INFLUENCES ON THE NATURE AND PERFORMANCE OF CONTRACTS FOR PRIMARY CARE: CASE STUDIES FROM SOUTHERN AFRICA

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ABSTRACT

Contracts are promoted as a tool which governments can use to involve the private health care sector in the delivery of public sector services. In low and middle income (LMIC) countries they have been suggested as a useful means both for involving the private sector and for controlling it. However, evidence from developed countries suggests that the nature of contractual relationships with the public sector can be highly complex and that they may not always operate as envisaged by market-based economic theory. Very little evidence is available from the different setting of low or middle income countries.

This research examined the nature of three different contractual relationships for primary care services in South Africa and Lesotho. A principally qualitative, case study approach, drawing on ideas from new institutional economics, was used to examine the broad context in which these contracts were set, and formal and informal controls upon their operation. A broad framework of factors for the analysis of contractual relationships was used throughout the study and to increase the generalisability of the case study findings. Theories about the varied shape and possible incompleteness of contracts were used as the basis for an examination of formal and informal controls on the operation of contracts in an LMIC setting.

The contracts examined were all found to be incomplete and reliant on external factors to determine the way in which they operated and the nature of the contractual relationship. Primary care services were observed to be both difficult to specify in a contract and very problematic to monitor. The role of factors such as market competition, the nature of the provider, informal monitoring, trust and dependence were each highlighted in the results of the case studies. The importance of taking such factors into account, and recognising the highly variable nature of contracts likely to arise in different settings, were key findings of the study. These findings support a more cautious approach to some of the expectations placed on contracting in low and middle income settings, but also highlight its potential value when approached appropriately.

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DECLARATION OF CANDIDATE'S ROLE IN THE RESEARCH INVESTIGATION

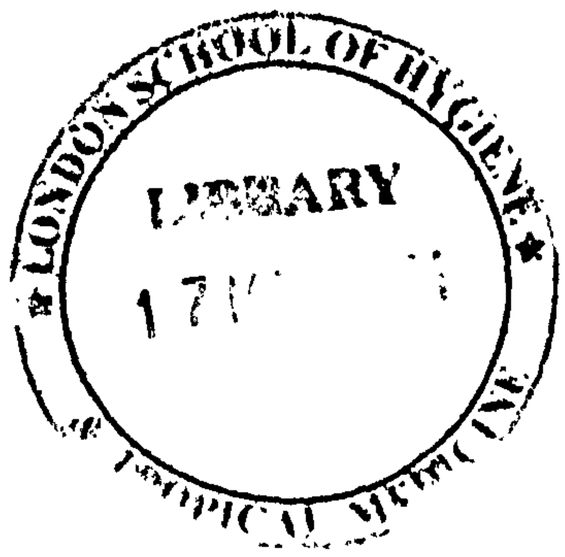
The research investigation reported in this thesis was conceptualised, executed, analysed and written up by myself while I was working as a staff member of the London School of Hygiene and Tropical Medicine on the DFID funded research project "New purchaser/provider relationships in health care: the desirability of contracts between health authorities and private providers".

Chapters 7 and 8 draw on some data on the performance of different health facilities which were collected and analysed as part of this larger research investigation. These data are presented in tables 7.1 to 7.6 and 8.1 to 8.6. These data were partly collected and analysed by me as part of the larger project and partly by other researchers with my support and supervision. Other than that the entire investigation as reported here was undertaken by me as my own work, with support provided by my PhD supervisor Anne Mills and PhD committee members Jenny Roberts and Di McIntyre.

Natasha Palmer

I confirm the accuracy of the above statement.

Anne Mills (supervisor)



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ABBREVIATIONS

ANC..... African National Congress

DOH..... Department of Health

GOL..... Government of Lesotho

LHDA ..... Lesotho Highlands Development Authority

LHWP ..... Lesotho Highlands Water Project

LMIC ..... Low and middle income country

MASA..... Medical Association of South Africa

NDOH..... National Department of Health

NHS ..... National Health Service

NPM..... New Public Management

OECD ..... Organisation for Economic Co-operation and Development

PDOH.....Provincial Department of Health

PHC ..... Primary Health Care

PDS..... Part time District Surgeon

RSA ..... Republic of South Africa

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CHAPTER 1: INTRODUCTION

The research on which this thesis is based was conducted as part of a larger project examining the potential for new purchaser provider relationships, governed by a contract, in primary health care in Southern Africa[1]. This thesis focuses on these contracts and the nature of the contractual relationships which arose from them. It also examines the role played by factors outside of the written contract in determining the nature and operation of these contractual relationships. It is hoped that this will shed light on the most appropriate manner in which to approach contracting out primary care services in low or middle income country settings.

Walsh et al (1997) observe that an interesting side-effect of global change lies in the exchange of ideas and experience that has taken place between countries. This is also particularly true between high and low income countries, and one aspect of it is an enthusiasm for exporting types of public sector reform, such as those coming under the umbrella title of New Public Management (NPM), to the rather different setting of low and middle income countries (LMICs). Contracting out of health services to the private sector, or performance agreements between different levels of government, is now a common component of reform packages promoted by bilateral and multilateral agencies for many such countries (England 1997; Mills 1998; World Bank 1997a; World Bank 1997b; WHO 1999). However, this enthusiasm neither appears to be based on evidence specific to the settings of LMICs or to take into account recently emerging evidence on the nature of public sector contracts in developed countries, which increasingly highlights their multi-faceted and complex nature (Walsh et al 1997; Coulson 1998; Roberts, Bartlett and Le Grand 1998).

[1] 'New purchaser provider relationships in health care: the desirability of contracts between health authorities and private providers' research funded by Department for International Development to Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine, 1997-2000

Dunleavy and Hood (1994) refer to the dangers of inappropriate cloning of policies. The increased popularity of contracts as a reform prescription in LMICs highlights the need to understand their nature and the manner in which they are likely to operate in a developing country context. The subject for this thesis was chosen in recognition of the potential mismatch between the contracts envisaged by some proponents of contracting for health services in LMICs, and emerging evidence about the way in which contracts for public services actually operate. As the ideas of NPM are exported, there is a tendency to use the phrase "contract" as if it refers to a well-defined package of specifications and a certain type of relationship which can be guaranteed in all eventualities. Whilst important issues such as the identity and motivation of the contracting parties, the nature of the service being contracted, the nature of the market and the degree of trust between purchaser and provider are increasingly shown in developed country literature as important controls on behaviour under a contract, they have been given scant attention in any discussion of the desirability of contracts for LMICs. It may be that the over-enthusiastic promotion of contracts in inappropriate settings is more likely to hinder than assist the achievement of health policy goals.

The different organisational settings of most LMICs are likely to have implications for contracting, and some of the problems highlighted by evaluations of contracting in well resourced organisations such as the UK's National Health Service (NHS) are likely to be exacerbated. Characteristics common to the environments of LMICs, such as poorly developed institutional capacity, a shortage of administrative and contract writing skills, and poorly developed markets will further complicate the manner in which contracts function. 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 LMICs (Schick 1998). Contracting with the private sector, the most likely option in most LMICs, is also fundamentally different from the type of internal market favoured in some high income countries. As control over contracted providers is lessened, issues of incentives and motivation become central, and yet are very difficult to tackle. The danger that a notion of contracting is superimposed on an existing hierarchy of traditional relationships and inter-dependency is also strong. Equally, resources for the

adequate specification and monitoring of contracts and overseeing the bidding process may be more severely lacking in an LMIC setting. Such factors could fundamentally alter the outcome of market-based reforms. Given that there is still considerable debate about the nature of the contractual relationships emerging in countries such as the UK (Walsh et al 1997; Flynn and Williams 1997) in an LMIC system it is perhaps even more important to evaluate to what extent market-based theory is reflected in reality.

THEORETICAL AND EMPIRICAL BACKGROUND

The so-called New Public Management (NPM) has transformed public sector management in some OECD countries by its emphasis on the introduction of market incentives into the traditional domain of the public sector (Hood 1991; Deakin and Michie 1997; Ferlie et al 1996). It is now heralded by some as the solution to similar government failure in many low and middle income countries (Walsh et al 1997; Bennett McPake and Mills 1997; Turner and Hulme 1997). In health as in other sectors, this move is shaped by a consensus that the state is overextended, inefficient and needs to be "rolled back". In its place it is assumed that private sector management practice will automatically be more effective (Bennett McPake and Mills 1997; Jackson and Price 1995; Turner and Hulme 1997). Contracts are promoted in low and middle income health sectors as a tool of NPM - moves away from hierarchical organisations towards the creation of a split between purchasers and providers often depend on a contract to govern the new relationship.

Arguments in favour of the use of market incentives, and especially contracts, in publicly financed health services are often couched in terms of potential gains to efficiency. It is argued first that increased provider competition will increase technical efficiency on the supply side, second that contractual relationships enhance efficiency via the incentive structure of the contract, and third that the contracting process itself promotes transparency in trading and the decentralisation of management responsibility, which will again have beneficial effects in terms of efficiency (Broomberg 1994). There is a tacit assumption that contracts will be adequately specified and

monitored, allowing such tasks to be fulfilled. However, initial research (Broomberg 1997; McPake and Banda 1994) has highlighted that this may not always be the case, and poor contract design or insufficient capacity to monitor may be a feature of many contracted out services. In some cases this may result in the poor operation of these services, in others it may be less important. Hence the spotlight is shifting from the desirability of contracts *per se* to issues of contract design and the nature and influences upon a range of contractual relationships.

Preliminary evidence relating to the nature of contractual relationships in primary health care in the NHS shows that it is common for contracts to be vague about both risks and responsibilities, and that sanctions are rarely specified and even more rarely exercised (Flynn and Williams 1997; Spurgeon 1997). In compulsory competitive tendering (CCT) for local government services where detailed contract specification is more the norm, a weakness is again observable, but this time in a lack of formal monitoring (Davis and Walker 1998).

