reducing the number of administrative levels, the managerial structure could be simplified and duplication and transaction costs avoided. The personnel released from intermediary levels of administration could then be retrained to carry out activities related to contracting.

4. Human resources should be trained as part of the process of contract implementation.

As noted earlier, most of the staff working in the health sector are physicians with no training other than medical education. From experience in the United Kingdom and Germany, it is clear that the development of human resources will be one of the critical elements for the successful implementation of contracting in Kyrgyzstan. This study recommends an institutional approach to readjust the current mix of skills through training in key areas such as health services management, epidemiology, public health and health economics. Collaboration with international organizations which have technical knowledge in these key areas is a possible solution in the short term to the lack of resources for investment in training.

5. Formal channels should be created for the public to participate in the contracting process.

Current reform proposals do not make clear which mechanisms will be in place to allow the public to express their views and participate in the contracting process. Moreover, there is no tradition of citizens expressing their views. Thus, it is suggested that more specific forms of participation should be developed. Some examples have already been discussed. From experience in the United Kingdom and Germany it can be concluded that elected representatives on health boards or other committees tend to be more respected and better accepted by the public. The formalization of public participation could increase legitimacy to the level necessary for implementing reform. In the long term, as the democratic process matures in Kyrgyzstan, it is expected that public interest and participation will also increase.
6. *Fundholding should not be introduced.*

It is argued that the current situation in the country is not favourable to such a scheme. There is a chronic lack of skilled people, information systems are not developed and the financial resources to run a fundholding scheme are not available. In these circumstances it can be concluded that under the proposed system for Kyrgyzstan, budget-holding functions should be a task for the OHAs. This arrangement could be revised in the future, once the key players become more familiar with the new health care system and develop their negotiating skills.

Other countries in central Asia are apparently also contemplating the development of fundholding models. However, since their backgrounds and current situations are very similar to those of Kyrgyzstan, it would be expected that the recommendations discussed here will also apply to these countries. The introduction of sophisticated contracting mechanisms at this point in time may be unwise.

7. *There is a good opportunity for the Government to use contracts as a mechanism for rationalization.*

The Government has already defined specific priorities in order to foster the improvement of health. Contracts can incorporate mechanisms which contribute to the achievement of these priorities, bringing an increase in allocative efficiency by ensuring provision that reflects the needs of the population.

Rationalization in all countries is subject to a number of conflicting pressures, mainly from national and regional political structures and from doctors and other providers. Notwithstanding the existence of such pressures, it is clear that the momentum in Kyrgyzstan is still favourable to the implementation of rationalization. Changes in the health system appear to be expected and accepted by the population. This particular historical context, which contrasts with the context in the United Kingdom and Germany, gives the Government the opportunity to implement rationalization policies at an early stage. As the process of change and rationalization becomes more explicit, pressures will also come from the public and from economic macro-trends, making it harder for such policies to be implemented.

10.3 *DISCUSSION*

The conclusions and recommendations detailed thus far need to be reviewed in the light of the strengths and weaknesses of the MACH approach.
10.3.1 Strengths of the MACH

1. The MACH considers contracting within the context of health care systems as a whole.

During the study, the use of the MACH favoured an approach that looks at contracting as part of the overall health care system of any particular country under review or development. Thus, the methodology addresses all the main components of health care systems, paying attention to the existing links between contracting mechanisms and these components. This is justified by a belief that contracting should not be addressed as an independent mechanism which can easily be placed in different contexts. On the contrary, health care systems are complex and require a certain degree of harmony between their different components. If one part of such a system is developed independently to perfection but does not fit the whole, it will almost certainly present problems.

2. The MACH looks at contracting as part of a dynamic process.

Currently, many countries are implementing reforms, and the discussions and common understanding of the reform process are constantly changing. The methodology could not, therefore, look at contracting from a static point of view. The approach showed the use of contracts at different stages of the process of implementation of health care reforms. It did so by looking at the contextual factors surrounding contracts and by looking at the process of managing change.

3. The MACH tries to present a neutral view of contracting.

The constant attention to neutrality meant that the final work presented here neither advocates nor deprecates the use of contracts in health services. From the point of view of policy-makers, the methodology aims to provide a framework that will help them to decide whether they want to implement contracts and, if so, how. Moreover, they would be able to identify some important strong and weak points of contracting mechanisms in different contexts.

4. MACH provides a checklist for decision-makers.

The MACH systematically covers all the main issues considered relevant to those interested in contracting mechanisms. This is important in helping policy-makers to take account of all the different aspects which are relevant for reviewing and developing contracting mechanisms.
10.3.2 Weaknesses of the MACH

1. *The MACH has not made full use of the methods proposed for the development of grounded theory.*

Grounded theory in this study has been useful, mainly during the process of reorganizing, classifying and regrouping existing concepts. However, it has only been partly used for developing new concepts, mainly in Section 5.3 above on the characteristics of contracts. For this purpose, the methodology was applied up to the point just before what Strauss & Corbin (1990) call “axial coding”, i.e. before the step when data should be put together to form a theory. Since the objective of the work was not to develop a theory, it was felt that the methodology could not be used any further.

2. *The MACH does not contain any criteria for the evaluation of contracting.*

When the first map of contracting was drawn up, an important issue was the development of evaluation criteria for contracting. Clearly, the effectiveness of contracting in translating a country’s policy goals into reality should be known. This could be done through the use of some evaluation criteria. However, such a discussion has not formed part of this study, since the work of developing such criteria would be so extensive that it would merit a separate study.

3. *The MACH does not provide a decision-making template.*

Although a systematic approach has been applied to the presentation of the MACH, it would be fair to say that such a presentation could benefit from the development of a step-by-step guide or flow chart. This could be in a form which would help the user to identify the relevant parts to be considered quickly, without the need to browse through the whole document. If such a tree or logical flowchart were to be created, perhaps in computer form, it could help the user to form a mental framework of the MACH and make it more user-friendly and perhaps less time-consuming. Such a task would, however, require some techniques which are beyond the scope of this study.

4. *The MACH has not been tested by decision-makers in any country.*

The methodology has been applied in the United Kingdom and Germany for review purposes and in Kyrgyzstan for development purposes but these
have essentially been academic exercises. As a result, there is no empirical knowledge as to how useful the MACH would be for internal use in any particular country. It would have been better if the methodology had been tested by policy-makers in different countries who could themselves evaluate its usefulness. Nevertheless, due to the limited resources and time available, such a trial could not be carried out.

5. The value of the MACH is limited by the number of countries which could be included in the analysis.

In essence, the methodology originates from empirical work carried out in a very limited number of countries. Although these countries have been carefully selected, it is believed that the final result of this study could have benefited from an analysis of the experience of other countries. In particular, contracting as implemented in Finland, Greece, Israel, the Netherlands, New Zealand, Portugal, Spain (Catalonia), Sweden and the United States can differ substantially from the two main models considered in this study. The study of any (or all) of these countries or others, would certainly have improved the methodology. For example, in Portugal, the Lisbon health authority is experimenting with the implementation of contracting mechanisms with a separation of functions within an integrated NHS but with purchasers that do not hold budgets. This is an interesting approach, and other approaches to the use of contracting could certainly be identified in other countries.

10.3.3 Other considerations

At least two more important observations remain to be made about the MACH. These observations are not necessarily weaknesses or strengths and they are therefore left to the judgement of the reader.

1. The user of the MACH should have a deep and broad knowledge of health care systems.

Although the work presented here is intended to be used by anyone interested in contracting, just as a watchmaker needs to know the functions of all the wheels inside a watch, those interested in using this methodology will need to develop a deeper knowledge of the different components of health care systems. This could be construed as a weakness, since use of the MACH would require people who knew what they were doing. On the other hand, making this a requirement might be an advantage in that it would avoid well intentioned but unprepared people making erroneous recommendations based on the MACH.
2. The MACH provides a qualitative approach.

