The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries

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Contracts for the delivery of public services are promoted as a means of harnessing the resources of the private sector and making publicly funded services more accountable, transparent and efficient. This is also argued for health reforms in many low- and middle-income countries, where reform packages often promote the use of contracts despite the comparatively weaker capacity of markets and governments to manage them. This review highlights theories and evidence relating to contracts for primary health care services and examines their implications for contractual relationships in low- and middle-income countries.

Keywords: primary health care; contract services; private sector; review literature; developing countries; United Kingdom.

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Introduction

Selective contracting out of services to the private sector is often a component of reform packages promoted by bilateral and multilateral agencies for low- and middle-income countries (*1–6*), where the private sector is increasingly acknowledged as an important and often well-resourced provider of health care services (*7–10*). The motivation for contracting with the private sector is both to utilize these resources in the service of the public sector and to improve the efficiency of publicly funded services (*11–14*). Although the use of contracting is increasing, little is known about the nature of many contractual relationships, especially in low- and middle-income countries. Furthermore, emerging evidence from health systems in developed countries is beginning to point to contractual relationships of a nature different from that originally envisaged, with competitive contracting showing a tendency to develop rapidly into durable, mutually dependent relationships (*15–17*).

The increased popularity of contracts as a reform prescription highlights the need to understand their nature and the manner in which they are likely to operate in the context of a developing country. This paper reviews some aspects of new institutional economics and evidence about the nature of contracts for primary care in the United Kingdom, one of the few countries where contractual relationships for health are well documented and researched. Both theory and practice highlight likely challenges in attempting to introduce a policy of competitive contracting in the context of low- and middle-income countries. The implications of this for a policy of contracting out in such countries are then discussed.

Primary care has been chosen as the focus of this review for several reasons. First, there is an inescapable trend in low- and middle-income countries to patronize private providers at primary care level: *The world health report* of 1999 concludes that "most people now prefer to use traditional or private sector providers of primary care", and further country-specific studies also support this view (*5, 7–10*). Contracts for primary care with private providers are often therefore seen as a quick and simple solution to gaps in coverage, especially in areas where government provision is inadequate and there are private providers already practising (*13*). Motivation to contract may also be inspired less by ideas of a comprehensive United-Kingdom-style internal market than as a practical approach to bringing the unregulated private sector under some type of control. A review of the experience of health systems in higher income countries to inform the likely direction of similar policies in low- and middle-income countries also seems valid at primary care level, given that the nature of the service and its providers are essentially comparable despite differing income levels across countries.

Contracts and the new public management

Since the late 1980s, contracts and contracting have become central themes of the transformation in

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public sector management taking place in many countries (*18–20*). In health, as in other sectors, prescriptions for change are rooted in a belief that the state is over-extended, inefficient and needs to be "rolled back", alongside a strong presumption that the practice of private sector management is more effective (*12, 18, 21*). In many government systems there has been a move away from hierarchical organizations towards the creation of a split between purchasers and providers, often governed by a contract (*22*). Although there is no single prescription for the type of market mechanisms to be used, common themes such as the desirability of competition and the use of contracts between purchasers and providers are discernible.

Although this so-called new public management is recognized as a striking trend worldwide, empirical evidence on its effects is often lacking. The issue of the applicability of the theory of private sector management to the public sector has also been intensely debated, especially in the context of low- and middle-income countries (*12, 19, 21–27*). Existing contractual relationships in health systems in developing countries are attracting increased attention and evaluation (*2, 12, 14, 25, 28–30*), but evidence relating to the advantages and disadvantages of the approach is still scarce. With the exception of Broomberg (*25*), little is known about the desirability of contracting for clinical services in low- and middle-income countries. Little attention has also been paid to the nature of contracts required for health services — features of their design and implementation including pricing methods — and what capacities governments require to put contracting mechanisms in place (*2*).

Arguments in favour of the use of market incentives in health care have been summarized as follows (*26*).

- Increased provider competition may increase technical efficiency on the supply side and therefore allocative efficiency within the system.
- Contractual relationships enhance efficiency on the purchaser and provider sides via the incentive structure inherent in the contract.
- The contracting process itself may promote transparency in trading and decentralization of managerial responsibility, both of which may have beneficial effects on efficiency.