Different theories which can frame a discussion of how contracts operate come from neo-classical market theory and more recently from institutional economics. Each approach highlights different dimensions to be considered as influences on the shape that contracts will take. Ideas supporting the benefits of market mechanisms (and therefore the use of contracts) originate from the assumption that under a certain set of conditions, competition between multiple homogenous providers will increase technical and allocative efficiency. For such assumptions to hold, conditions include the existence of a sufficient number of similar firms in the market place to create a competitive market, that all purchasers and providers have access to the same costless information, and that transactions are costless. No allowance is made for specialism either of knowledge, service or geographically. Important concepts for the analysis of contracting arising from these arguments are therefore the nature of competition between providers, the costs associated with accessing information, and whether there are other transaction costs which impinge on the smooth functioning of the market.

However, some economists argue that analysis of contracting along such neo-classical lines is altogether insufficient to accommodate a number of important phenomena in contracting (Hart 1995; MacNeil 1974,1978; Williamson1975,1985). Recognition of factors such as transaction costs, uncertainty, limits to human comprehension (bounded rationality), and the difference between firms' capacity to deliver a specific service, has given rise to a different approach to contracts which allows for their costliness, their likely incompleteness, and therefore the existence of other factors determining the behaviour of the contracting parties. The dynamic of the broader relationship between the two contracting parties and their environment begins to come to the fore. In particular, issues such as the role of trust, mutual dependence and market power introduce a picture of the contracting landscape that has many more dimensions.

Institutional economics focuses on contracts within this broader institutional and social setting and argues that they may take on a variety of forms according to this. That the term 'contract' can describe a multitude of arrangements ranging from the very formal to the extremely flexible is increasingly recognised. The form that a contractual relationship takes can vary along a spectrum of contracts from the very formal and well defined to those where the relationship between the two contracting parties has become more important than the contract itself. In such a 'relational' contract, the reference point has ceased to be the contract itself and becomes "*the entire relation as it has developed through time*" (MacNeil 1974). There is also an important role for individuals in influencing how a contract operates. All this is far-removed from the homogenous firms and products in the anonymous market place of neo-classical theory. As well as undertaking neo-classical market analysis for the understanding of contracting for health services, it therefore appears highly relevant to assess issues such as the nature and motivation of both purchaser and provider, the nature of the service to be provided, and the degree to which it can be (and has been) specified and monitored. If it appears that a comprehensive contract cannot be written, as is often the case with a service as difficult to specify as health (Walsh et al 1997), then these become key to understanding what is driving the contractual relationship.

THE RESEARCH

The research reported in this thesis set out to look at three examples of functioning contracts for primary care services in South Africa and Lesotho. Mainly qualitative methods were used in a case study approach. Such an approach to examining contracts has so far been more commonly used in countries such as the UK, where case studies have been used to develop a body of evidence examining different facets of the nature of contractual relationships (e.g. Allen 2000; Bartlett Roberts and Le Grand 1998; Coulson 1998; Flynn and Williams 1997; Walsh et al 1997).

The case studies in this research examined the nature of contracts and their setting. Attention was paid to standard features such as their design, award process and monitoring. However, where contracts appeared incomplete, an attempt was made to understand additional informal contractual mechanisms which may also control or influence the contractual relationship. Particular attention was given to:

1) how certain factors which make up a contract's setting would also determine the likely nature of its operation;
2) what was controlling the behaviour of providers under a contract and to what extent these controls were formal or informal.

Each of the contracts studied had to be recognised as a phenomenon taking place in a unique social setting. A case study approach was adopted to include allowance for the context of each contract and the potentially complex causal links between many variables which may have influenced its operation. It was also chosen because, despite the urgency of these questions as a policy issue, there were insufficient examples of functioning contracts in existence to allow for any type of large scale quantitative analysis of any aspect of the contractual relationship.. A principally qualitative approach was also felt most appropriate for trying to access information about such a complex social phenomenon. It was recognised that to a large extent the contractual relationship was defined by

those who worked within it and so a key part of the study design was to acknowledge the nature of the data to be collected as being personal, interpretive and relative. As with most qualitative case studies, the approach adopted was interviewing people, reading documents and observation.

PURPOSE, SCOPE AND CONTENTS

Purpose

This thesis explores the reality of three contractual relationships in different settings for primary care services in LMICs. It aims to use findings to make recommendations to policy-makers on the best way to approach a policy of contracting out of services in different settings, and how to minimise potential conflict and pitfalls in the contracting process.

The aim of this thesis is to evaluate the nature of three examples of contracts for primary care services in an LMIC and the context in which they operate, in order to inform policy-makers on the desirability of the use of different types of contract in different settings, and how to improve contract design and management. Objectives are:

- To describe and analyse contracts in terms of their award process, design and specification
- To describe the nature of the contractual relationship between purchaser and provider
- To identify and describe external factors and how they impact on the nature of the contractual relationship e.g. nature of provider, nature of service, degree of dependence, degree of trust
- To relate these factors to those which would be predicted to be important by theory supporting the use of contracts for health care
- To explore both formal and informal controls potentially determining the nature of the contractual relationship and the behaviour of the contracted provider
- To make recommendations on how policy-makers in South Africa and elsewhere could best approach a policy of contracting with the private sector, and what is likely to be appropriate for different types of service and different types of provider.

Scope

The research focuses on contractual relationships in South Africa and Lesotho but the predominant focus is South Africa. South Africa was chosen as the focus for the larger research project because it was thought to offer a range of examples of contracting with the private sector for primary care services. At the time of the commencement of the research, the South African government's policy was to extend contracting out of primary care services to the private sector (South Africa 1995), although this policy initiative was subsequently not clearly implemented. South Africa has a very large and well resourced private sector which makes the issue of how to attempt to draw on its resources via use of selective contracting a particularly relevant one. The country also has difficulty attracting doctors to work in the public sector, which means that in some areas access to a doctor via the public sector automatically means some type of public private interface.

The study focuses in depth on one contract, which governs the Part-time District Surgeon (PDS) system in South Africa, and then uses briefer case studies of two other contracts to broaden the discussion possible around the determinants of different contractual relationships. A common framework is used to analyse all three contracts, their surrounding context and the nature of their operation.

The contracts examined in the study are as follows:

1. The Part-time District Surgeon (PDS) contract governs the delivery of primary care, medico-legal and emergency services in rural towns in many parts of South Africa. The system has existed in some form since the inception of any government provided health services in South Africa towards the end of the last century. There are four categories of district surgeons, namely full-time, part-time, sessional and hospital-based, and the research reported here focuses on the part-time district surgeon system (PDS). An unofficial tally of PDS in South Africa in 1996 counted approximately 450 (De Villiers 1995). The form of the contract is as follows: an individual or group practice of general practitioners (GPs) are contracted to deliver curative services on behalf

of the state. Typically they do this alongside running a small private practice, operating two quite distinct practices, often of quite distinct quality, within the same building. The main component of their district surgeoncy work (80-90%) usually relates to the provision of curative primary care services. Preventive care and some other primary care services are usually provided at the public sector clinic in the same town. District surgeons are also required to provide certain forensic functions (e.g. the examination of victims of sexual and common assault, examination of drunken drivers, and the performance of post mortem examinations) and ex-officio functions (e.g. examination of persons for employment in the public service, persons applying for disability grants and prisoners in jail).

The PDS contract is interesting because it is widespread and well established, and raises many highly relevant issues about the strengths and weaknesses of contracts in dictating or controlling the behaviour of private practitioners. The weakness of the PDS contract as an example is that it came into existence long ago to fill a gap in health service provision under the apartheid regime, and in many towns remains stigmatised and stigmatising in the way that it treats publicly funded patients. As a result, PDS contracts in all provinces in South Africa are under review. The fact that the system was in a state of change is likely to have heightened feelings of uncertainty and confusion expressed by both purchaser and provider and to have shown the weaknesses of the system in sharp relief.

2. Also examined more briefly is a contract for the delivery of services by two clinics adjacent to construction sites in remote areas of Lesotho. A commercial South African company runs these clinics. The company is reimbursed for providing primary care services to members of the local community as well as to the workforce of the various construction companies operating at the site. This contract provides a second perspective on the successes and pitfalls of contracting for health services by demonstrating what can be achieved in a well resourced setting where expertise in writing and monitoring contracts is available. The model of using existing private

sector capacity and expertise in remote areas for the benefit of the local community is also one which is relevant to wherever mining, oil or other heavy industry or large scale commercial farming is taking place in LMICs.

3. The third case study is of an arrangement functioning entirely within the private sector, where primary care services are delivered by a chain of commercially run clinics in urban areas throughout South Africa. Care is delivered to industrial workers under a capitated contract with the purchaser being an industrial company (the employer) and the provider the company that runs the clinics. Each clinic delivers services to patients subscribing under a number of similar contracts with different industrial companies, as well as to others who pay fee for service. Service delivery in all clinics is managed using strict internal controls and state of the art computerised financial and medical systems. The inclusion of this case study provides an additional perspective by demonstrating how a different contractual relationship can develop when external factors such as the nature of the market and the nature of the provider alter.

Contents

Chapter 2 reviews theoretical literature about the way in which contracts operate and evidence about the performance and nature of contracts from the UK and some LMICs. Key concepts of relevance for this study arising from the literature review are presented in a framework by which the case studies from this research can be analysed.

Chapter 3 describes and justifies the methods that were used for the study and discusses the nature of the data they have generated.

Chapter 4 gives background description relevant to all of the contracts presented in the thesis. Information on the history and policy context of the South African situation is particularly drawn upon for the in-depth case study of the PDS contract.

Chapters 5-7 then present data about the in-depth case study of the PDS contract. **Chapter 5** reviews the external factors shaping the context in which the PDS contract has to operate: e.g. nature of the market, nature of the service, government capacity. **Chapter 6** reviews the contract design, award process and the opinions of both purchaser and provider on the design of the PDS contract. **Chapter 7** explores the nature of the operation of the PDS contract. This includes the nature of service delivery, how monitoring is performed, payment by the purchaser and how changes to the contract are agreed upon. This leads into a discussion of other factors which appear to act as informal controls on the functioning of the PDS contract. In particular a dependent relationship between purchaser and provider and the individual motivation of providers are highlighted as influential in the operation of this contract.