The methodology is not a mathematical model and it cannot be used for arriving at conclusions based on quantitative results. The analysis of empirical phenomena for review and development of contracting was solely based on a qualitative methodology rooted in the principles of grounded theory. The end result is a qualitative methodology which might be a disappointment to policy-makers interested in using mathematical representations of reality.

10.3.4 Further research

The MACH can serve as a useful tool to analyse and develop contracting in different contexts. Clearly, as it is presented, this methodology has also some weaknesses. Thus, in applying it, policy-makers would need to be cautious and to test and fine-tune it as they went along. For the future use of the MACH, it is recommended that further research is required in order to develop evaluation criteria for contracting.

Application of the MACH to any health care system would assist the user to understand the content in which contracting was being implemented or would be developed, the functions and characteristics of contracts, and the process of developing contracting. However, it would only give a limited understanding of the extent to which contracting was contributing to policy goals.

Although such policy goals vary from one system to another, possible examples could be health gain, equity, efficiency, effectiveness, responsiveness to patients’ needs, quality of care, cost containment, etc. The relationship between contracting and these goals merits further research in order to provide further information. Through such research it would be possible to develop evaluation criteria and even a composite index to measure the impact of contracting in achieving policy goals.


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Annex 1

People interviewed in the study

1. Representative of the local medical committee, West Glamorgan, Wales, United Kingdom.
2. Representative of Federal/State Association of Enterprise Funds, Essen, Germany.
3. Federal level representative of Sickness Fund (AOK), Bonn, Germany.
4. Representative of the Bundesärztekammer (Chamber of Physicians), Federal Level, Cologne, Germany.
5. Federal level representative of the Deutsche Krankenhausgesellschaft (German Hospital Association), Düsseldorf, Germany.
6. Representative of the Ministry of Health, Bonn, Germany.
7. GP fundholder, West Glamorgan, Wales, United Kingdom.
8. Group discussion with four members of the Welsh Office, Wales, United Kingdom.
9. Staff of the Welsh Health Planning Forum, Wales, United Kingdom.
10. Staff of the West Glamorgan Health Authority, Wales, United Kingdom.
11,12,13,14,15
   Interviews with five directors of an NHS trust, Wales, United Kingdom.
16. Staff of a family health service authority, Wales, United Kingdom.
17. Staff of West Glamorgan Health Authority, Wales, United Kingdom.
19. Unit general manager in a central clinic, Wales, United Kingdom.
20. GP non-fundholder, Wales, United Kingdom.
21. Staff from the business division of an NHS trust, Wales, United Kingdom.

Discussants in the panel:
1. Director, Corporate Development, NHS Trust Hospital, Staffordshire, United Kingdom. Medical doctor with specialization in public

\[\text{In some institutions more than one person was interviewed.}\]
health and considerable experience working for a health authority in Wales on clinical effectiveness, service specifications and contracting.

2. Director, National Institute in Bulgaria. Demographer and statistician with experience in pilot projects for the implementation of contracting mechanisms in Bulgaria.

3. Dean, Faculty of Health Sciences, part of a major university in the Netherlands. Political scientist with interest in contracting.

4. Research Fellow, University of Tübingen, Germany. Medical doctor specializing in public health and interested in health policy and management issues.
Annex 2

Basics of grounded theory in qualitative analysis

Grounded theory is a theory that is inductively derived from the study of the phenomenon it represents. Qualitative research is understood as any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification (Strauss & Corbin, 1990).

For the development of grounded theory, Strauss & Corbin (1990) propose a specific methodology to guide qualitative analysis. A great part of this methodology is based on a systematic set of procedures to break down, examine, compare and categorize data.

These procedures have been used in this study in order to organize the available data and develop the first map of contracting. In particular, the technique described as open coding was adopted. “Open coding is the part of analysis that pertains specifically to the naming and categorising of phenomena through close examination of data ... during open coding the data is broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about the phenomenon ... through this process, one’s own and others’ assumptions about phenomena are questioned or explored, leading to new discoveries.” (Strauss, 1990)

In order to understand in practice how grounded theory was used in this study, it is helpful first to clarify some definitions of terms.

**Code notes:** These are the products of coding. Coding is the process of breaking down, examining, comparing, conceptualizing and categorizing data. Thus, code notes are like memos that contain information about conceptual labels, theoretical observations and general information about the issues under study.

**Conceptual labels:** Concepts can be named in different ways. By analysing an observation and giving it a name, we are creating a conceptual label. The label stands for or represents the phenomenon. In order to do this one asks questions such as: What is this? What does it represent? By comparing
incident with incident as the research progresses, one can give similar phenomena the same conceptual label.

**Categories:** This classification is used when concepts are compared one against another and which appear to pertain to a similar phenomenon. Thus the concepts are grouped together under a higher order, more abstract concept called category.

**Properties:** Categories and conceptual labels can have different attributes; these are known as properties. For example, the category “block contract” has a property which relates to the risk associated with the use of this type of contract.

**Dimensional range:** Properties can be dimensioned within a defined range. For example, the contracting process can be more or less pluralistic, depending on the context in which it takes place. Or, taking an example with extremes, the level of negotiations for contracting primary health care services in a particular country can be classified as being individual or collective.

**Theoretical notes:** These are like memos containing the products of inductive or deductive thinking about relevant and potentially relevant relationships, properties, etc. They can also contain reminders of possible literature on which to focus, pointers to other parts of the work, etc.

As an example of the application of the methodology described above, one can consider analysing the different types of contracts as they are classified in the United Kingdom. Initially, information about contracts in general was gathered. Through the analysis of this general information, it was possible to identify that one form of classifying contracts is according to their different types. Thus, a conceptual label called “types of contract” could be created and this constituted a first category for study. Under this category, other concepts such as “block contracts” and “cost per case” could be grouped. They are all concepts associated with different types of agreement or contract which are specified during the process of negotiation between purchasers and providers.

Different types of contract may have different levels of associated risk which it is relevant for both purchasers and providers to consider. These risks can vary within a dimensional range, from high to low, depending on which side’s point of view is being considered (the purchaser’s or the provider’s) and depending on the type of contract. The level of risk is therefore a
property inherent to each type of contract and one that is determined by the point of view taken (the purchaser’s or the provider’s). Similarly, the cost of the necessary transactions associated with each type of contract is another property.

In the code note created for the analysis and briefly described above, the information looked similar to the example below. A theoretical note was also created to explain the criteria used to define the different types of contract. Other theoretical notes, related concepts and properties could also be included, depending on the material available.

In the final text of this study, all this information was put back together in a more logical way. In the case of types of contract, the properties were used to define the advantages and disadvantages of each type of contract.

CODE NOTE A

1. Category: Types of contracts

   1.1 Related concept: block contracts

      1.1.1 Properties:  a) Risk

      Dimensional range: high/low

      • for providers?
      • for purchasers?

      b) Transaction costs

      Dimensional range: high/low

      • for providers?
      • for purchasers?

   1.2 Theoretical note: The different types of contracts were defined in function of:

      a) their characteristics and
      b) the way purchasers remunerate providers.

The process of conceptualizing data is important for three main reasons:
1. issues could be identified and developed in terms of their characteristics (properties);
2. this study started from a basic level of knowledge and therefore some form of logical selection had to be applied to the data; the use of coding notes and concepts as proposed by qualitative researchers applying grounded theory methodology served for this purpose, helping to select the important from the not-so-important and to organize the data; and
3. code notes and the logical grouping of concepts formed the basic background for the development of a map of issues which was later used to discuss contracting further.
Annex 3

Content of contracts

The parties to a contract may need to discuss the areas to be covered in the preparation of the contracts. This annex gives an overview of some of the different aspects which can be included in contracts.