These arguments are clearly rooted in the "clean" models of microeconomic theory, which tend to assume a well-defined information structure, that actors' preferences are predetermined and that they have unlimited capacity for processing information (*31*). The applicability of these assumptions to health care services, especially in developing countries, must be questioned. Indeed, attempts to translate such theory into practice have highlighted several tricky assumptions, particularly that (*14, 26*):

- enough potential providers exist to enable the creation of provider competition;
- provider competition, without any change on the purchasing side, can enhance efficiency;
- the benefits of introducing market incentives outweigh the costs of their implementation and maintenance;
- government has adequate capacity to enter into and manage contractual relationships with the private sector.

Several characteristics common to the environments of low- and middle-income countries, such as poorly developed institutional capacity, a shortage of administrative and contract writing skills and poorly developed markets, further decrease the likelihood of much of the above being realized. The capacity of markets to behave competitively and transparently or of government to support the creation of such markets is likely to be limited in many such countries (*32*). The danger that a notion of contracting is superimposed on an existing hierarchy of traditional relationships and interdependency is strong. Equally, resources for the adequate specification and monitoring of contracts and overseeing the bidding process may be lacking. Such factors could fundamentally alter the outcome of market-based reforms.

Consideration of the type of contracts and contractual relationships that arise from market-based reforms has progressed further (as have the reforms) in industrialized countries, notably New Zealand, the United Kingdom and, in a slightly different form, the USA. The way in which policy has been translated into practice in developed countries, and some theories explaining why this may be so, can shed some light on the path that contracting for health in low- and middle-income countries is likely to follow. Some theoretical approaches from new institutional economics and some evidence on the nature of contracts for primary care within the United Kingdom National Health Service (NHS) are reviewed to enable lessons for contracting to be ascertained.

Contracts in their many forms

All exchange is governed by some type of contract, but the form that this takes varies widely. A useful starting point for analysing contracts for health care is MacNeil's classification of different contractual forms (*33, 34*). He attempts to reconcile the concept of a contract as a legal document, fully specifying services to be delivered, with what he describes "the real life of contractual behaviour", describing a spectrum of relationships between parties wishing to exchange goods and different types of contract that will be used to formalize exchanges along this spectrum. At one end of the spectrum, the purchase of fuel at a petrol station is illustrative of a transactional event — short, limited in scope, measurable and with no foreseeable or necessary future. This is contrasted with the contractual relationship implied by marriage:

> "The latter consists not of a series of discrete transactions, but of what happened before (often long before), of what is happening now, and of what is expected to happen in the future. These continua form the relation without a high degree of consciousness of measured transactions. Nonetheless, exchange, both economic and social, takes place in such a relation, even if not in the measured terms of the transaction" (*34*).

Corresponding to the different types of relationship that they must govern, MacNeil developed a classification of contracts: classical, neoclassical and relational. At one end of the spectrum, classical contracts govern truly discrete transactions between people who will never see each other again. All that is relevant to the exchange is contained within it, implying that there is no "before" or "after" and no need to allow for flexibility within the terms of the contract. Neoclassical contracts govern transactions that are less discrete and therefore contain techniques for allowing flexibility within the terms of the contract, such as third party determination of performance (*34*).

Relational contracts

It is the concept of relational contracting that is now attracting attention in the literature of developed countries about the nature of contracts for primary health care. Relational contracts occur when the reference point of the relationship ceases to be the contract itself and becomes "the entire relation as it has developed through time" (*34*). Specific stipulations of a contract become subordinate to the need to harmonize conflict and preserve the relation.

MacNeil concluded that the dominant mode of economic organization was becoming increasingly the relational and not the discrete transaction:

> "Advanced economies require greater specialisation of effort and more planning than can be efficiently achieved ... through discrete transactions: they require the projection of exchange in to the future through planning of various kinds, that is, planning permitting and fostering the necessary degree of specialisation of effort." (*33*)

Despite this prediction, and the fact that MacNeil's thinking is increasingly echoed in recent texts (*35, 36*), it is interesting that recent reforms of public sector management continue to be predicated on the idea of classical or neoclassical contracting (*37, 38*), and these are often also the arguments put forward for contracting in low- and middle-income countries.

Incomplete contracts

The concept of incomplete contracts is also pertinent. Hart emphasizes the difficulties of writing comprehensive contracts and their subsequent incompleteness and therefore argues that the "ex post" allocation of power (or control) matters, to reduce what he terms "haggling" or "hold up behaviour" by one party to the transaction (*39, 40*). Again, some form of integration or long-term relationship may lead to more efficient outcomes, and recognizing the incompleteness of contracts also raises further questions about how the behaviour of contracting parties is determined. With contracts failing to specify each party's actions fully, additional factors must be at play that determine how the contracting relationship is to operate.