Chapter 8 reviews information on the same set of factors described for the PDS contract for two more case studies – the Lesotho contract and the private capitated scheme contract. In this much more abbreviated review of these contracts, similarities and differences between the case studies are highlighted.

Chapter 9 discusses the findings of each case study, the strengths and weaknesses of the methods used and then compares findings across the case studies.

Chapter 10 presents substantive conclusions about each of the case studies reviewed. The nature of generalisability of findings is then discussed and conclusions drawn of relevance elsewhere. Policy implications and areas for further research are then suggested.

CHAPTER 2: LITERATURE REVIEW

All exchange is mediated by some form of contract, some are in written form and others verbal. Verbal contracts are common in many exchanges where the two sides of the transaction occur almost simultaneously, and here the contractual element may be downplayed (Hart 1990). Other exchanges are formalised in advance by the issuing of a written contract which binds the buyer and seller to the conditions of the exchange (McPake and Banda 1994). The reshaping of organisations and greater emphasis on contractual forms heralded by NPM highlights a need for a greater understanding of the various forms that contracts can take (Ferlie et al 1996).

This chapter reviews the literature describing what forms contracts can take and what influences this. Trends in public sector management which have encouraged the use of contracts are described and economic justifications and explanations of contracts and their operation discussed. The idea of different types of contracts being used to govern different transactions is introduced and institutional and individual factors impacting on this discussed. The concept of trust and its role in determining the likely nature of contractual outcomes is also investigated. Last, evidence from the NHS and LMICs about the nature and performance of contracts for health is reviewed.

CONTRACTS AND THE 'NEW PUBLIC MANAGEMENT'

Since the late 1980s, contracts and contracting have become key components of the transformation in public sector management taking place in many countries often referred to as the 'new public management' (Stewart 1993; Jackson and Price 1994; Deakin and Michie 1997, Walsh et al 1997; Hood 1991). This change of approach has been based on the belief that the state has failed in the key task of delivering efficient, quality public services. This failure is blamed upon fundamental deficiencies in the way that the public sector is managed, a critique associated primarily with theories of the political right and "public choice" (Walsh et al 1997). The standard prescription for such failure has become the increased use of market mechanisms, notably the creation of a split between

purchasers and providers governed by a contract (Stewart 1993; Hood 1991). The resulting contractual arrangements can take a variety of forms: purchasers are usually public or quasi-public organisations whilst providers range from public to private (for profit or non profit). The nature of the services being contracted can also vary from highly selective to wide-ranging.

This trend towards the use of contracts is also common in health systems internationally, where contracting out is seen as a means of benefiting from private sector efficiency while maintaining control over what services are to be provided and to whom (Mills 1997). Contracts used in health services may range from a contract to provide laundry services to a hospital (selective) to one which governs the delivery of all health services in a particular region (comprehensive). They may exist between two parts of the same public sector organisation (public-public) or a private provider and a public purchaser (public-private).

In relation to developing country health systems, selective contracting out of services to the private sector is the form of 'marketisation' most frequently discussed (ibid). The private sector is increasingly acknowledged as an important provider of health care services in developing countries, although there is considerable debate over the cost and quality of care which they deliver (Berman 2000; Bhat 1993; McPake 1997; Swan and Zwi 1997; Uplekar 2000; Yesudian 1994). In particular, the ability of users to judge the technical quality of the care that they receive for important public health problems such as sexually transmitted infections (STIs) has been questioned (Brugha and Zwi 1998; Schneider 2000) and there is considerable anecdotal evidence that patients judge the quality of private services according to inappropriate measures such as the frequency with which injections are given. Nevertheless, 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 (England 1997; World Bank 1997a; World Bank 1997b; World Bank 1993; WHO 1999).

Whilst contracts are promoted as a means by which relationships within the public sector, or between public and private organisations, can be made more accountable, transparent and efficient, surprisingly little is known about their nature. Even in relatively well-resourced institutions such as the UK's National Health Service (NHS), evaluation of contractual relationships is still scarce (Walsh et al 1997; Robinson and Le Grand 1994) and their form and function often is shown to be still developing (Walsh et al 1997). Contractual relationships in LMIC health systems have attracted increased attention and evaluation recently (McPake and Banda 1994; McPake and Hongoro 1995; Broomberg 1997; Bennett, McPake and Mills 1997; Mills 1998; Mills Hongoro and Broomberg 1997; Broomberg Masobe and Mills 1997; WHO 1997) but evidence as to their functioning is still scarce. In particular, with the exception of Broomberg (1997) little is known about the desirability of contracting for clinical services, and even less about the nature of the contractual relationships that tend to develop in an LMIC setting.

LMIC contractual settings are likely to exhibit different features from their developed country counterparts, in particular, issues such as the institutional setting, the nature of purchaser and provider and the capacity available in LMICs may alter the nature of contracting. They therefore warrant specific examination in light of the enthusiasm to 'export' policies promoting contracts from developed countries to LMICs (England 1997; WHO 1997; WHO 1999).

Bennett, Russell and Mills (1996) summarise several economic and institutional rationales for government purchase of private services:

Table 2.1 Economic and Institutional rationale for government purchase of health services from private providers

Economic rationale	Institutional rationale
Create competition amongst providers	*Clarification of organisational objectives* promoting transparency and good planning
Increase technical efficiency through economies of scale or economies of scope	*Autonomy:* a means of protecting decision makers from unnecessary political or central government interference
Improved allocation of risk: contracting allows a redistribution of risk, which may be efficient if different actors have different degrees of risk averseness	*Freedom from bureaucratic regulations:* e.g. escape over-rigid personnel or procurement systems
	Innovation : private sector niche players may bring creative ways of doing things into the public sector

Source: Bennett, Russell and Mills (1996)

The explanation for contracting as a pragmatic attempt to capture private sector resources into the service of the public sector does not fit exactly into any of these theoretical rationales, but is nevertheless in many cases an additional motivation (Alvarez et al 1995; McIntyre 1997; McPake and Hongoro 1995; Bennett, McPake and Mills 1997; Abramson 1999).

As in other sectors, the theoretical rationale for the introduction of contracts usually relates to public choice and property rights theories which diagnose government as failing in the efficient provision of quality services. Change is rooted in an emerging consensus that the state is overextended, inefficient and needs to be 'rolled back', alongside a strong presumption that private sector management practice is more effective (Bennett McPake and Mills 1997; Turner and Hulme 1997). Arguments in favour of the use of market incentives in health care can be summarised as follows (Broomberg 1994):

a) increased *provider competition* is argued to increase technical efficiency on the supply side and therefore allocative efficiency within the system

b) contractual *relationships* enhance efficiency on the purchaser and provider side via the incentive structure inherent in the contract

c) the contracting *process* itself may promote transparency in trading and decentralisation of managerial responsibility, which may both have beneficial effects in terms of 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 pre-determined and that they have unlimited capacity for processing information (Clague 1997). The applicability of these conditions to markets for the delivery of health care services, especially in developing countries, is questionable (Schick 1998). Attempts to translate the above theory into practice highlight several tricky assumptions, particularly (Broomberg 1994):

a) that enough potential providers exist to enable the creation of provider competition
b) that provider competition, without any change on the purchasing side, can enhance efficiency
c) that the benefits of introducing market incentives will outweigh the transaction costs (of their implementation and maintenance of the market structures)
d) that government has adequate capacity to enter into and manage contractual relationships with the private sector.

The question of whether the appropriate conditions exist in many government services for a policy of competitive contracting is further tackled by Walsh et al (1997), who refer to a:

"potential contradiction between the declared sovereign virtue of competition (in principle) and the urgent necessity for co-operation (in practice)." (p.11)

They observe that:

"it is evident from the outset that public authorities are significant if not monopsonistic purchasers of services which themselves tend to monopoly in provision." (p.31)

Due to the local consumption of goods, which contain high levels of asset specificity in equipment or expertise, there may not be a great deal of competition within any local field. The special conditions of each situation may give rise to different types of contract.

MACNEIL'S CLASSIFICATION OF CONTRACTS

The different types of contract which may arise are described usefully in the work of MacNeil (1974; 1978), who draws attention to the fact that contracts govern a variety of transactions and can have a variety of shapes to match the varied attributes of these transactions. In his essay "The Many Futures of Contracts" (1974), MacNeil attempted to reconcile the simple concept of a contract as *"a promise....for the breach of which the law gives a remedy"* with what he described as *"the real life of contractual behaviour"(p.693).* He described a spectrum of relationships between parties wishing to exchange goods, and argued that different types of contract would be used to formalise exchanges along this spectrum. For instance, at one end of the spectrum, the purchase of fuel at a petrol station is illustrative of a *transactional* event – it is short, limited in scope, the exchange is measurable and there is no foreseeable or necessary future to the transaction. This is contrasted with the type of 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"* (MacNeil 1974 p.721).

Corresponding to the different types of relationship which they must govern, MacNeil therefore developed the following classification of contracts:

a) **Classical contracts** govern truly discrete transactions, occurring between total strangers, brought together by chance and sure never to see each other again. The exchange must be made by barter as even common money would imply a social structure to which both parties belong. Thus, there is no 'context' to a discrete transaction; all that is of relevance to the transaction will be contained within the act of exchange, implying that discrete transactions can be planned with complete accuracy.

b) **Neo-classical contracts** govern relationships which face some limitations in their planning for different contingencies and therefore utilise a range of techniques and processes within the

contract to create flexibility over the longer term (e.g. third-party determination of performance or one party control of terms).

c) **Relational contracts** describe a situation in which a contractual relation has moved beyond the bounds of either the classical or neo-classical system, and discreteness and presentiation[2] are reduced to roles equal or often subordinate to the need to harmonise conflict and preserve the relation. The reference point has ceased to be the contract itself and becomes "*the entire relation as it has developed throughout time*" (MacNeil 1974).

MacNeil concluded that increasingly the dominant mode of economic organisation was the relation 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 into the future through planning of various kinds, that is, planning permitting and fostering the necessary degree of specialisation of effort." (MacNeil 1978 p.857)

Despite this prediction, many public sector management reforms appear to still be predicated on the idea of classical contracting (Bennett and Ferlie 1996; Goddard and Mannion 1998).