**Kind and type of service**
Kind refers to a service on a more general level, while type refers to a service which falls within a given kind. For example, gastric operations represent a kind of service, with partial gastrectomy and truncal vagotomy representing two types of service within this kind of service (Savas & Tragakes, 1995).

**Quality standard (professional quality, organizational quality)**
Details concerning quality standards may vary, but the principles are very similar. Quality standards comprise two main categories:

- professional quality: e.g. degree of qualification of practitioners and staff involved in providing health care;
- organizational quality: waiting times, quality of hotel services available, etc. (Savas & Tragakes, 1995).

**Outcomes**
Example: at least x% of those seen with heart attacks should survive at least y days after treatment; x months after hip replacement more than y% should be weight bearing and fewer than z% should have died (Figueras et al., 1993).

**Volume of services**
The volume can be expressed by the number of inpatient days, number of outpatients treated, number of operations, etc.

Contracts that include volume levels usually specify procedures in the event of a variation in the level. They also determine levels of tolerance for variation in activity in normal circumstances and during the occurrence of unpredictable events that can seriously affect activity level but are not the fault of either party, such as epidemics (West Glamorgan Health Authority, 1993).
Coverage
Contracts may include clauses defining limited coverage for some elective health care services. For example, the contracted provider should give treatment to x% of the eligible cases of osteoarthrosis of the hip per year.

Eligibility
Who is eligible for treatment? For example, only those who are resident in a specific geographical area and have a hearing loss greater than x dB should undergo surgery for glue ear.

Minimum level of activity
Where providers are responsible for some community services, contracts can require minimum activity levels. For example, a contract can establish that there should be at least y people screened for breast cancer.

Facilities
Example: the provider should include access to a coronary intensive care unit, a kidney unit, etc.

Human resources
Example: the service should include at least x full-time equivalent consultant orthopaedic surgeons.

Availability
Contracts may specify that all services or some specific services are available 24 hours, including weekends and holidays.

Location
Services to be provided off-site (that is, in places other than at the main location) may need to be specified in the contract.

Subcontracts
Large contracts with one provider can be subdivided into specialties, care groups and case mix (for example, three levels of complexity for all cases in one specialty, or ICD9/OPCS4 or health-related/diagnostic-related group categories (Øvretveit, 1995b).

In British contracts, subcontracting clauses specify whether part of a contract can be subcontracted to secondary providers.

Process
Example: clinic cancellation rates should be less than x%; waiting time for procedures x should be less than y weeks.
In the United Kingdom, the “Patients’ charter” established several process-related targets which were later incorporated into the contracts between purchasers and providers.

**Extra-contractual referrals**
Contracts can specify what happens when tertiary referrals are made by the provider to another unit. Usually it involves notification in writing, with details about the patient, the receiving provider and the anticipated costs.

**Definitions and interpretations**
To avoid misunderstanding, contracts can include detailed definitions of the terms used in the agreement. These may include interpretations of the terms used. For example, what “prompt service” means in the context of the contract.

**Organizational requirements**
Provision of documents, arrangement of regular meetings for clinical auditing, etc.

**Notifications**
Contracts may have specific clauses clarifying whether notices need to be in writing or not, whether they require registered mail, how much time should be allowed for specific reasons, what procedures require notification, and so on.

**Termination**
Some contracts clearly specify conditions under which the agreement can be terminated. These can include persistent or serious default by the provider, bankruptcy of the provider, mutual agreement with notice in writing, etc.

**Prices**
Contracts may determine prices for the services to be provided. They can specify minimum, maximum and average prices, single payment categories, package prices (e.g. diagnostic-related groups), positive and negative bonuses, step-up prices, reference prices, inflation adjustment methods for prices, etc. (Maarse, 1994).

**Commencement and duration**
Almost certainly the contract will have a predefined duration, specifying when the agreement starts and finishes.
Premiums
Contracts can include clauses that guarantee opportunities for providers to earn additional income. Such premiums can be linked to the achievement of targets or performance above the average (West Glamorgan Health Authority, 1993).

Payment methods
Fee for service, capitation, per diem, per case, etc.

Miscellaneous restrictions/recommendations
For example, contracts may require that a provider notifies its main purchaser of intent to make available new services in the region. This practice can avoid competition in areas where demand for health care services is limited. Ultimately, purchasers will be interested in avoiding a situation in which a particular unit destabilizes local provision.

Monitoring
Contracts may stipulate that the third party payer can monitor the activities of the provider. This may be requested for the purpose of allowing assessment of the degree of compliance with the terms of the agreement (Savas & Tragakes, 1995). Main checks are on complaints, patient satisfaction and poor medical quality. It can also involve comparison of the provider’s performance with national or international averages. Some detailed contracts stipulate due dates for the provision of information for monitoring. Others specify a formal contract review at the end of a specific period of time. It is also possible that monitoring can take place at any time, subject to a written request.

The way monitoring is carried out can also vary. Possibilities include:

- internal:
  - first-hand: the purchaser monitors the provider directly (e.g. spot checks by agency staff);
  - second-hand: the purchaser monitors the provider’s records and checks validity (reports, for instance); this implies that records must be kept and that information systems are in operation;
- external: an external agency audits or monitors the provider and the purchaser uses the reports or data; this method can also be used in first- or second-hand monitoring;
- governmental: monitoring is carried out by official authorities;
- mixed.
Sanctions
Sanctions can be applied in cases of breach of contract, unexpected termination of contract or as a result of unsatisfactory service. Common sanctions include summonses, counselling, fines and denial of right to practise or of contract renewal (temporary or permanent). Examples of unsatisfactory service that can trigger sanctions include:

- poor quality practice, e.g. failure to record essential information concerning a patient or to send follow-up information to a hospital or ambulatory facility;
- over-use of services, e.g. if a doctor, without a clear indication, orders examinations or medical interventions (injections, pills), or a hospital extends a patient’s stay without clear medical reasons for doing so;
- poor management, e.g. waiting lists longer than a previously agreed limit.

Confidentiality of information
Some contracts in the United Kingdom include explicit rules regarding the use and manipulation of information relating to patients (NHS Management Executive, 1990).
Annex 4

Key participants in the British health care system

The Government retains the primary responsibility for legislation, policy matters and strategic decision-making. Through the NHS Executive, the Government has exercised detailed supervision of all operations. This has prompted criticisms that even with the reforms the British system remains too centralized (Ham, 1994). Broad functions of the Government include:

- ensuring that the basic principles of the health care system are not sacrificed due to vested interests in the contracting process;
- setting up the strategic framework of the NHS;
- developing regulations for the internal market;
- guaranteeing the stability of the system, both financially and politically.

As far as contracting is concerned, some of the practical decisions which are taken at central government[^19] level include (Ham 1994, Hurst 1992):

- definition, when applicable, of guidelines for strategic purchasing (for example, formal requests for units to move from block contracts to other types of contracting);
- allocation of budgets to the health authorities;
- approval of major capital expenditure decisions and hospital closures.

Regional health authorities (RHAs) were, until 1996, the link between the Secretary of State in London and the local authorities of the English NHS. In recent years, the expansion in the number of GP fundholders, among other factors, has prompted district health authorities (DHAs) into forming larger commissioning authorities or consortia (Øvretveit, 1995a). In practice, the initiatives led to integration of the DHAs’ functions with those of other agencies responsible for commissioning primary care, such as the family health service authorities (FHSAs) (Robinson & Le Grand, 1994).

[^19]: Some of these decisions are taken and managed by the NHS Executive and its administrative branches.
The FHSAs have played a major role in the encouragement and support of the initial waves of GP fundholders. However, the Government decided that the merger between the FHSAs and DHAs would improve the integration between primary and secondary care, and in April 1996 the health authorities (HAs) were created by the merging of FHSAs and DHAs.