Costs of contracts

The work of economists such as Coase and Williamson goes one step further by examining the costs of specifying, monitoring and managing contracts (*41, 42*). They observe that costless transactions, as assumed by neoclassical theory, are rarely encountered in life (*41, 43*). Transaction costs are an obstacle to the efficient operation of private exchange, and if firm and market are alternative means by which to organize transactions (*41*), whichever is able to do so at least cost (that is, lowest transaction costs) becomes the most desirable and efficient form of organization. Indeed, debates around the advantages or disadvantages of contracting can be characterized in terms of a discussion of the relative merits of firms versus markets and the transaction costs associated with each (*39*).

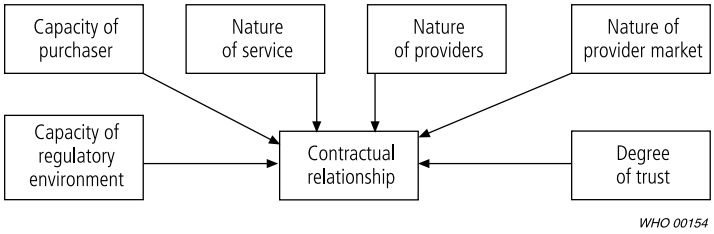
The economics of transaction costs begins to address this issue via a discussion of what might determine boundaries between different organizational structures, such as firm and market. Again, the notion is of a spectrum of contracts corresponding to the type of relationship. The market (highly transactional contracts) is at one end and firms (hierarchical relations) at the other, with different forms of increasingly relational contracting between the two. This idea that efficiency purposes are served by matching governance structures to the attributes of transactions in a discriminating way, implying that the nature of a transaction determines the type of contract which will govern it, is closely related to the work of MacNeil. Again, relational contracting is a response to the increasing duration and complexity of contracts or to a high degree of dependency between the two contracting parties.

Future contracts for primary care

What do these various theoretical approaches tell us about the possible shapes contracts for primary care in low- and middle-income countries might take? Fig. 1 highlights some of the possible influences. If a contract is shaped by the type of relationship it is to govern, it is useful to examine the nature of likely purchasers and providers of primary care alongside the nature of the service to be contracted. The capacity of the broader institutional and organizational environment to support the operation of contracts must also be acknowledged as an important influence.

The level of competition between providers and the capacity of the purchaser are also relevant.

Fig. 1. **Examples of influences upon the nature of a contractual relationship**



Whereas the number of potential providers may seem great in some urban areas in low- and middle-income countries, many may be unqualified (*5*), and the degree of competition in most smaller towns and rural areas is likely to be low. In addition, a key motivation to contract with the private sector is often to remedy gaps in coverage, which tend to arise in more sparsely populated or periurban areas. A limited choice of provider implies that a degree of dependence is likely to develop, increasing the long-term importance of the relationship. Newman observes that:

> "Contracts tend to be short term where switching between different provider organisations is likely to deliver benefits to the client. In situations with few, powerful providers, the market is more likely to be shaped by providers themselves, who may seek to secure the benefits of longer-term, relational contracts." (*44*)

Even in urban areas where there are more plentiful potential providers, switching contracts between providers is costly in terms of time and capacity and hence not an attractive prospect for health authorities. This would suggest that contracts will tend towards the relational rather than transactional. Incomplete contracts are also likely, due to a shortage of capacity in contract writing at the purchaser level. Primary care may also encourage the use of incomplete contracts, due to the difficulty of adequately specifying and monitoring the range and quality of services that must be provided by a primary health care service. Although the nature of primary care may seem relatively straightforward to specify compared with hospital services, it becomes problematic to do this in any detail given the range of services that must be dealt with. Both "technical" and "non-technical" aspects of quality will be difficult to specify and monitor, again encouraging the use of more relational, trust-based contracts (*44, 45*).

Incomplete, relational contracts may therefore be the most efficient approach to health care contracts in a low- and middle-income setting; costs of writing, managing and monitoring complete contracts would pose a great burden on under-resourced health departments. Even if contracts were specified in great detail, lack of resources and capacity for monitoring may render them effectively incomplete by poor monitoring. Furthermore, the trust that develops in a longer term contractual relationship may act as a more efficient alternative to costly monitoring, although there is also a danger that what eventually governs the relationship may be more resignation than actual trust.