ECONOMIC APPROACHES TO THE STUDY OF CONTRACT

Economics has an impressively extensive and formal theory of exchange but lacks a correspondingly extensive theory of contract (Deakin and Michie 1997). Whilst economic approaches to explaining the nature of contracts vary considerably, none appears able to offer a comprehensive framework for analysing the many aspects of contracts satisfactorily. The shortcomings of neo-classical theory in explaining how contracts operate are described below, followed by the contributions of market failure literature on asymmetries of information (principal agent theory, transaction costs). Last, 'new' or 'modern' institutional economics' willingness to incorporate both context and the role of individuals in determining a contractual transaction is described. This has given rise to new insights in the study of contracts and also suggests interesting new avenues for approaching the question of contracting for health in LMICs.

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[2] a way of looking at things in which a person perceives the effect of the future on the present. It is a recognition that the course of the future is so unalterably bound by present conditions that the future has been brought effectively into the

It is a paradox that although many of the NPM policies described earlier have been inspired by a belief in the efficiency of market forces, neo-classical economic theory appears unable to offer much to the understanding of the new organisational forms to which its application has given rise. Contracting out is in essence an issue of changing organisational form and much of neo-classical theory is particularly ill-suited to analysis of the effects of this, given its reliance on the idea of multiple, homogenous firms. It lacks an approach to the recognition of what may influence individuals in different organisational settings – being in fact quite lacking in any recognition of what influences individuals, what Bates refers to as the *"fundamental embarrassment of neo-classical economics"* (Bates 1997 p.28). Hodgson (1988 p.57) quotes Pareto's comment *"the individual can disappear, provided he leaves us this photograph of his tastes"*. The neo-classical approach is equally uninformative about the organisations or firms that are the actors within its analysis, with an apparently unbridgeable gap between the firm as an economic actor and the firm as an administrative and financial organisation as it operates in the 'real world' (Toye 1997). Also frustrating to a study of contracting are the standard assumptions of neo-classical theory of costless transacting, perfect foresight and complete information, as these render almost any attempt to explain different organisational forms redundant.

A description of how contracts would work according to neo-classical theory as summarised by Walsh et al (1997 p.33) below, appears quite utopian:

"Contract, in its traditional, neo-classical form is a relatively impersonal process in which the parties to an agreement state their formal commitments to each other. They may be held to these commitments and, should they fail to honour them, sanctions may be brought to bear. The law stands behind the agreement, as the means of resolving differences. The contract serves to allocate risks, responsibilities, and rewards precisely between the parties to the contract. The relationship between the client and contractor is limited to matters specifically concerned with the exchange. The time limit of the contract is strictly defined. Terms and conditions of contract are written, detailed, and cover the substantive issues."

This approach to contracting assumes that contractual promises are the legal expression of rational utility-maximising individuals making discrete exchanges in perfectly competitive markets (Campbell

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present so that it may be dealt with just as if it were in fact the present (MacNeil:1978)

and Harris 1993) and corresponds to MacNeil's idea of 'classical contracts.' Empirical studies have found that this classical understanding of the nature of contract has a tendency to misrepresent what actually happens (for instance Macauley 1963 and Beale and Dugdale 1973 cited in Walsh et al 1997).

The literature on market failure such as asymmetries of information (Akerlof 1984; Arrow 1973) begins to highlight complicating factors relevant to the study of contracts, in particular the principal agent relationship, and transaction costs (Coase 1960). A 'principal-agent' relationship is created where one individual or organisation depends on the actions of another, who is supposed to act in furtherance of their interests (Pratt and Zeckhauser 1985; Guesnarie 1990). The need for contracts arises to set out what each party will deliver in an exchange, and in some cases to spread risk and align incentives, such as in the case of share-cropping (Toye 1997). However, without perfect information at zero cost (in other words, with asymmetries of information and transaction costs), this relationship becomes problematic, in that the agent is given scope for opportunistic behaviour which benefits himself or herself and usually also reduces the welfare of the principal.

Asymmetries of information therefore explain both the need for contracts and also why they may not operate optimally. Principal-agent theory indicates that incentives are key to the appropriate design of contracts, but due to asymmetries of information their operation may be problematic. However, principal agent theory, whilst recognising asymmetries of information between principal and agent, usually assumes that fully comprehensive[3] contracts can be written. Little insight is drawn as to what types of contractual or hierarchical relationship may be appropriate in different settings although Arrow (1973) emphasised that the degree of trust between a principal and his agent may be a key determinant of how efficiently asymmetries of information can be dealt with. It is also interesting to note that many compensation mechanisms are not as complicated as those predicted by models of principal agent theory, implying that there are other factors at work determining the nature of the

[3] comprehensiveness here defined as the contract being able to specify all parties' obligations in all future states of the

relationship. The idea of 'incomplete contracts', which are discussed in more detail below, begins to enter the picture (Hart 1995).

Transactions costs are another result of asymmetries of information. They are the costs of seeking and processing information in any principal-agent relationship or exchange. All transactions involve costs, those of discovering what the relevant prices are, negotiation and enforcing the contract *ex post*. Contracts also have transaction costs in writing, monitoring and managing them. The costless transactions assumed by neo-classical theory are more of a logical construct than a reflection of reality (Cooter 1989; Coase 1960; Williamson 1985) and transaction costs have been recognised as an obstacle to the efficient operation of private exchange. This means that the firm, or some form of internal organisation, may be an alternative, cheaper means by which to organise some transactions (Coase 1960) and that the implications of transaction costs must be taken into account in considering the desirability and viability of different types of contract. Coase (1960 p.16) observed:

"the main reason why it is profitable to establish a firm would seem to be that there is a cost of using the price mechanism".

Whilst still maintaining the rational choice perspective of neo-classical economics, game theory offers some interesting insights into what influences the nature of contractual relationships, and recognition of the context of a transaction makes its first appearance - in particular what Axelrod (1984) terms the 'shadow of the future'. He observes that a mutually cooperative approach to any exchange will be dependent upon whether there is a good chance of continuing future interaction. This is echoed in work by Oliver Williamson reviewed below (1975: 1985) which also emphasises the importance of the likely frequency of exchange in defining the nature of a transaction. Similarly, Toye (1997 p.60) used game theory to model the relationship between the World Bank and a borrowing government as a contract and found that:

"the key feature of the game turned out to be whether or not the borrowing country required a further round of borrowing from the Bank".

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world.

Finally, realisation that the neo-classical market paradigm is insufficient to accommodate a number of important economic phenomena (Hart 1990), has led some economists to increasingly focus on other approaches which may be able to offer more insight. Kelm (1996) observes that the price mechanism is not the only way to bring about co-ordination; there are also the other 'conscious' mechanisms of institutional arrangements and organisational integration. Writers such as Hodgson (1988), referring to their work as 'modern institutional economics', stress the role of both the individual in determining how economic activity is shaped, and the role of society and institutions in determining how an individual behaves. Neo-classical economics is criticised for its expectation of rational, maximising behaviour by all individuals and its failure to represent chronic information problems. Hodgson makes the link between the importance of individuals and the importance of institutions and context as follows:

"Whilst it can be accepted that information and knowledge have important subjective and individual features, the concepts and theories that are used in their acquisition are not...purely subjective as if they resulted from an isolated individual....Cognitive processes are essentially social as well.. We are all individuals and the totality of our knowledge and experience is unique, but the mechanism of our perception and acquisition of knowledge are unavoidably social and unavoidably reflect social culture and practices"(Hodgson 1988 p.7).

Recognition of information problems such as uncertainty and limits to human comprehension (bounded rationality) also give rise to greater insight into the constraints of using contracts to govern exchange and greater understanding of the complexities of contractual relationships. More allowance is made for the influence of context in determining how contracts will operate. Campbell and Harris (1993) characterise contracts as a mechanism to make the future more tractable via suggesting methods for dealing with unseen events and establishing patterns of social relationship and communication that will be robust. This alternate view argues that contracts act more as a bonding mechanism, not allocating risks in great detail but signifying willingness to co-operate (Gordon 1985). In this view, the social process surrounding contracts is at least as important as the contract itself, about which parties may be relatively ignorant. Individuals partaking in contracts may behave more as if they are in a continuing organisational relationship, making the distinction between market

and hierarchy more blurred (Walsh et al 1997). Contracts may have more to do with the relationship which frames them than with what is to be exchanged. This echoes MacNeil's view that:

"Planning how to do things and how to structure operating relations ...rather than simply defining what is to be exchanged, has come to dominate a great deal of modern contract" (MacNeil 1974 p.762).

Highly formalistic approaches to contract may indeed hinder the development of flexible, robust contractual relations. Stewart (1993 p.12) refers to the importance of acknowledging *"what cannot be expressed in contracts"*.

It is increasingly argued that more relationally oriented contracts are more likely to be socially as well as technically sufficient, able to cope with unforeseen circumstances and able to deal with problems of observability, information asymmetry and the possibility of opportunism. Trust is basic to effective operation of contracts as indeed to all organisations, and vagueness and ambiguity may even contribute to its development. Longer term relationship contracts increase the value of the shadow of the future, making reputation important and both parties less likely to cheat.

Roberts (1993) has applied some of these theories to the internal market of the NHS and found that the initial annual cycle of contracting in the NHS was inappropriate for the vast bulk of contracting (this cycle has subsequently been extended in the new White Paper (DOH 1997)). 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. She observes that in the context of a service which entails large sunk costs or specific assets, markets are unlikely to provide the discipline necessary to ensure efficiency, both due to suboptimal investment and the likely departure from the market of those who do not win the contracts. In similar vein, a number of other writers have argued that the introduction of contracts in health care may not enhance efficiency due to the increase in transaction costs which they imply (Ashton 1998; Bartlett 1991) although Ashton has pointed out that this is dependent upon the nature of the service. Again, it is observed 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" (Ashton 1998 p.367).