The Welsh Office has been performing the role of RHA in Wales. As in England, the Welsh Office merged with parts of the Welsh DHA to form a joint HA and is now the de facto HA and Department of Health in Wales (Deacon, 1994).

The newly integrated HAs created in Great Britain have incorporated the functions of the agencies they have for which they have substituted, including:

- evaluation of the health status and the health care needs of the local population in order to develop a local strategy;
- development of a strategy to meet national and local priorities;
- implementation of local strategies by purchasing services via contracts with NHS units and other providers;
- providing information to practices, supporting the purchasing role of GP fundholders;
- administering arrangements with local providers, including the terms of service of NHS contractors.

In Wales, the merger has resulted in five integrated HAs which work closely with the Welsh Office. The expected benefits of the merger include: the capability to perform unified needs assessment and information management, implementation of unified contracting policy, increased accountability, financial benefits of economies of scale in purchasing, and simpler relationships with local authorities and other bodies (Øvretveit, 1995a). Nevertheless, because they have only recently been created, the role performed by the new Has has not yet been evaluated.

General practitioners are also key participants. Most primary care services in the United Kingdom are delivered by GPs. Almost the entire population are registered with their local GPs, who are responsible for referring patients to other levels of care, i.e. carrying out a gate-keeping role.

A basic distinction exists between non-fundholder GPs and fundholder GPs. In essence, the difference concerns who manages the available resources for the GP practice and how. Non-fundholders continue to operate with centralized planning, with HAs deciding on priorities and management of
contracts with providers at different levels. GP fundholders receive a certain budget to manage and spend on a defined set of purposes.\(^{20}\)

GP fundholders were established in April 1991. The scheme has remained voluntary since its creation and by April 1994 there were 2000 practices in England, covering approximately 36% of the population (Ham, 1994). The nature of fundholding implies responsibilities in purchasing hospital outpatient services, admissions for elective surgery, diagnostic tests, community health services and paramedical services, among other things. Fundholders must also cover their prescribing expenses, staffing and other administrative costs from their budgets. In order to purchase services, fundholders are free to contract with independent providers as well as NHS units.

NHS trusts can contract with fundholders and other purchasers to provide a wide range of services, including acute care, community services, mental health and ambulance services. Although classed as non-profit organizations, trusts can earn income through their contracts.

Although former directly managed provider units have not been forced to become trusts, the Government has encouraged NHS hospitals and community services to become trusts. As a result, by the summer of 1994, 96% of hospitals and community health services were trusts (Øvretveit, 1995a).

As well as contracting with NHS trusts, purchasers in the United Kingdom can also contract with the private sector. In parallel, NHS trusts are also allowed to sell services to the private sector. As early as 1992 HAs were contracting with private hospitals and many GP fundholders were following suit. Nevertheless, relative to the size of the NHS, the market for private health care is small in the United Kingdom. The market is highly specialized and consists basically of private insurers who are mostly involved in financing elective surgery and private providers who also specialize in this type of activity (Culyer et al., 1992). The only exception is possibly the provision of private nursing home care (Pollock, 1995).

\(^{20}\)The initial fundholding scheme included five main components: hospital inpatient care for a restricted range of operations, all outpatient visits, diagnostic tests done on outpatient basis, pharmaceuticals prescribed by the practice, practice staff. This was extended in 1993 to include community health services, district nursing, health visiting, chiropody, dietetics, mental health services, health services for people with learning disabilities. Terminal care and midwifery were excluded (Glennerster, 1994).
When considering other players that can exert an influence in the contracting process, the royal colleges are possibly one of the most powerful associations in the United Kingdom (panel discussion, 1995: interview). Their functions are to oversee the training of specialists and to organize this training through the accreditation of hospital departments and through competitive examinations for membership/fellowship of each royal college.

Since the royal colleges also prepare lists of requirements for hospitals to hold training accreditation, they can have an impact on the way contracts will be set up. This is because most hospitals in the United Kingdom rely on participating in postgraduate training schemes. If a hospital's accreditation as a training centre is withdrawn, not only will it not be able to train doctors, it will also have difficulties in hiring any doctors at all.

The normative function of the royal colleges can also indirectly shape a hospital's business plan and prospects for attracting new contracts. For instance, if a hospital's management team decides to start a new paediatric centre within the existing facilities, it might also be required to have an obstetric centre in order to be accredited by the royal college. Following the same logic, failure to achieve the established standards in the paediatric centre may imply that the obstetric service will also have to be closed down or that no accreditation will be given for either of the two centres.
Annex 5

Key participants in the German health care system

The Federal Government, respecting the principle of self-governance, has a major role to play as a regulator, guaranteeing that all actions taken are in accordance to the law. Its competence is limited to certain specific tasks, including:

- establishing the legal basis of the system:
  - laws concerning the structure, organization, tasks, rights, duties and membership of the self-administering bodies;
  - guidelines defining the minimum standard of performance of the sickness funds and providers;
- controlling the sickness funds’ financing arrangements, e.g. guaranteeing the stability of the premiums they charge;
- guaranteeing the provision of comprehensive and high-quality health care for all citizens;
- performing jurisdiction:
  - in the Social Law Court – legal matters concerning the statutory system;
  - in the Constitutional Court – examination of laws to determine their accordance with the constitution;
- planning for investments in the hospital infrastructure.

The supervisory role is divided between ministries. The Federal Minister for Health and the Federal Insurance Office supervise the sickness funds which are responsible for areas which cover more than one Land. For the others, the role of supervision rests with the Ministers for Labour and Social Affairs.

The Länder governments do not have a major role in contracting. However, Land authorities can indirectly affect the negotiating process since they have the final decision on the planning of hospitals and deciding whether or not a hospital will continue to receive patients from the sickness funds. Land authorities can also decide on the location of new hospitals within their jurisdiction. “They ask the sickness
funds, but we have no veto. The decision-maker is the state authority, the Ministry of Health. But they are under pressure from local politicians and the communities.” (Interviewee 3, Germany, 1994: interview.)

The sickness funds carry out several activities that reflect their right to self-governance. Examples of activities carried out by the AOK – one of the major statutory funds – include (AOK, 1994):

- appointment and election of committees:
  - election of their representatives by insured members
  - election by representatives of the insured members of the chairperson of the board
  - appointment by the fund of the members of the negotiating committees;
- internal administration:
  - preparation of its own budget (organizational and financial autonomy)
  - management of contracts for employment (personnel regulations)
  - development of internal statutes;
- external administration:
  - establishment of contacts with the insured members
  - drawing up of contract with the associations of physicians, dentists, etc.
  - representing members in court.

The funds form associations at the Land and federal levels. At both levels, the associations operate as corporations under public law. These associations do the bulk of negotiating and contracting.

The ASFPs are regionally organized. Physicians who wish to treat patients from the sickness funds must belong to a regional association of sickness fund physicians. The associations have two main functions.

1. They are responsible for negotiating with the sickness funds the total payment they will receive from the funds. This payment is based on the anticipated income of the funds and the expected expenditures. The rate is given by the Ministry of Health (Interviewee 3, Germany, 1994) and (Knox, 1993).
2. The money to be paid to physicians is paid by the sickness funds to the associations as a lump sum. The associations distribute the money
to the physicians in accordance with the level of services provided and the negotiated procedures.\textsuperscript{21}

Hospital associations are formed at both \textit{Land} and federal level. These are responsible for setting the annual wage increases for clinicians and nurses, based on the outcome of negotiations with their respective trade unions. Hospitals and sickness funds negotiate at the regional level, but annual global budgets are set through direct negotiations between individual hospitals and sickness funds (Knox, 1993).