Evidence of such issues from low- and middle-income countries is at present limited, but preliminary evidence relating to the nature of contractual relationships in primary health care in the NHS can shed further light. Although the NHS is operating in an environment that is far better resourced, differences between the NHS environment and that of a low- and middle-income country are less fundamental than ones of degree. Primary level care is purchased by health authorities who have recently been introduced to the role of purchaser. The pool of suppliers is made up of essentially self-employed agents, whose geographic availability and structure are quite inflexible in the short to medium term.

The next section examines possible lessons from NHS experience in more detail as a further indicator of the direction in which contracting in low- and middle-income countries is likely to develop.

The nature of contracts for primary care in the NHS

Whereas arguments in favour of contracts are often couched in terms of increasing competition and accountability, the emerging evidence from the United Kingdom NHS is of something altogether more complex, less competitive and less transparent. MacNeil's prediction that relational contracting will dominate has been confirmed by several recent surveys of contracting in the NHS (*16, 17*). These noted that most contracts were broadly focused, informally worded and adopted a pragmatic approach to monitoring. They were less likely to have provisions on how to deal with failure than on how to vary the clauses of the contract and tended to rely on informal mechanisms for dealing with disputes. All of these points indicate a tendency towards relational contracting.

In the NHS, it was found that it is common for contracts for primary care to be vague about risks and responsibilities, to ignore sanctions that are available for failure to perform and to be imprecise about time (*37, 38*). Indeed, in many cases contracts were deliberately left incomplete and parties may even have been able to behave in ways that directly contradicted what the contract stipulated (*20*).

Heavy regulation is shown to compromise further, perhaps fundamentally, the nature of the contracting process (*38, 46–49*). Hughes & McGuire refer to the "conceptual gymnastics" needed to sustain the metaphor of the market within the NHS, given the nature and extent of government regulation (*47*). Roberts argues that the initial annual cycle of contracting in the NHS was inappropriate for the vast majority of contracts (*50*). An annual cycle will not be conducive to optimal investment in specific assets, as the potential threat of losing a contract may be too

great to justify the investment. In the context of a service that entails large investment in specific assets, markets are unlikely to provide the discipline necessary to ensure efficiency, owing to both suboptimal investment and the likely departure from the market of those who do not win the contracts. In a similar vein, several other writers have argued that the introduction of contracts in health care may not enhance efficiency due to the increase in transaction costs that they imply (*51, 52*). In the case of New Zealand, Ashton observes that "as the market matures together with the relationships within it, the style of contracting is likely to shift away from the transactional end of MacNeil's contracting continuum further towards the relational pole" (*51*).

The capacity to manage the contracting process is a further issue. In low- and middle-income countries, Mills observes that a series of studies of contracting demonstrated that many problems had their origins in poor contract design and weak management of the contracting process (*2*). Little attention was paid to the specification of the service in the contract or to the nature of the incentives in the pricing method adopted. Capacity has also been an issue in the introduction of the internal market in the NHS. Appleby et al. examined the form of contracts and negotiating process during the first two years of the NHS internal market (*53*). Factors identified as important and often problematic in the contracting process were expertise, timetable, level of information available, existing purchaser/provider relationships and the quality of care specified/delivered. All these factors are encompassed by a broad definition of capacity.

In terms of the adequacy with which contracts are specified, Allen reviewed a series of NHS contracts for primary care and found them to be poorly specified compared with the normal tenets of commercial contracts (*46*). She noted that performance requires a description of the actual tasks to be performed, the standard to which they should be performed and when services must be provided. The concepts of inputs, outputs, throughputs and outcomes need to be differentiated: volume of services alone is an incomplete specification, despite its enthusiastic use in many NHS fundholders' contracts (*46*). Standard — or quality — of performance should also be specified as much as is possible, including quality of the process (e.g. maximum waiting time) and the quality of the outcome (e.g. health gain). NHS fundholders' contracts were found to be seriously deficient in all these respects. This has further implications for the subsequent monitoring of performance, which is closely tied to the contract being adequately specified originally.