Hart (1995) further emphasises the difficulties of writing comprehensive contracts, their subsequent incompleteness and therefore that the '*ex post*' allocation of power (or control) matters, in order to reduce what he terms "haggling" or "hold up behaviour" by one party to the transaction, suggesting that some form of integration or long term relationship is likely to lead to more efficient outcomes. Hart's emphasis on the incompleteness of contracts raises further questions about how the behaviour of contracting parties is determined. If incomplete contracts fail to specify each party's actions fully, additional factors are at play which determine how a partially defined contracting relationship is to operate. Recognition of the likely incompleteness of contracts then begs the question of what other forces are at play determining the behaviour of parties in an incompletely defined contractual transaction. Behaviour within some contracts may be determined as much by factors external as internal. The environment in which contracting takes place and other external factors become correspondingly more important as determinants of how contracts will operate. Determinants of the contractual relationship are no longer contained purely within the contract. Equally the way in which individuals react to the contract may not be best explained by ideas of instrumental rationality, but may be to at least some extent socially determined. The co-operation implied by increasingly complex and relational contracts relies upon the presence of an institutional and organisational framework within which to operate, and to some extent the nature of contracts will be determined by this framework. Walsh observes that the impact of contracts needs to be understood within the total institutional context within which they operate (Walsh et al 1997). Similarly Tyler and Kramer note that a:

"*chorus of writers has argued for greater attention by scholars to the social context within which individuals behave*" (Tyler and Kramer 1996 p.2).

Institutional economics emphasises the importance of the role of both institutional and environmental factors and individual beliefs and motivations in shaping the way that contracts will operate. What the introduction of each of these two dimensions can bring to the study of contract is examined in turn below.

INSTITUTIONAL AND EXTERNAL FACTORS

The contractual environment plays a key role in supporting incomplete contracts, the social, institutional and organisational context within which contracts operate should all be considered (Arighetti, Bachman and Deakin 1996). This includes its competitiveness and the nature of the service to be specified. MacNeil termed the broader contractual environment as 'socio-economic' support, or the 'social matrix', noting that it may be moral, legal, economic, social or otherwise (MacNeil 1974). Norms and conventions embedded in the social, institutional and organisational arrangements of the contracting environment allow the generation of trust, enhance the operation of the system and may determine how widespread and successful the use of contracts is (Burchell and Wilkinson 1996; Deakin and Wilkinson 1995).

Sources of institutional norms include the legal system, mechanisms of economic management directly available to the state (taxation, public spending, industrial and macro-economic policy), other forms of regulation and non-state bodies of various kinds including trade associations. Organisations, including firms, network relations and also markets themselves are less stable and operate within the general framework set by institutional norms, while themselves also operating as structures for the governance of exchange (Deakin and Wilkinson 1995). Other institutional factors which influence the contracting environment include those related to labour legislation, norms of employment, income protection and the activities of trade associations and other professional bodies (ibid). The norms established by these means serve to minimise the risk to firms in trusting other firms and in entering into long term asset-specific relationships. Efficiency and effectiveness of the regulatory environment is another key influence upon the contractual environment. The role of the nature of the market, nature of the service being contracted, legal enforcement and regulatory capacity are each examined here in turn. Trust is dealt with in greater detail in the next section as a factor which is gaining increasing attention as playing a central role in the determination of how contracts operate.

A key feature of the external context has been highlighted as the nature of the market, notably the

degree of competition and the rate of change and stability (Williamson 1975; Walsh et al 1997). The degree of market competition will influence what types of contractual relationships develop, how they will operate and the nature of co-operative behaviour within them. It may encourage co-operation within contractual relationships, due to a lack of alternative providers/purchasers. A higher degree of competition may encourage purchasers to move away from relational contracting to a more transactional approach. However, according to Williamson's concept of the 'fundamental transformation' (Williamson 1985), a large number of bidders for a contract at the outset does not necessarily imply that such competitive conditions will continue to apply in cases where a transaction requires some form of specialised investment. Furthermore, LeGrand and Bartlett (1993) highlight the importance of competition on the purchaser as well as provider side of the market to avoid monopoly purchasing power, and observe that in a number of quasi-market settings studied in the UK, the district health authority was furthest from meeting this requirement. Mills (1997b) reflects on equal difficulties attached to achieving competition on the purchaser side in LMICs where individual's cash incomes are low and achieving choice of purchaser would require large state subsidies.

The nature of the service will also have a key influence, through the impact on the degree to which the service can be specified, and the ease with which performance can be monitored (Walsh et al 1997). In the case of a service such as primary care in the setting of a district health system in South Africa, the difficulties inherent in both specifying contracts and monitoring delivery have been highlighted (McCoy, Buch and Palmer 2000)

It has been argued that a key role of the contractual environment is to assist in fostering and maintaining trust between contracting parties (Burchell and Wilkinson 1996). The importance of institutions in trust formation has also been demonstrated and the more effective the contractual environment is in increasing information and reducing conflict, monitoring and risk from the individual relationship, the greater will be the potential for trust building (ibid).

Rather than trust, the classical theory of contract places legal enforcement at centre stage. However, both Williamson (1985) and MacNeil (1974) comment on the assumption in classical contracting theory that every contract is accompanied by effective laws which will be resorted to where necessary. Whilst some studies argue that the role of the legal system in underpinning relational contracting is arguably greater than has been previously allowed for (Arighetti, Bachmann and Deakin 1996), many theoretical and empirical studies question any emphasis on the role of the law in underpinning contractual relations. This is both on account of the difficulty for the courts in being able to assess the values of parties' *ex ante* contractual expectations, and more importantly because resort to court-ordering is very harmful to long term relational contracts (Deakin and Wilkinson 1995; Arighetti, Bachmann and Deakin 1996; Williamson 1985). A study of inter-firm contracting in Wisconsin found that managers were highly sceptical about the value and relevance of breach of contract damages. Extra legal sanctions and pressures, in particular the need to maintain the firm's reputation, were more important than the threat of legal action in inducing performance (Arighetti, Bachmann and Deakin 1996). In the case of the NHS internal market, resolution of contractual disputes is specifically kept out of the courts (Allen 1995). Last, efficiency and effectiveness of the regulatory environment must be considered. Several studies have found this typically to be quite low in LMIC settings (see Kumaranayake 1997), in particular the lack of enforcement of existing regulations. This is largely due to weak capacity and too few resources expended on regulatory activity (ibid).

INDIVIDUAL FACTORS

In contrast to the anonymous actors of neo-classical theory, Williamson (1975) acknowledges the importance played by human factors in attempting to grapple with problems of economic organisation, such as what defines the nature of contracts. He observes that these are often suppressed in many of the conventional models of economic man:

"more self conscious attention to rudimentary human attributes is essential if we are to adequately

characterise and more accurately understand many of the problems of markets and hierarchies" (Williamson 1975 p.2)

In particular, Williamson highlights the two "elementary attributes" of human decision makers as bounded rationality[4] and opportunism[5] and a key environmental factor as whether there is a competitive market, which in later work (Williamson 1985) he develops further as the idea of asset specificity[6]. He observes that the costs of writing contracts will vary according to the characteristics (bounded rationality, opportunism) of the human decision-makers that are involved in the transaction on the one hand and the objective properties of the market on the other (small-number conditions). Firm and market are characterised as alternative ways of governing transactions, between the boundaries of firm and hierarchy lie various degrees of contract specification and contractual difficulty (Williamson 1975;1985).

A summary of the way that opportunism and bounded rationality may interact and the types of contract most appropriate in different settings is shown in table 2.2. Where both bounded rationality and opportunism are absent Williamson characterises the operation of the market as "bliss" e.g. there are no contractual difficulties. With opportunism but no bounded rationality, it is possible to write 'comprehensive contracts' which specify all contingent supply relations comprehensively, but the introduction of bounded rationality would make such comprehensive specification impossible. Where bounded rationality is admitted but there is no opportunism, a 'general clause contract' contains clauses designed to guide the parties to the contract by joint profit maximisation considerations and an appropriate sharing rule, designed to make them act co-operatively when unforeseen circumstances arise. Finally, the presence of both bounded rationality and opportunism are likely to lead to 'serious contractual difficulties'. In such a context internal organisation (a hierarchy) may be preferable, as contracts will be unable to be comprehensively specified and

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[4] Bounded rationality arises because *"the capacity of the human mind for formulating and solving complex problems is very small compared with the size of the problems whose solution is required for objectively rational behaviour in the real world* (Simon 1961*)*. This definition of bounded rationality involves both neurophysiological and language limits (Williamson 1975 p.21)

[5] *"a lack of candour or honesty in transactions, to include self interest seeking with guile"*(Williamson 1975 p.21)

[6] Parties engaged in a trade that is supported by nontrivial investments in transaction-specific assets are effectively operating in a bilateral trading relation with one another (Williamson 1985)

opportunism suggests that parties to the contract are likely to exploit such a situation. Internal control is argued to offer access to a further set of incentive and control techniques (via the organisation of a firm) which may be more effective than reliance on any market form of contracting (Williamson 1975).

Table 2.2 Williamson's four-way classification of contract

	BOUNDED RATIONALITY	
OPPORTUNISM	**Absent**	**Admitted**
Absent	Bliss	"General clause contracting"
Admitted	Comprehensive contracting	Serious contractual difficulties

Source: Williamson (1985 p.67)

Williamson therefore highlights the importance of the interaction between three key variables in any contracting relationship: the nature of the service being contracted, the motivation of the individuals involved in the contractual relationship, and the nature of the market in which the contract is let.

A second important role of the individual in any discussion of contracts is to consider how different contract types interact with their motivation. Contracts aim to create an incentive structure to which individuals respond; contract design is about incentives (or sanctions) that will operate efficiently in a given contractual environment. However, recent work emphasises that not all individuals respond in the same way to the same set of incentives. Other motivational influences upon individuals delivering services under contract need to be considered. Effective design therefore requires an understanding of the motivations of the contracting parties (both the firm and the individuals within it), their capacity and the existing institutional and organisational capacity to support the contract. Motivations include the attitudes of contracting parties to risk, to the service provided and to the people to whom the service is provided. Profit making firms or individuals will be largely influenced by financial incentives and a perception of the organisational and institutional environment (effectiveness of regulation and monitoring). It is less easy to speculate as to the incentives most important for a non profit making firm or each individual operating alone or within an organisation.