As a condition for practising medicine, physicians in Germany are required to belong to their respective \textit{Land} Chamber of Physicians (Ärztekammer) and to respect its elaborate code of professional conduct. The Chambers are “bodies of public law” responsible for the self-governance of all physicians. Their public functions are defined by law and include preparation and supervision of the ethical code, continued medical education, arbitration and representation of physicians, registration of all physicians and quality assurance. The Chambers of Physicians (and the equivalent Chambers of Dentists) are not directly involved in the contracting process. However, physicians constitute one of the most organized professions in German society (Knox, 1993). As a result, the Chamber has considerable power in expressing the interests of its members through more formal channels of influence such as the government and the ASFPs.

Trade unions exist for clinicians, nurses and other staff employed by hospitals (salaried professionals). The major function of these unions is to negotiate annual wage increases for their members with the hospital associations. The outcome of the negotiations is a contract on wage levels.

Insured persons and the public can participate in the sickness funds’ decision-making bodies through their representatives. In principle, this would allow for decisions which take into consideration the views of the people who benefit most from the insurance system. However, empirical evidence suggests that the mechanisms in place to allow for the nomination of representatives and the process of participation is far from perfect.

\textsuperscript{21} The sickness funds have a say in how the money will be distributed, e.g. fees for services rendered or lump sum payments. The system of payment varies from \textit{Land} to \textit{Land} and depends on negotiations between the sickness funds and the associations (Interviewee 3, Germany, 1994 #3:interview).
There are many other voluntary organizations and societies representing every conceivable subgroup of professionals or patients. Depending on their support and membership, some of these associations can be very powerful even when they are not directly involved in the contracting process. For instance, orthodox physicians see the lobbying of homeopathy as being capable of changing the direction of the decision-making process: “Their pressure interferes with the negotiations” (Interviewee 4, Germany, 1994: interview).
Annex 6

Quality through contracts

Successful attempts to use contracts for increased quality of care seem to be influenced by the following factors.

1. The existence of incentives for both purchasers and providers to include quality specifications in their contracts. Based on the experience of the United Kingdom, Øvretveit (1993) highlighted some of the potential benefits of including quality in contracts:
   - service design and quality attitudes help staff to meet patients’ expectations, thus avoiding dissatisfaction and complaints;
   - a quality approach helps to avoid negligence claims and can reduce insurance costs;
   - even if contracts have very detailed quality specifications which cannot be constantly monitored, purchasers/providers can refer to them when contract disputes arise;
   - a quality approach increases income by attracting more patients and winning more contracts.

2. The existence of a monitoring function to follow up to what extent the contracts are meeting the agreed quality standards. Common schemes for supervision/inspection include:
   - retrospective peer review
   - review by an external professional organization
   - disciplinary bodies (associations for medical review)
   - inspection by government authorities
   - internal monitoring.

3. The existence of some form of guidelines or quality standards that define the minimum accepted level of quality in different aspects of service provision. These have to be scientifically or socially accepted as legitimate, otherwise influential players may put up strong resistance (Kerrison, 1993). Common issues to look at include:
   - registration of providers (defining who is allowed to be a provider);
• certification/accreditation (permission to be providing services in the name of a particular institution or in a geographical area);
• maintenance/creation of a database or legislation that permits comparison for quality assurance;
• certification of equipment suppliers;
• development of performance measures, e.g. lengths of stay, percentage of day cases, outpatient non-attendance, days in hospital prior to operation, different waiting times and different costs, and also quality of medical reports (Øvretveit, 1995b).

4. The existence of some form of customer service or other means for patients to express their views or preferences in relation to the system.

In a competitive system, this may involve giving patients a choice of provider. If patients are given the opportunity to express their satisfaction/dissatisfaction, they become agents of quality control. Nevertheless, there is a word of caution here, since patients are often not capable of making well informed decisions in relation to their medical treatment. Thus, patients are better agents of quality control for organizational aspects of quality such as length of wait and quality of hotel services available. Technical aspects of quality (appropriateness of the medical intervention, level of knowledge of the medical professionals, etc.) will not normally be properly evaluated by patients.

5. The existence of some form of professional development programme. This can include training, provision of technical literature, participation in seminars and conferences, etc. The basic idea is to have a means of informing the parties involved about different approaches that can induce more quality.

This study concludes that experience with the use of contracts to improve quality is highly diversified, even when considered within national borders. There are several assumptions about contracts and improved quality which need to be considered cautiously.
Annex 7

Provider payment methods

This annex discusses provider payment methods in accordance with the classification of contract types found in the literature. Firstly, provider payments are discussed in the context of contracting in the United Kingdom. This is followed by a discussion on provider payments in the German context.

United Kingdom

The methods of payment described below refer to the main types of contract used between purchasers and units which provide secondary and tertiary care (NHS trusts).

Block contracts

Block contracts work in a similar way to a budget for a defined service. The purchaser agrees to pay a fee in exchange for a broadly defined range of services for a given period of time. In the simplest block contracts, there is no specification of the number of patients (volume) and cost per patient. Block contracts, combined with other types of contract, have been used in the United Kingdom between hospitals and purchasers such as GP fundholders and district health authorities.

One of the reasons for using block contracts is to avoid the often complex exercise of calculating the costs and volumes of services to be negotiated. Also, when information for such calculations is not available, block contracts have been used as a compromise (Artundo et al., 1993). In practice, in the United Kingdom, block contracts predominated at early stages of the implementation of contracting (Mason & Morgan, 1994). However, the trend is towards differentiating large block contracts into smaller, separate contracts. The reason for doing so is to agree on better incentive and risk-sharing arrangements, as well as to follow new instructions from central government: “The NHS Management Executive has instructed Health Authorities and Trusts to end the use of block contracts after 1994-5 and

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22 This discussion is mainly based on Savas & Tragakes, 1995:15; Artundo et al., 1993:76; Cairns, 1993:130; Figueras, 1993:228; Glennerster et al, 1994:101.
negotiate explicit agreement on sharing risks if activity exceeds contract levels (Health Service Journal, 8 July 1993:4)” (Øvretveit, 1995b).

Block contracts have also been used as the preferred alternative for emergency treatment since emergency services are more difficult to control or predict (Interviewee 10, 1994: Wales).

**Variations**

(a) *Block contract, with indicative cost and volume.* In practice, block contracts have incorporated some degree of volume control, for example an indicative figure for the total number of patients.

(b) *Block contract, with indicative specialty cost and volume.* Similar to variation (a), but more specific in terms of the specialties and services to be paid for.

**Perceived advantages**

• Lower transaction costs: block contracts are easier to specify and monitor, particularly when they are broadly defined.

• Basic form of controlling expenditure: “Block contracts were undoubtedly a crude tool but they at least had the virtue from the purchaser’s point of view of controlling expenditure” (Ham, 1994).

• Smooth tool: because block contracts are usually set up on the basis of past activity levels, they do not interfere with patterns of referral. It is expected that, in an environment of uncertainty created by the use of new tools such as contracting, block contracts will prove a less destabilizing approach. It can be the first step in a gradual process towards more complex contracts (Cairns, 1993).

**Perceived disadvantages**

• Less efficiency: providers are paid to run a certain level of capacity. Whatever they do in terms of efforts to be more efficient, they will not benefit from it.

• Not a good tool for balancing risks: on the one hand, if the provider unit receives more cases than expected, it may face the dilemma of having to carry out the work and lose money or act against ethics and turn people away. On the other hand, “... providers may do as little work as they can, so patients and purchasers bear the risk: the patients in not being treated or having to wait and the purchasers in being held accountable for the failure of the system” (Roberts, 1993:308).

• Not a good tool for planning: “Crucial decisions concerning the volume and nature of the outputs to be produced stay on the provider side... for elective procedures [it] offers little scope for using contracting in pursuit of policies and priorities.” (Figueras, 1993).
Cost and volume contracts are considered to be a refinement of the block contracts, since payment for specific services is more explicitly related to the services to be offered and the amount of work to be performed. For example, they may entail an agreement whereby the purchaser pays a specified amount for a specified number of persons to receive specialty treatment.