Health care may just not lend itself easily to specification by contract. In a comparative study, Walsh et al. analysed the design of a series of contracts for health, social care and other local government services according to the dimensions of form, focus and content (*20*). In the case of contracts for health care, 176 contracts for primary and hospital care were studied, the focus of which was highly varied between emphasizing input measures or attempting to define results. In terms of content, contracts for health tended to be much less detailed than in the other services and were sometimes no more than statements of procedures and prices. A tendency to use rather unsophisticated output measures, for example, number of interventions, was noted. Language was also found to be less legalistic and less detailed than in some other sectors studied. In terms of ensuring quality, health contracts were found to have sections on quality tending to emphasize the need for a cooperative, incremental approach involving both client and contractor. Default measures were only specifically addressed in just over 50% of the health contracts analysed. Failure to deliver would incur financial deduction in only 15% of contracts analysed. Only 19% of contracts made specific provision for termination of contract for failure of performance (*20*). Although none of these observations about the nature of contracts in the NHS imply that contracting has failed, it has clearly taken on a form somewhat different from that envisaged by many of its original proponents. Despite a change of government, the United Kingdom Department of Health is continuing with contracts for primary care but is now encouraging a longer term perspective to the contractual relation (*54, 55*).

Contracts in any sector are complex to write, administer and manage. Competitive contracting for health is further complicated by sparse competition and the problems of adequately specifying and monitoring the delivery of health services. Studies reviewed in this section emphasize the many forms that contracts can take, even in the comparatively well resourced environment of the United Kingdom's NHS. Contracts for health with the private sector in low- and middle-income countries must make allowance for greater weakness in both markets and institutions and by so doing are likely to move even further away from the models espoused by new public management theory.

Conclusions

Contracts with public or private providers are currently advocated as an effective method to improve the performance of publicly funded health systems in low- and middle-income countries, although empirical evidence to support this is still limited. This review has highlighted some differences between common justifications for the introduction of contracts for health and their practical application. Some theories from new institutional economics alongside evidence about the nature of existing contracts for primary care in the United Kingdom both call into question the viability of a policy of competitive contracting in the context of low- and middle-income countries. This does not mean that contracting is an inappropriate policy for such

countries to pursue, as contracts between different levels of government or with the private sector may often be highly effective policy tools. What is required is a greater recognition that contracts are increasingly relational in their focus and that often what is important is the overall relationship between the contracting parties, its degree of flexibility and cooperation, rather than the specifics of the contract document. Such a change of emphasis would have clear implications for the perceived benefits and disadvantages of contracts as well as for how a policy of contracting should be approached.

The need for further research into the nature of contractual relationships for health in low- and middle-income countries and the factors that determine these is therefore clear. Despite arguments expounding the benefits of competition, in many settings some form of long-term contractual relationship is more likely to arise. This relational approach to contracting may be appropriate in situations where monitoring is imperfect, choice of provider is limited and transaction costs are high. Alternatively, in some cases the phrase relational contracting may be used to make poorly specified and managed contracts sound more desirable than they should. Closer scrutiny of the dynamics of contractual relationships in such settings is required.

It is unlikely that any approach to contracting can be comprehensively transposed from developed country markets for health, which in turn are not functioning entirely as envisaged, to the different environments of a range of low- and middle-income countries. Greater clarity as to what policy is being pursued when contracts are suggested is desirable. In some cases it may be preferable not to aim for supposedly competitive transactional relationships but to concentrate on promoting partnerships. Such partnerships could more easily recognize issues such as dependence, aiming to consolidate mutually beneficial relationships over the long term. Contracts may be written quite differently, for instance emphasizing issues of trust rather than monitoring, but should also pay more attention to achieving appropriate incentives, which may not always be financial, for both purchaser and provider. Other factors influencing the operation of contracts must also therefore be taken into account — the degree of trust between contracting parties, their willingness to rely on trust and whether this in turn is by choice or dependence should all be considered. The motivations and incentives faced by purchaser and provider are also key influences. If such apparently intangible concepts could be grappled with, it should be possible to more effectively analyse the dynamics of contracting for health in low- and middle-income countries and its advantages and disadvantages. ■

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Résumé

La sous-traitance des soins de santé primaires au secteur privé : théorie, faits et enseignements pour les pays à revenu faible ou moyen