Robinson (1997) goes some way by characterising NGOs as either voluntary organisations or public service contractors, with the latter being more market-driven and less value-driven. However, very little is known about the motivation of any of these types of providers and the interplay of that with other factors in the contractual environment, especially in developing countries.

Handy (1993) notes the complexity of elements involved in motivating individuals and the failure of theories of organisational behaviour to come up with one generally applicable theory of how incentives operate. This is echoed by Le Grand (1997 p.153) who observes that whilst *"assumptions concerning human motivation and behaviour are the key to the design of social policy"* we may find that we are ignorant about what he terms the *"mainsprings of human motivation"*. He identifies two possible forms of motivation, each calling for quite different policy, and therefore in this case, contract design. The first type would principally respond to financial incentives and is self interested (*"the knave"*) whilst the second *("the knight"*) assumes that people are predominantly public-spirited or altruistic. Policies or contracts constructed on one set of assumptions would clearly be markedly different from those constructed on the other.

The literature on response to incentives by health care providers observes this broad distinction between financial and non-financial motivation or incentive response. In the case of financial incentives for GPs in the NHS, these can range from simple target payments for certain services, as was introduced into the GP contract in the NHS in 1990, to the more complex approach of GP fundholding. Much research into the impact of both of these policies emphasises the 'non-linear' relationship between financial incentives and the desired effect on the behaviour of providers (see Lynch 1994; Hughes and Yule 1992 on the GP contract and Whynes, Heron and Avery 1997; Gosden and Torgerson 1997 and Stewart Brown, Gillam and Jewell 1995 on fundholding), although other work on the NHS has found that doctors do respond to financial incentives by managing demand (Giuffrida and Gravelle 1999). Overall, studies highlight the many attenuating influences on the

effectiveness of a pure financial incentive, including the level of the incentive, the identity of the provider, and socio-economic factors relating to the community in question.

Other motivating factors which can attenuate the influence of financial incentives can be divided into environmental and personal. On the environmental side, Preker and Harding (1999) suggest issues of governance (such as how residual claims and decision rights are distributed) and market environment are both important alongside the payment mechanism in determining an environment of incentives. In the case of contracts with individuals such as GPs, individual motivation must also be given considerable weight. To examine Le Grand's "*mainsprings of human motivation*", there is a wealth of literature in organisational and management theory attempting to answer one fundamental question, here phrased by Simon (1991 p 34 quoted in McMaster 1998 p51):

"*...not why free riders exist, much less employees who exert something less than their maximum - but why there is anything besides free riding? Why do many workers exert more than minimally enforceable effort?*"

Many aspects of New Public Management recognise that in any production process:

"*the key resource is human, hence the emphasis is placed on techniques for rewarding and motivating staff*" (Walsh et al 1997).

Frequently studies of health provider behaviour have to acknowledge the importance of this factor.

For instance evaluations of GP fundholding in the NHS reforms (Le Grand, Mays and Mulligan 1998) make reference to the "*professional ethic*" and that:

"*those working in the service continued to see themselves as engaged in the provision of public services based on relations of mutual trust*" (Le Grand, Mays and Dixon 1998 p.132)

Seeking to explain a lack of evidence for cream-skimming, when all theory would point to the GP fundholder contract encouraging it, the same authors suggest:

"both purchasers and providers were not perhaps as single-minded in the pursuit of a narrowly defined self - interest as the internal market required; e.g. they continued to operate more like knights than knaves" (LeGrand, Mays and Dixon 1998 p.133).

Feelings of altruism or social responsibility may be just as important in determining how a health care provider delivers care to a patient as what is written in their contract. Equally, altruism has been argued by authors such as Titmuss (1970) and Axelrod (1984) to benefit the giver, although they

hypothesise how this happens in different ways. According to Axelrod, individuals co-operate to reap strategic benefits whilst Titmuss emphasises the satisfaction which the giver receives from knowing that they have been of benefit to society.

TRUST

Trust is frequently posited as a key factor in the operation of different types of contract and one that encompasses both individual and institutional/social factors. A shift towards the use of contracts in public services, and a concern with the subsequent identification of the problems of developing, specifying and monitoring complex services, has been one of the driving forces for a new interest in trust in public management (Newman 1998), and is a key concept in the analysis of the way in which individuals work, individual organisations work and how they relate to one another (Walsh et al 1997). The concept of trust has become indispensable to any discussion of the role of motivation, incentives and monitoring in the operation of contractual relationships. It is increasingly seen as playing an essential role in underpinning efficient contractual relationships, reducing the need for complex and expensive information and monitoring inherent in principal-agent relationships (Arrow 1973; Deakin and Wilkinson 1995; Gambetta 1988; Goddard and Mannion 1998). On the other hand, its role as the great panacea in public sector contracting is also beginning to be questioned (Newman 1998; Watt 1998; Pufitt 1998; Davis and Walker 1998). The degree of trust will influence the approach that different individuals and organisations take to contracting (Walsh et al 1997). In addition, some approaches to public sector contracting are argued to undermine the development of trust or erode existing hierarchical and trust-based relationships (Walsh et al 1997; Davis and Walker 1998).

Defining Trust

Perhaps part of the appeal of trust is the difficulty of defining it or its role in the operation of any agreement. It seems in danger of assuming the role of "that-which-is-to-be-relied-upon-when-all-else-fails" in contracting relationships – whereas in practice its role appears both more complex and

more elusive.

Several authors have tried to categorise and formalise the concept of trust. Sako (in Goddard and Mannion 1998) identified three kinds of trust which address different aspects of the principal agent relationship: *contractual trust* (based on the parties adhering to specific written or oral agreements); *competence trust* (the likelihood of the agent performing in a competent way); and *goodwill trust* (the willingness to go beyond mere fulfilment of explicit promises to taking initiatives to assist the other party, and to resist taking advantage of incomplete contracts). Similarly, Coulson (1998) observes that many disciplines offer an attempt to define trust. He draws on offerings from psychology, sociology, anthropology and economics. Psychologists have categorised trust relationships into three groups which are fairly comparable to Sako: *calculation based trust (*based on a calculation that suggests that the course best serving an individual's interests is to trust) *experience based trust (*where one has related to a person or organisation repeatedly and is able to build up an impression of their likely behaviour) and *instinctive trust (*where the decision to trust is instinctive and without any calculation). These latter two categories would be close to Burchell and Wilkinson's (1996) *personal or social trust* which forms from long term relationships and shared values or goals. A further, sociological or anthropological approach to trust emphasises its culturally determined aspects (Coulson 1998; Fukuyama 1995) implying that trust is "socially embedded" and that one society is more likely to trust than another. Related social conceptions of trust hold that it has social meaning beyond rational calculations, that it can have a strong orientation to society and that people help others and/or their groups because they feel it is the morally appropriate action (Tyler and Kramer 1996). Last, some economists approach a definition of trust in terms of risk. Actors calculate the odds and chose to trust if the benefits from collaborating appear good enough. Coulson (1998) queries whether something so calculated can really be trust; this approach tends towards game theory and relates to the work of Axelrod (1984) discussed earlier, which shows that it is possible for a decision to co-operate to be made strategically and purely out of self-interest.

Common to all these definitions is the recognition that trust is a changeable concept and exists in several forms, each of which is as likely to transform or disappear as to remain static. Mishra (1996) observes that previous research on trust has often been both definitionally and conceptually vague. Other authors have also become frustrated with its apparent slipperiness. Newman (1998) terms trust a "promiscuous concept" and points out that its many guises mean that it is at the same time promoted as a route to efficiency (Arrow 1973) and as a kind of idealised counterweight to the encroaching role of economic rationality. She concludes that "*this polyvalence leads to the problem of talking about trust in a coherent and consistent way*" (Newman 1998 p.51).

Following a literature review, Mishra (1996) identifies four distinct dimensions or components of trust:

"one party's willingness to be vulnerable to another party based on the belief that the latter party is a) competent b) open c) concerned and d) reliable" (Mishra 1996 p.265)

This therefore allows for trust based on calculations or experience and trust based on instinct, but all involve an element of risk and the recognition that someone who trusts is vulnerable and may be exploited or let down. It also includes an element of belief, which could be based on research, calculation or instinct. Last, trust is voluntary, involving willingness not compulsion and it also includes a view of the other party, that they are ultimately trustworthy, that they will not let you down.

Broadening the concept, Puffit (1998) constructs the idea of a continuum between "trust" and "distrust" as concepts which might underlie any principal-agent relationship. The continuum moves from distrust at one extreme, through "indifference", to "hope" and finally to "trust". This idea is particularly relevant to the discussion of contracts in an LMIC setting as one of the principal determinants of which of these choices is to prevail is seen as the degree of resources available to the regulator, and this is likely to be low in many LMICs (Kumaranayake 1997). For instance, "hope" may prevail in a situation where:

"a zealous regulator, recognising the impossibility of constant surveillance due to the shortage of resources nevertheless believes that compliance is likely or at least possible" (Puffit 1998 p.220).

Unfortunately likely to be more relevant in the case of health care, distrust is considered the appropriate action where, amongst other factors, the link between cause and effect is uncertain, standards are non-specific, adverse results of non-compliance are significant and the risk of concealment, corruption and cooption is high. Many of these factors will particularly apply to health care contracting in a resource poor environment (Puffitt 1998).

The relationship between trust and contract

Trust has attracted so much attention in relation to contracting because it is argued to be a highly efficient substitute for many of the most difficult aspects of contracting already discussed, such as specification of a complex service and monitoring its delivery. By enabling these to be minimised, transaction costs are also reduced. Trust is therefore seen as an all round winner, by making contracting easier and cheaper. This is a seductive argument, not least by its simplicity. However, it does not remain simple for long, once the relationship between trust and contract is examined. How do they inter-relate? Do trust and contracts act as substitutes or complements? Do you make a contract with someone because you don't trust them or because you do? What types of contract are appropriate for different degrees of trust between contracting parties?

Arrow (1973 p.24) observed an element of trust in every transaction:

"typically, one object of value changes hands before the other one does, and there is confidence that the countervalue will in fact be given up" (in Davis and Walker 1998 p162).