Because of the uncertainty in the demand for services, it has been customary that the volume specified in the contracts is not reached or that targets are exceeded. If the volume contracted is exceeded, additional work can be paid for on a cost-per-case basis or any other arrangement. It has been reported that some hospitals have offered discounts of up to 50% for cases above the contracted volume (Glennerster et al, 1994).

When provision is below the agreed volume, purchasers will usually seek a refund or remedy the situation in the next contract. A refund will usually cover only the variable costs of the cases which were not treated. For instance, if a provider contracted for 1000 cases but received only 900 patients, it will credit the purchaser the equivalent of the variable costs of treating 100 patients. The fixed costs will not be paid back. Therefore purchasers have an incentive to send as many patients as they can up to the agreed volume.

From the purchaser’s point of view, cost and volume contracts have been considered to be more appropriate for services which allow for choice about when and where treatment takes place. Cost and volume contracts have been favoured by the British Government. The Department of Health issued planning guidelines for the period 1994–1995 requiring districts to move away from simple block contracts towards cost and volume contracts.

Variations
(a) Case-mix cost and volume. A more sophisticated version of cost and volume, these contracts include different payments according to the severity of illness and/or intensity of treatment. This implies having different categories of cost, for example high, medium and low cost categories (Øvretveit, 1995a).

Perceived advantage
• Strong potential for planning: for the providers, cost and volume contracts guarantee a minimum level of funding and activity. For the purchasers, such contracts offer greater control over what is being purchased,
since the level and nature of the services can be closely specified and monitored. “It seems that the form of cost and volume contract best fills the role of a mechanism for implementing plans.” (Figueras, 1993)

Perceived disadvantage

- High transaction costs: compared to block contracts, this type of contract requires more sophisticated information systems and personnel to keep track of the patients treated. Also, people involved in drawing up the contracts will need to have a clear idea as to the relative cost of different case treatments. If cost and volume contracts use the case–mix variation, this will imply extra costs to create and monitor guidelines defining the different levels of severity of illness.

Cost-per-case

In the usual cost-per-case contract, a single cost is set for each item of service. The volume of cases is not fixed in advance. The purchaser agrees, prospectively or retrospectively, a price for the treatment of each individual case.

In the United Kingdom, cost-per-case contracts are often used to fill the gaps not covered by other types of contract. For example, the cost per case is the basis for extracontractual referrals and is also used when additional services need to be purchased beyond the maximum specified in a cost and volume contract. More refined cost-per-case contracts require a prospective agreement between purchaser and provider over costs.

Perceived advantages

- Flexibility: cost per case allows the highest degree of flexibility for purchasers and, in some cases, for patients as well. Purchasers can compare prices and place their contracts according to specific plans. GPs, on behalf of their patients, can have more freedom in choosing the place and time for treatment. The flexibility of cost-per-case contracts has been reported as being of particular interest to providers of palliative care, where there are more accurate data on costs (Clark et al., 1995).
- Increased efficiency: if contracts are agreed on a cost-per-case basis and purchasers can control access to the contracted providers, they might be able to create financial pressure on providers to be more efficient. In the case of GP fundholders it has been reported that, by contracting on a cost-per-case basis and shifting referrals between providers, they have

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23 Some authors refer to this type of contract as fee-for-service (Roberts, 1993:308) or single item (Øvretveit, 1995a).
managed to put pressure on hospitals to be more efficient (Glennerster et al., 1994).

Perceived disadvantages

• High transaction costs: cost-per-case contracts require the greatest amount of information and are the most difficult to manage.

• Opportunism: “The purchaser is exposed in this system to opportunistic over-treatment by providers. Fee-for-service contracts are usually popular with providers, who are tempted to change the thresholds of care to ensure more work. This is a classic case of moral hazard.” (Roberts, 1993)

• Not a good tool for planning: “…with an open-ended commitment to pay whenever and wherever treatment occurs, the purchaser has no control over the number, nature and often the price of the outputs produced ... this gives the purchaser no leverage in terms of the pursuit of policies and plans.” (Figueras, 1993)

• Increased risks: purchasers may have expenses which they will only become aware of when an invoice arrives. In such cases, the unanticipated expenditure represents a financial risk. To avoid this risk, hospitals negotiating with fundholding practices in the United Kingdom have been asked to: (a) notify the purchasers in advance when admission will take place; (b) notify them when the treatment has started; and (c) invoice the purchaser within a month after treatment has been completed.

• Social inefficiency: the planning exercise in hospitals involves adjusting prices according to expected volume of services. On a cost-per-case basis and without much notice, purchasers may decide to shift contracts from one hospital to another. For the hospital that loses the patients, prices for services will go up, affecting other purchasers contracting with this hospital. This is because managers will need to adjust prices in order to deal with the hospital’s fixed costs. For the hospital that gains the patients, this will be an unexpected income, since their fixed costs were already covered. Overall, there will be inefficiency in the system characterized by an artificial surplus of provision on one side and above average demand on the other.

• Lack of economy of scale: it has been suggested that a disadvantage for purchasers using cost-per-case contracts is that “… there will be no economies of scale through bulk purchase and a premium may have to be paid if the provider does not achieve satisfactory levels of utilization” (Cairns, 1993).

Germany

The contractual relationships are part of a system of collective contracts. For ambulatory provision, the collective bargaining results in agreements
which are binding for all participants in the system. Thus, the scope for creating individualized contracts with specific characteristics and risk-sharing mechanisms is lower compared with the United Kingdom. Moreover, the traditional division between ambulatory care providers and hospital providers has an influence on the different types of contract that can be discussed.

In contrast to the United Kingdom, it is difficult to identify in Germany clear-cut types of contract. This may be because criteria such as volume of services play a smaller role in Germany, since the transfer of resources from the insurers to the providers is achieved via negotiated budgets that do not explicitly constrain volume. In fact, volume is decided mainly between patients and individual doctors (OECD, 1992). As a result, German contracts tend to be classified in accordance with the method used to pay the providers.24

**Ambulatory care**

Currently, physicians working in ambulatory care are paid by their local ASFP on a fee-for-service basis.25 In contrast to fee-for-service payments in other countries and as practised by private physicians, the fees are not at the discretion of the physician. Rather, they follow a fee schedule agreed between the ASFPs and the sickness funds.26 The fee schedule sets the amount of points doctors accumulate for each service they provide. The total budget used to calculate the monetary value of each point has to be negotiated with the sickness funds, making the regional budget for ambulatory care one of the most important aspects of the negotiations between the ASFPs and the sickness funds.

Different forms of budget negotiation have been tried in recent years. However, these forms of negotiation are used only for the purpose of calculating the total budget for ambulatory services in a region. According

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24 This study uses as examples the contracts for ambulatory care and hospital care. Although also significant, dental care is not addressed here for reasons of space. Nevertheless, the similarities between the contracting process for dental care and ambulatory care are expected to be sufficient for the analysis developed here.

25 Plans to change the reimbursement method of physicians have been introduced by the 1993 Health Care Act. In short, the move is towards reimbursing physicians on the basis of so-called service groups (*Leistungskomplexe*), rather then on a fee-for-service basis (NERA, 1993:27).