La sous-traitance de certains services au secteur privé fait souvent partie des modalités de réforme que privilégient les organismes bilatéraux et multilatéraux pour les pays à revenu faible ou moyen. Cependant, si la sous-traitance augmente, on sait peu de chose de la nature de bon nombre des rapports contractuels qui s'établissent ainsi, surtout dans ces pays. Dans cet article, on examine certains aspects de la nouvelle économie institutionnelle et les indications disponibles concernant la nature des contrats passés au Royaume-Uni de Grande-Bretagne et d'Irlande du Nord pour les soins de santé primaires. La théorie comme la pratique soulignent les problèmes qui peuvent se poser lorsqu'on essaie d'introduire une politique d'appel d'offres dans des pays à revenu faible ou moyen. En particulier, elles mettent l'accent sur le fait que ce type de politique peut montrer une tendance à évoluer rapidement vers des rapports de dépendance mutuelle durables.

On y évoque la classification des contrats (classiques, néoclassiques et relationnels) et les concepts de sous-traitance relationnelle et incomplète, ainsi que l'impact des coûts de transaction sur la forme que peuvent prendre ces contrats. On y montre que les rapports à long terme entre les parties contractantes en sont une conséquence probable dans certaines circonstances. Des enquêtes récentes sur la sous-traitance dans le National Health System (NHS), où la plupart des contrats sont assez ciblés, sont rédigés de façon informelle et adoptent une approche pragmatique de la surveillance, vont dans ce sens. Ces contrats renferment moins de dispositions sur la façon d'appréhender un échec que sur celle de modifier les clauses du contrat et ils ont tendance à reposer sur des mécanismes informels pour gérer les conflits. Il est courant dans les contrats relatifs aux soins de santé primaires que les clauses concernant les risques et les responsabilités soient vagues, que les sanctions prévues en cas d'échec soient ignorées et qu'il y ait une imprécision quant aux délais.

On y discute également de l'environnement dans lequel les contrats vont être accordés, rédigés et surveillés dans les pays à revenu faible ou moyen, en attirant l'attention sur les aspects liés à la concurrence et aux moyens d'action. La nature des soins de santé primaires en tant que service devant faire l'objet d'un contrat est également évoquée, avec les problèmes de

surveillance que cela pose. On y montre que, quel que soit le secteur, la rédaction et la gestion d'un contrat sont complexes. En matière de santé, la rareté de la concurrence et les problèmes d'information viennent encore compliquer les appels d'offres. Les études examinées soulignent les nombreuses formes que peuvent prendre les contrats, même dans le contexte du NHS du Royaume-Uni, où les ressources sont comparativement bonnes. Dans les pays à revenu faible ou moyen, les contrats de santé passés avec le secteur privé doivent tenir compte d'une faiblesse bien plus importante des marchés et des institutions. En procédant de la sorte, il y a des chances qu'ils s'écartent encore davantage des modèles qu'épouse la théorie de la nouvelle gestion publique.

A l'évidence, il est nécessaire de procéder à des recherches approfondies sur la nature des rapports contractuels passés en matière de santé dans les pays à revenu faible ou moyen et sur les facteurs qui les déterminent. Il est peu probable qu'on puisse entièrement transposer l'approche de la sous-traitance des marchés de la santé telle qu'elle s'opère dans les pays développés, et qui déjà ne fonctionne pas entièrement comme on le pensait, aux différents environnements d'un certain nombre de pays à revenu faible ou moyen. Il est souhaitable d'être plus clair sur le type de politique suivie lorsque l'on propose une telle sous-traitance. Dans certains cas, il sera peut-être préférable de ne pas viser des transactions censément concurrentielles, mais de se concentrer sur la promotion de partenariats. Quant aux contrats, ils peuvent être rédigés très différemment, par exemple en insistant sur la confiance plutôt que sur la surveillance, mais ils doivent également prévoir davantage de mesures d'incitation, qui ne seront pas forcément financières, à l'intention des deux parties contractantes.

Il faut également tenir compte d'autres facteurs qui influent sur la passation de contrats : par exemple, le degré de confiance entre les parties contractantes, leur propension à se fier au contrat (que ce soit par choix ou du fait d'une dépendance) et les motivations du dispensateur de soins. Si l'on peut s'attaquer à des concepts apparemment si intangibles, il devrait être possible d'analyser avec plus d'efficacité la dynamique de la sous-traitance en matière de santé dans les pays à revenu faible ou moyen et les avantages et inconvénients qu'elle présente.