Coulson (1998) expands this point, arguing that the world of contract and the world of trust are very closely related:

"specifying the details of a relationship in a form that can be enforced is often presented as an alternative to trust. Those who have trusted and been disappointed may turn to their contracts and the law to recover their position. But contract and trust are not alternatives.... A contract actually assumes an underlying relationship of trust; because if you expected to have to take your contractor to court you would not have chosen that contractor in the first place" (Coulson 1998 p.16)

Equally, Newman (1998) argues that the perception that public management is moving along a

clearly defined arc from hierarchy, via contract, to trust based relationships is an oversimplification. There has always been some type of trust holding any organisation together. The current question is which type of trust is replacing which when contracts are introduced, and whether this is necessarily a step forward.

This voice of caution in the embrace of trust-based contracting for the public sector is echoed by other authors who question the appropriateness of the public sector relying on a notion as vague as trust to oversee the use of its resources. Davis and Walker (1998) look at the environment in which Compulsory Competitive Tendering is taking place in one region of the UK. By analysing what they would expect a "high trust" contracting environment to look like they conclude that this type of enforced public sector contracting has not been characterised by a high degree of trust. They query the appropriateness of contracting out being decreed by government and question whether a private sector firm would not stick to the "make" rather than "buy" decision when faced with this type of service to provide. This leads to the further question of whether trust based contracting can take place in local government – the authors argue that contracting may actually undermine the longer term relationships that were in existence before. Their conclusion stresses the problems with accountability inherent in relational contracting:

"There is little likelihood that the looser more informal contracting that characterises some parts of the private sector would prove acceptable when set against accepted and expected standards for the conduct of public life" (Davis and Walker 1998 p.178).

Watt (1998) observes that in the case of contracting for white collar services in local government a reliance on trust may provide conditions in which corruption can grow. The efficiency benefits of trust in reducing transaction costs must therefore be weighed against the potential costs of the development of corruption. Puffitt concludes:

"The citizen might prefer that those who regulate on their behalf be skilled and practised in the art of distrust rather than trust, for imprudent kinship with the latter may well result in no more than a dance with the devil at the citizen's expense" (Puffit 1998 p.223)

It is therefore clear from this literature on trust and public sector contracting that trust is probably

desirable (although the extent to which it should be relied upon is questionable), but that it comes in a myriad of forms, is elusive and probably difficult to create. Mackintosh (1997) highlights how subjective trust is, emphasising the learning process in the development of trust and the important link between the expectations of another's behaviour and the determination of one's own. Nevertheless, it is arguable that beliefs relating to the motivation of the other contractual party may influence the type of contract adopted, and if not, perhaps should do.

CONTRACT DESIGN

The formal expression of the terms of a contract both arises from and influences the three sets of factors described above - institutional factors, individual factors and trust. Checkland (1997) describes contract form as "shorthand for a complex social process". A contract's design is likely to reflect all the social, institutional and organisational factors described above, as well as assumptions about how they will interact in the future. In turn, contracts influence the way in which contracting parties behave, providing a bridge between purchasers and providers which reveals many different aspects of how demands and other intentions are expressed, clarifying the information needs of markets and showing how risk is to be shared (Appleby et al 1994). The form that a contract takes creates incentives which aim to influence the behaviour of the provider in a certain way desired by the purchaser. Thus, specification of contracts and their management is a key determinant of their impact.

Like the transactions which they govern, the shape, form and content of contracts vary hugely. At one end of the spectrum is the pure transaction (e.g. purchase of petrol) governed by contracts which are unwritten because there is no time and no need, and at the other end is the relational transaction (e.g. marriage) governed by contracts which are unwritten or highly incomplete due to the difficulty of writing them. Also on this spectrum lie the types of contracts which govern health service delivery, some of which are legally binding and quite detailed, others may merely be a letter or one side of A4 paper which sets out an 'agreement to agree' (Flynn and Williams 1997; Checkland 1997;

Spurgeon 1997). In the case of developing countries, very little attention has 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 in order to put contracting mechanisms in place (Mills 1998).

Nevertheless, the type of contract used is important and will have an effect on the capacity of any market to operate efficiently. Contracts can act as a powerful tool by which value for money is delivered (Allen 1995). The contract can be used to specify accurately what quantity and quality of services are required, their price, the methods of monitoring whether they have been delivered and the sanctions to be applied if they have not. However, such specifications each take time and expertise and any discussion of contract design/specification must include consideration of the transaction costs of designing and running a contract and issues of capacity[7]. Mills (1998) observes that in a series of developing country studies of contracting, many problems with contracting had their origins in poor contract design and weak management of the contracting process. There was an absence of specification of both service nature and quality and a lack of penalties for non-performance. Mackintosh (1997 p.5) emphasises the prevalence of contracts for health care which contain perverse incentives:

"If you pay for cheapness in health care you eventually get cheapness – at the expense of quality. If you demand achievement of measurable targets based on data which can be manipulated at agency level, eventually the agency staff will manipulate them."

Appleby et al (1994) examined the form of contracts and negotiating process during the first two years of the internal market and identified the following as important factors in the contracting process: expertise, timetable, level of information available, existing purchaser/provider relationships and the quality of care specified/delivered. All these factors relate to a broad definition of capacity.

In accordance with the tenets of commercial contract drafting, Allen (1995) observes that there are

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[7] *Ex ante* transaction costs are the costs of drafting, negotiating and safeguarding an agreement; whilst *ex post* are all those incurred after the contract is in place e.g. maladaption costs, haggling costs and the costs of setting up and running governing and monitoring structures (Williamson 1985).

certain key provisions which should be contained in a contract to deal with the most likely and important eventualities which may occur during the life of an agreement. These are: i) specification of performance; ii) monitoring of performance; iii) method of pricing; iv) method of enforcement of performance; and v) method of dispute resolution. The manner in which each aspect of these provisions is dealt with will influence the overall incentive structure of the contract. Each is examined below.

Specification of 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, and Allen observes that volume of services alone is an incomplete specification, despite its enthusiastic use in many NHS fundholders' contracts. 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). Monitoring is closely tied to the adequate specification of performance and if this has been inadequately done, the ability of the purchaser to monitor adequately will also suffer. Allen (1995) found NHS fundholders' contracts to be seriously deficient in this respect. Specifying quality runs into problems of information asymmetry and observability; with some services even a definition of quality may be difficult because of their intangibility. Inputs and outputs may also be difficult to observe where, for instance, the input may be as intangible as effort. In many cases in contracting for health services, it is likely that both inputs and outputs will be difficult to measure. Walsh et al (1997) observe that where monitoring is very costly, and effort and state of the world are "effectively" unobservable, contracts will depend upon the outcome alone. The problem is the outcome may also not be observable. Neither client nor contractor may know what outcomes are. A product such as health in many cases may have to be treated as a credence good.

Method of pricing should be clearly stated, as well as an indication of where the risk will fall if anticipated volumes are not met. Methods of enforcement of performance can take the form of

financial incentives (or penalties), termination or other legal or financial sanctions. These need to be sufficiently detailed to act effectively. Finally, some allowance for dispute resolution should normally be included, be it arbitration or informal conciliation. Evidence from both NHS and developing country contracts indicates that these elements of contract design are usually inadequately specified or lacking in most health service contracts (Allen 1995; Mills 1998). Sanctions could be 1) deduction of money 2) requirement to repeat the work 3) delay in payment 4) termination of contract 5) refusal to work with a contractor again. Sanctions may still have a role in relational contracts, even if just as a threat which should deter those who think they will not be able to deliver the services required. However, some sanctions are unlikely to be implementable in the context of health care delivery; for instance, there may be no choice of provider, preventing a contract from being terminated, or it may not be possible to repeat work. Therefore incentives may be more appropriate than penalties, particularly in cases where output is dependent on the commitment of the contractor. The importance of common norms and values and an understanding of the motivation of providers in such a situation begins to be clear.

Walsh et al (1997) highlight the impact on the relationship between client and contractor of factors such as the distribution of risk, the level of trust, the observability of inputs and outputs, the extent to which quality can be defined and measured, and the timespan of the relationship. Elements of contract design likely to determine distribution of risk and hence the cost and quality of service provision in health services are pricing methods, price changing rules, service and quality specifications, contract duration and sanctions for poor contractor performance (Mills 1998; Broomberg 1997). Even in sectors other than health, it is noted that many issues concerning the optimal contract form and duration as well as the optimal level of contract formality and enforceability remain far from clear (Deakin and Michie 1997).

Last, by influencing the distribution of risk and reward between purchaser and contractor, the design of the payment mechanism is likely to be a powerful influence on the way providers deliver services,

even if the role of non-financial incentives as laid out in the previous section is also acknowledged. Contracts would commonly make provision for providers to be paid by salary (or some form of block grant), fee for service or capitation. Mills and Ranson (2001) evaluate the incentives presented by these options as follows (Table 2.3):

Table 2.3: Key payment methods and their incentives to providers

Payment method	Unit of paid services	Key financial incentives for providers
Salary	Per month, week etc. of work	Restrict number of patients seen or services provided
Fee-for-service	Individual acts or visits	Expand number of cases seen and service intensity: Provide more and expensive services and drugs
Capitation/block contract	All relevant services for a patient in a given time period	Attract and keep more registered patients (especially the healthier): Minimise contacts per patient and service intensity

Source: Mills and Ranson (2001)

Clearly, choice of payment mechanism can create dramatically different incentives even for the delivery of essentially similar services. Often the choice of payment method may be limited due to circumstance; for instance in many LMICs the feasibility of running a capitated system is low due to the high level of administrative capacity required and to high levels of migration between communities.

EMPIRICAL EVIDENCE

Evidence on the nature and results of the introduction of marketisation reforms in the UK and developing countries highlight first the prevalence of relational contracts in the UK and second, issues of poor capacity in developing countries.

From the UK

Whilst much has been written about the NHS reforms, comprehensive summaries of their impact are still rare, with some exceptions (Le Grand, Mays and Mulligan 1998; Robinson and Le Grand 1994).