26 The physicians calculate their claims on the basis of a standard scale, the *Einheitlicher Memesungmasstab* or EBM.
to the literature reviewed and the interviews carried out, the major methods which have been used by the sickness funds for setting budgets and paying providers are as follows.\footnote{Combinations of these methods are also allowed.}

*Kopfpauschale* (capitation)

*Kopfpauschale* is used to arrive at a prospectively determined *per capita* budget. Under this type of contract, the sickness funds and the ASFPs negotiate annually the size of a lump sum payment to cover all ambulatory services provided to sickness fund members. The negotiations start with a capitation rate, the prospective *Kopfpauschale*. This value has to be agreed between the parties and it is then multiplied by the total number of sickness fund members to provide for an aggregated budget. The aggregated budget is divided by the total number of points scored by all office-based physicians in the *Land*, the result corresponding to the monetary value of one point. Using the forms received from the sickness fund doctors, the ASFP calculates the amount due to each professional and payments are normally made on a quarterly basis.

The definition of the capitation fee takes into consideration possible variations in the income of the insured, the risk of illness and differences in costs between different regions. Thus, the ASFP negotiates capitation rates with sickness funds on a regional basis,\footnote{Nationally-based substitute funds (the *Ersatzkassen*) have been an exception to this rule. However, the 1993 Health Care Act requires that all contracts be negotiated on a regional basis.} which means that each German *Land* has its own *Kopfpauschale*. Also, patients whose care is considered to be more expensive, such as pensioners, have their own capitation rate.

**Perceived advantages**

- Administration costs for capitation fees are low when compared to other forms.

**Perceived disadvantages**

- Variations in costs among different age groups, regions, etc.

*Einzelleistungsvergütung* (fee-for-service)

(a) *Retrospective fee-for-service*. This type of contract is not based on a negotiated budget. Only the monetary value for each service is negotiated and
agreed prior to provision, and the total reimbursement per doctor will depend on the services provided. As used during the 1960s in Germany, retrospective fee-for-service contracts were open-ended forms of reimbursement. Through discussions, ASFPs and sickness funds were supposed to establish expenditure targets which would be rolled back in subsequent years if overspending occurred. This in fact never happened and reforms in 1986 changed the system by implementing prospective expenditure caps.

(b) Prospective fee-for-service. Prospective fee-for-service contracts have been used since the 1980s in Germany to counterbalance the consistent overrun of expenditure targets that occurred under the retrospective fee-for-service payments system. Without abandoning the concept of fee-for-service payments based on the points system, reforms in 1986 tied the annual increments in ambulatory care costs to the increase in the average German wage. Thus, payment increases for doctors became dependent not only on the amount of services provided but also on the overall increase in the contributions paid by the insured.

Perceived advantages
- Fee-for-service payments provide a direct link between the work performed and payment.
- More market-like, since in principle the fee can be determined by market forces (Normand, 1994).
- Creates incentives for professionals to provide services without unnecessary delays.
- Easy mechanisms for informing interested parties about the cost of individual services.

Perceived disadvantages
- Physicians may be tempted to carry out more services than necessary.
- Physicians may be tempted to reduce quality (e.g. cut the time per consultation or delegate tasks to lower-paid personnel such as technicians and nurses) in order to increase their individual income.
- Retrospective fee-for-service payments make it particularly difficult for managers to plan and contain the costs of providing health care.

29 The points system allocates a certain number of points to each activity a doctor can perform. Hence, a home visit, for instance, can be worth 360 points for the doctor involved. Later those points are converted into a salary using the agreed conversion factor. This type of fee-for-service reimbursement gives doctors an incentive to over-treat and thus increase the overall cost of health care.
• Fee-for-service payments are likely to be more expensive payment systems to run than any other (Normand, 1994:64).

Hospital care
Hospital care is provided by:

• university clinics
• hospitals which are part of the hospital plan in any Land
• hospitals which have a contract with a Land association of sickness funds.

Traditionally, sickness funds negotiated flexible prospective annual budgets based on occupancy rates from previous years and taking into account expected increases/decreases. These budgets are mainly based on per diem rates, although cost-per-case figures are also used. Under the 1993 Health Care Act, per diem rates will eventually be replaced by prospective cost-per-case payments. In doing so, the Government expects to create incentives for improved efficiency (NERA, 1993).

Hospitals and sickness funds will contract on the basis of different forms of payment, depending on the type of treatment and the recommendations discussed at federal level.

Pflegesatz (hospital per diem rates)
These are figures used independently of the disease treated. They cover all services and expenses per patient per day (medical treatment, drugs, bandages, etc). With per diem payments, the only parameters the providers can manipulate are the total costs per period through the length of stay.

Perceived advantages
• Payments based on per diem rates contain an implicit incentive to economize, since the rates are all-inclusive.
• A per diem fee is relatively easy to establish and monitor. The administration of a payment by daily rates is relatively cheap.

Perceived disadvantages
• The implicit incentive to economize on the hospital side may undermine the quality of the treatment provided.
• It is relatively easy for hospitals to keep patients longer than necessary in order to profit from cheaper costs at the end of treatment. Thus, in 1985 a federal regulation on hospital care charges introduced a flexible prospective budgeting system which limited the scope for profiting from
long hospital stays. The system allowed for payment of only marginal costs (25% of the agreed per diem rate) if the number of patient days went beyond the agreed number. In contrast, if occupancy fell below the projected volume, hospitals were paid 75% of the per diem rates (Knox, 1993).

- Per diem rates inevitably lead to cross-subsidization across specialties.

Sonderentgelte (special per diem rates)

Some types of treatment are paid according to special rates. Examples include haemodialysis and intensive care. Under this type of payment, the main medical services are paid by a prospectively fixed lump-sum amount, while other costs such as administrative overheads are covered by a hospital-specific basic daily rate and a reduced departmental daily rate. This method of payment is intermediate between the cost-per-case and per diem payment systems. The 1993 Health Care Act determined that, with effect from 1995, approximately 155 procedures should be paid using Sonderentgelte (GAO, 1994).

For the hospitals, special rates guarantee that more expensive cases are remunerated at a higher rate. The advantages and disadvantages are the same as for per diem rates.

Fallpauschalle (cost-per-case or lump-sum-per-case)

These contracts have been used for some forms of specialized treatment and surgery. Examples include cancer and dialysis. Under the cost-per-case system, payment of a fee is made for each patient treated. In simple terms, cost-per-case payments are like budgets for specific cases.

The 1993 health care reforms determined that hospitals and sickness funds should move from per diem contracts to contracts based on reimbursements for specific procedures and treatments, similar to the diagnostic-related group system used in the United States (GAO, 1994). However, because this development is very recent, only limited data are available on outcomes. Some general considerations about the advantages and disadvantages of this method are discussed below.

Perceived advantages

- Provides a better way of controlling costs, as payment is prospectively determined and related to output.
- Removes the incentive for longer stay and therefore undermines artificial pressures for more investment in hospital beds.
- Provides strong incentives for diagnosis before admission and early discharge.
Perceived disadvantages

- Incentives for early discharge may be too strong, leaving very frail patients to be looked after somewhere else or not at all.
- Opportunistic behaviour may occur when patients are discharged and re-admitted a day or two later to allow for a second claim on the same patient.
- Opportunistic behaviour can also occur because hospitals have an incentive to “upgrade” the diagnosis of a patient to a different case which yields a higher payment.
- Hospitals may reduce their costs per case, potentially producing services of inferior quality.
- If allowed, hospitals may select cases with the best cost–benefit ratio, sending the more expensive cases elsewhere.

Comparison between the United Kingdom and Germany

The different methods of paying providers in the United Kingdom and Germany are summarized in Table 2. Due to the distinct historical development of health systems in these countries, it is not surprising that different methods of payment are used.

In Germany, the system compels sickness funds and the ASFPs to negotiate and agree on how and how much physicians will be paid. In fact, payments

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*In the United Kingdom, payment of physicians and other medical staff is not negotiated in the contracts between purchasers and providers.*
for ambulatory care physicians are one of the most important issues negotiated in Germany. In the United Kingdom this matter is left to the trade unions and central government. As a result, there is no contracting between purchasers and providers on the remuneration of physicians.