Resumen

Subcontratación de servicios de atención primaria con el sector privado: teoría, pruebas científicas y lecciones para los países de ingresos bajos y de ingresos medios

La subcontratación selectiva de servicios con el sector privado es un componente frecuente de los paquetes de reformas promovidos por los organismos bilaterales y multilaterales para los países de ingresos bajos y de ingresos medios (PIBM). Sin embargo, aunque cada vez se recurre más a las subcontratas, apenas se tiene información sobre la naturaleza de muchas de esas relaciones contractuales, sobre todo en los PIBM. En este artículo se analizan algunos aspectos de la nueva economía institucional y las pruebas científicas sobre la naturaleza de las contrataciones de servicios de atención primaria en el Reino Unido de Gran Bretaña e Irlanda del Norte. Tanto la teoría como la práctica ponen de relieve los obstáculos que cabe prever en cualquier iniciativa de introducción de una política de licitaciones en el contexto de los PIBM, y subrayan en particular que ese tipo de contratación tiende a veces a materializarse rápidamente en relaciones duraderas de mutua dependencia.

Se pasa revista a la clasificación de los contratos en clásicos, neoclásicos y relacionales y a los conceptos de contratación relacional e incompleta, así como a la repercusión de los costos de transacción en las modalidades de contrato. Se muestra que las relaciones prolongadas entre las partes contratantes son un resultado probable en determinadas circunstancias. Esta predicción se ve respaldada por algunos estudios recientes de las contrataciones realizadas por el Sistema Nacional de Salud (NHS), que revelan que la mayoría de los contratos tenían carácter general, estaban redactados de manera informal y aplicaban métodos pragmáticos de vigilancia. En ellos las disposiciones relativas a la manera de reaccionar en caso de incumplimiento de las obligaciones eran menos frecuentes que las dedicadas a especificar la manera de modificar las cláusulas del contrato, y para resolver las controversias se solían prever mecanismos informales. Las más de las veces los contratos para la prestación de servicios de atención primaria aludían sólo de forma vaga a los riesgos y responsabilidades, obviaban cualquier referencia a las sanciones disponibles en caso de incumplimiento, y no especificaban los plazos con precisión.

Se analiza el entorno en que se concedieron, redactaron y controlaron los contratos en los PIBM, subrayándose los aspectos relacionados con la competencia y la capacidad. Se habla también de la naturaleza de la atención primaria como servicio que debe especificarse en los contratos, así como de diversos aspectos de la vigilancia. Se muestra que la redacción, la administración y el manejo de los contratos, en cualquier sector, son tareas complejas. Una competencia escasa y la falta de información son factores que complican aún más la contratación competitiva de servicios de salud. Los estudios examinados resaltan las muchas formas que pueden adoptar los contratos, incluso en el entorno comparativamente bien dotado del NHS del Reino Unido. En los PIBM, los responsables de la contratación de servicios de salud con el sector privado han de asumir que en ese contexto tanto los mercados como las instituciones son más débiles. Reconociendo ese hecho, tenderán a apartarse aún más de los modelos propugnados por la teoría de la nueva gestión pública.

Queda clara, por tanto, la necesidad de llevar a cabo nuevas investigaciones sobre la naturaleza de las relaciones contractuales en el campo de la salud en los PIBM y sobre los factores que las determinan. Es difícil que una fórmula cualquiera de contratación pueda

exportarse íntegramente de los mercados de salud de los países desarrollados, que a su vez no funcionan del todo según lo previsto, a los diferentes entornos de los PIBM. Es deseable una mayor claridad respecto a la política seguida al proponer los contratos, y en algunos casos es preferible no intentar establecer relaciones transaccionales supuestamente competitivas, y centrarse en cambio en promover alianzas. Los contratos pueden estar redactados en términos muy distintos, privilegiando por ejemplo la confianza más que la vigilancia, pero prestando también más atención al establecimiento de unos incentivos apropiados, no siempre financieros, tanto para el comprador como para el proveedor.

Hay que tener también en cuenta otros factores que influyen en el funcionamiento de los contratos, como por ejemplo el nivel de confianza entre las partes contratantes, su voluntad de atenerse a los términos del contrato (ya sea voluntariamente o mediante subordinación) y las motivaciones y los incentivos por parte del proveedor. Si pudieran abordarse esos conceptos aparentemente intangibles, habría que poder analizar más eficazmente la dinámica de la subcontratación de servicios de salud en los PIBM, así como sus ventajas e inconvenientes.

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