Some differences exist in relation to payment of hospitals, but both countries use variations on methods of payment based on prospective budgets. In the United Kingdom, contracts have been mostly of the block type, while in Germany global budgets have been set via negotiations on *per diem* rates and cost-per-case payments.

In the future, it is expected that contracts in the United Kingdom will evolve from the crude block type to more elaborate contracts of the cost and volume type. In Germany, reforms in 1993 indicated that budgets will continue to be used but *per diem* rates will eventually be replaced by cost-per-case payments (*Fallpauschalle*) or other forms of payment which have a closer link between costs and resource utilization (NERA, 1993:33/54).
Annex 8

Overview of Kyrgyzstan

Kyrgyzstan has a population of approximately 4.5 million, of whom in 1989 52% were Kyrgyz, 22% Russian and 13% Uzbeks. As in other central Asian republics, these figures are subject to adjustment following the considerable migrations that have taken place since independence.

The estimated population is dispersed over an area of approximately 198,000 km². The average altitude is 2750 metres. The Kyrgyz population is relatively young: 37.7% is aged under 15 years, while those aged over 65 years constitute 5.3%. At the current birth rate of 24.3 per 1000, the population is expected to grow to 6.2 million by 2005.

The Kyrgyz people are believed to have migrated from the north-western part of Mongolia over 2000 years ago, occupying dispersed areas along the length of the Tien Shan mountain range. Nevertheless, it was only at the beginning of this century that the country as it is known today started to take shape, first as part of Turkistan and then as part of the former Soviet Union (from 1936 until 1991).

Currently, Kyrgyzstan is divided into 6 regions (oblasts), governed by oblast-level administrators (akeem) appointed by an elected president. The parliamentary character of the presidency is supported by two houses in charge of the legislative functions.

In each oblast there are several districts (rayons) headed by rayon administrators appointed by the akeem. There are 42 rayons. Beneath the rayon there are village administrations. Seventeen cities are administered separately by city administrations.

The economy is primarily agricultural and has suffered from a continued decline in production in the period immediately following independence from the Soviet Union. This decline has affected all sectors, including the health sector. Both the share of public health expenditure in terms of gross domestic product and allocations to health care from the national budget have been reduced recently. The speed and extent of the economic collapse have totally transformed the prospects in the short- and medium-term.
As a consequence of the difficulties of the transition period, the health status of the population as measured by the conventional mortality rate has deteriorated since the early 1990s. Factors that have contributed to this include the disruption of immunization programmes, shortages of drugs and other generic articles, poor nutrition and the progressive deterioration of the health service infrastructure.

Life expectancy at birth was 68.3 years in 1992, a slight decrease on the 1990 figure. The crude mortality rate showed an increase from 7 per 1000 in 1990 to 8.3 per 1000 in 1994. The major causes of mortality are cardiovascular diseases (40%), respiratory diseases (20%), accidents and poisoning (12%) and cancers (8.2%).

Mother and child health remains a major problem. The infant mortality rate was 29.4 per 1000 in 1994 and maternal mortality has increased in recent years to 80.1 per 100 000. A significant increase has also been observed in communicable diseases. The increase in the incidence of tuberculosis has been accompanied by an increase in deaths from the disease. Sexually transmitted diseases are also increasing, for example the incidence of syphilis increased from 1.9 to 22.4 per 100 000 in the period 1990–1994.

There has been a decline in vaccination coverage which has resulted in an increase in preventable diseases. In 1994 there was an epidemic of diphtheria, with the number of cases increasing from 6 in 1993 to 139 in 1994 and 322 in the first half of 1995.
Annex 9

The health care system in Kyrgyzstan

While Kyrgyzstan was a member of the Soviet Union, defining health service provision constituted part of the entire social and economic planning process (Semashko model). In practice, health services were considered to be a social entitlement and comprehensive provision was available to everyone. Since its independence from the Soviet Union in 1991, Kyrgyzstan has been in a broad transition period from a centrally-controlled economy to a market economy. As with other economies in transition, the process of reform has influenced the management, organization and provision of health services.

Under the current organizational structure (Fig. 3), the oblasts report directly to the Ministry of Health. Some administration is also carried out locally in the rayons. The Ministry of Health carries out all responsibilities and functions that were formerly undertaken in Moscow. Most of the policy-making processes in the Ministry are finalized at monthly meetings of a decision-making board, the Kollegya. Several other committees and players are also involved in policy-making and the planning and regulation of the health services at each level, with varying responsibilities.

Financing of health care is almost totally based on taxation. Currently, taxes are raised locally and are not earmarked for health. A small amount of funds also derives from user charges for some services.

As a result of the Soviet planning system, Kyrgyzstan has an extensive network of primary health care facilities and accessibility is relatively high. Nevertheless, they suffer from a lack of drugs and disposable equipment, resulting in unnecessary referrals to hospitals. In addition, traditional protocols have made it common to refer patients to hospitals even when treatment is locally available.

Hospital facilities are fragmented and characterized by an over-supply of beds. Admissions to hospitals and average lengths of stay remain quite high, due in part to payment methods and in part to legislation which requires
that a certain number of beds are used. Also, outdated treatment protocols (e.g. one year compulsory hospitalization of tuberculosis cases) have added to the high hospitalization rate and length of stay. Furthermore, it has been reported that hospital managers lack flexibility and incentives to increase efficiency. Plans have therefore been drawn up to give autonomous administrative status to hospitals in the near future. They are also expected to have more financial autonomy through global budgets instead of the present system of itemized budgets (Ministry of Health, 1996).

The number of physicians employed in Kyrgyzstan has been considered exceptionally high relative to the population served. Nevertheless, there is a geographical imbalance in the distribution of personnel. It is still difficult to attract personnel to the rural areas; this is normally overcome through compulsory medical service. Low productivity has also been considered a problem. There has been a significant exodus from

the health sector since 1990. This has taken two forms: emigration (predominantly by ethnic Russians, Germans and Jews) and moves to other sectors.

In general, medical education is oriented towards training specialists who are entitled to work after six years of education and one year of internship. As a result, the number of physicians qualified for general practice is low.

Kyrgyzstan has no facilities for producing modern drugs and imports more than 95% of all drugs prescribed. Currently there is a deficit in the availability of drugs, including those considered to be essential. In spite of this, a new protocol of essential drugs is being developed.

Estimates of drug needs are based on past consumption and there are problems with the storage, transport and inventory management of drugs. Furthermore, the current pricing system does not take into consideration the affordability of drugs both for hospitals and the general population. Irrational prescribing is considered to be widespread and medical professionals in general are not cost-conscious.

Health promotion has been weak. Very few efforts have been made to tackle lifestyles associated with diseases, especially the consumption of alcohol and tobacco and the high intake of animal fats.

The situation described above is expected to change through the implementation of several reforms. These are outlined in the document *MANAS national programme on health care reforms* (Ministry of Health, 1996). According to the programme, the major reforms will be as follows.

**Short-term (1996–1997)**
- Rationalization based on avoiding excess capacity of staff, beds and other facilities
- Rationalization of user charges
- Definition of a minimum benefits package.

- Strengthening of primary health care
- Introduction of more equitable formulae of resource allocation
- Introduction of global budgets for hospitals and capitation payments for primary health care providers
- Development of new structures and new roles for managers, including revision of the functions of the Ministry of Health
• Establishment of a public health institute
• Upgrading of the existing health information system

• Introduction of social insurance
• Introduction of the purchaser–provider split
• Primary health care facilities to have fundholding functions for their registered patients and ability to contract with secondary care providers
• Hospitals to have an autonomous status and to contract with the health fund and with primary health care providers
• Tertiary care to be provided by oblast hospitals and national institutions, and the latter to have contracts with the oblast health administrations.