A review of the literature surrounding them serves to highlight several key questions which are of relevance to the evaluation of any managed market reform, and also echoes many of the points highlighted by the preceding review of economic approaches to contracting:

1. The nature of competition created by the internal market is unclear. Despite the theory of competitive or contestable markets improving technical and allocative efficiency being central to the arguments in favour of marketisation, it is recognised that internal markets such as the NHS are far from competitive. Evidence suggests that whilst there may be some choice of provider 'at the margin', in general purchasers continue to use the same provider which they have done traditionally (Propper and Bartlett 1997). There is also limited evidence for any increased choice for patients (Mahon, Wilkin and Whitehouse 1994; Jones, Lester and West 1994). In addition there is a clear trend toward 'relational' contracting which tends toward long term arrangements and reduces the likelihood of purchasers actively 'shopping' in the marketplace at all (Flynn and Williams 1997).

2. The manner in which actors in the health care market respond to financial incentives is not straightforward. Studies examining the behaviour of GP fundholders in this regard suggest that responses can be highly varied and are influenced by many other issues besides money, such as geography or personal motivation (Lynch 1994; Hughes and Yule 1992). Again, textbook theory bears little relation to the behaviour of the health care 'market'. Furthermore, Paton (1995) concludes that the internal market system actually provides 'perverse incentives' for inefficient behaviour.

3. The transactions costs of marketisation are high. Administrative staff in the NHS increased from 4,600 to 13,000 when the internal market was introduced, creating an additional £400m of expenditure (Glennerster and Le Grand 1995). The new NHS White Paper refers frequently to

the high transactions costs of establishing the internal market and the need to transfer resources back into treating patients. (DOH 1997).

4. Marketisation may have had implications for equity. In the case of the NHS, cream-skimming by providers and the growth of a "two-tier" service in which patients of more effective purchasers receive better service have both been issues much discussed (Whitehead 1994; Glennerster and Matsaganis 1994).

5. Contracts can act only as a tool and not a substitute for policy. Checkland (1997) summarises the nature of contracts within the NHS as "shorthand for a complex social process which has been evolving steadily since reforms were introduced". He also notes that contracts *per se* have come to be perceived as having a more limited role than at first envisaged. The importance of clear planning and service specification is highlighted but not necessarily assisted by the use of contracts. Within the NHS the importance of an adequate definition of which services are the responsibility of which organisation is increasingly recognised. Indeed, the suitability of contracts and medical audit to 'drive' a clinical process is questioned (Hopkins and Soloman 1996).

Therefore, limited existing evidence relating to the nature of contractual relationships in primary health care from the NHS shows that, as MacNeil (1974) predicted, these contracts rarely conform to the classical or neo-classical model but are much more likely to be relational. Whilst many reforms, at their introduction, were phrased in the language of competition and classical contracting, it is common for contracts themselves to be vague about risks and responsibilities, to ignore sanctions that are available for failure to perform and to be imprecise about time (Bennett and Ferlie 1996; Goddard, Mannion and Ferguson 1997). In many cases, contracts are shown to be left deliberately incomplete, and parties often behave in ways that contradict what the contract stipulates (Walsh et al 1997). Most contracts are found to be imperfect in the sense that they leave many elements of

intended performance unspecified (Klein 1992) or need adaptation as circumstances develop (Watt 1998). Indeed, coping with an uncertain future may best be done by deliberately leaving contracts incomplete (Walsh et al 1997). Especially in cases where the investment is low it may not be worth the expense of tightly specifying contracts. Mackintosh (2000) finds a great emphasis placed on "flexibility" in a case study of local authority contracting for social care, and quotes one manager on the subject of incomplete contracts:

"you have a great long list of things, and you specify it really tightly, and what you end up with.....is a series of loopholes. You can specify things too tightly I think and you end up causing more problems...I think with a social specification you create um, not a regime, you create a sort of an atmosphere"(Mackintosh 2000 p4).

Even where contracts are well specified, many empirical studies now stress the importance of the distinction between the formal provisions of a contract and its day to day operation (Deakin and Michie 1997; Vincent-Jones and Harries 1998; Davis and Walker 1998).

Walsh et al (1997) in a comparative study in the UK 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. Contract focus relates to contract specification above, and examines whether the contract is specified in terms of inputs, methods or performance: what is required to do the work, how the work is to be done, or what are the results to be achieved. Contract form refers to the level of formality, whether the contract is based on a fixed or variable price and how it deals with the relationship between contract and price. Contract content deals with issues of how the services are to be provided, how they are defined, and the nature of contract conditions covering such issues as arbitration, variation and default.

In the case of contracts for health care, 176 contracts were studied, the focus of which were highly varied between emphasising input measures or attempting to define results. The contracts fell into three different categories of form: block (contractor pays fixed fee for defined range of services); cost-per-case (price of each treatment is specified); and cost and volume (baseline level funded on a block basis and all funding after that is on a cost-per-case basis). Contracts tended to be block

originally and become more sophisticated over time. 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, e.g. number of interventions, was noted. Language was also noted as being less legalistic and less detailed than in some other sectors studied. If contracts for health err on the side of 'vagueness', this may be a reflection of the difficulty of accurately specifying and monitoring the delivery of quality health services, or inadequate capacity to do so. In either case, the question remains of whether a more detailed contract design would effectively improve the standard of service delivered.

Key mechanisms within contracts, and therefore determinants of the cost and quality of services delivered, are identified as how they deal with risk, how they ensure quality and the use of default to cope with problems of unsatisfactory performance (Walsh et al 1997). Within each of these, variables of interest are the degree of detail, degree of adaptability, completeness and reliance on trust (ibid).

Health was noted as the most problematic of the three sectors studied with regard to dealing with issues of risk, and this influences the behaviour of contracting parties in health. In terms of ensuring quality, Walsh found that health contracts had sections on quality tending to emphasise the need for a co-operative, incremental approach involving both client and contractor. These statements varied from simple to more detailed declarations. Default measures were specifically addressed in only just over 50% of the health contracts analysed. Failure to deliver was seen as incurring financial deduction in only 15 % of contracts analysed. Only 19% of contracts made specific provision for contract termination for failure of performance (Walsh et al 1997). Purchasers may attempt to reinforce the commitment of a contractor by aligning values or choosing those who are believed to share the same values. In a separate work, Walsh observed:

"in the case of contracts for community care, a great deal of attention is typically given to ensuring that the contractor's philosophy is in line with that of the purchaser. .... it is easier to ensure commonality of values in long term contracts and if the contracting organisation is not primarily

oriented to profit" (Walsh 1995 p128)

Heavy regulation is shown to further fundamentally compromise the nature of the contracting process (Bennett and Ferlie 1996; Hughes and McGuire 1992; Propper 1995; Allen 1995; Maynard 1993). Hughes and McGuire (1992) refer to the "conceptual gymnastics" needed to sustain the metaphor of the market within the NHS, given the nature and extent of government regulation.

MacNeil's (1974) prediction that relational contracting will be a dominant form is further confirmed by recent surveys of contracting in the NHS (NAHAT 1994 cited in Flynn and Williams 1997; Spurgeon 1997). These have noted that the majority of contracts were very 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.

From LMICS

Evidence from LMICs is scarce and in particular there is virtually no evidence on the nature of the contractual relationship between purchaser and provider. Research has been more focussed on the desirability of more limited forms of contracting, particularly for non-clinical services. This is a reflection of the type of contracting most common in LMICs with the exception of several Latin American countries, Zambia and Cambodia[8].

The principal evidence relating to contracting in LMICs comes from a project in six countries where researchers documented the extent and nature of clinical and non-clinical contracting in their country

[8] Health sector reforms in Colombia involve distinguishing a purchaser provider split and Mexico is planning a similar reform (Gonzalez-Sedano 1995 and Frenk et al 1994 in Bennett, Russell and Mills 1996). Guatamale, Peru, the Dominican Republic and Costa Rica all have some form of contracting with NGOs (Abramson 1999). In Zambia, decentralization involves individual district health teams being contracted by the Central Board of Health to provide services (Bennett, Russell and Mills 1996) and in Cambodia a pilot project is experimenting with different models of 'contracting in' and 'contracting out' the provision of district level health services to private sector organisations.

and attempted to identify factors which contribute to the success or failure of contracting arrangements (Alvarez et al 1995; McPake and Hongoro 1995; Broomberg, Masobe and Mills 1997; Tangcharoensathien et al 1997; Bhatia and Mills 1997; Beracochea 1997; Gilson et al 1997). A common research framework (McPake and Hongoro 1995) evaluated the following:

- cost of direct provision versus costs of contracting versus costs to the contractor
- implications for workers
- differences in quality
- level of satisfaction of different groups
- the contracting process and associated problems
- capacity of the public sector to manage contracting
- factors which affect feasibility and success of contracting.

In all cases, the extent of contracting with the commercial sector and for clinical services was found to be limited. The rationale for contracting tended to be price in the case of non-clinical services, and a pragmatic response to non availability of the service (with no option to expand) in the case of clinical services. Design and specification of contracts varied considerably.

Clinical services were usually paid on a fee-for-service basis and non-clinical services with a lump sum payment or at a unit price set in advance by the purchaser. Non clinical contracts were consistently agreed through a competitive process although a change in supplier was very rare. Number of bidders was often low and clinical contracts were rarely awarded competitively.

With respect to capacity of the managing agency to handle the contract, the case studies provided both good and bad examples. Bad examples included contracts being allowed to persist that were highly favourable to the contractor (South Africa) and health departments becoming 'locked in' to contracts which they could not afford (in Zimbabwe, one province was paying 70% of its provincial health budget to one mine hospital). Weak capacity also implied poor monitoring and late payment

of contractors, which were likely to act as a disincentive to potential contractors being willing to work with governments. On the supply side, capacity issues were whether there were private sector firms willing and able to contract for the price the government would pay. Their ability to recruit a suitable workforce was a related issue.

Mills (1997) concluded that contracting out was not a substitute for good public sector management. Contracts are tools which still have to be managed and in certain respects this may be more demanding on managers than direct provision, requiring new skills. Contracting out was also not seen to be a solution to very limited budgets: if governments cannot afford to fund direct provision adequately, it was also highly unlikely that they would be able to fund contracts adequately. In fact, contracts may have the effect of protecting an arbitrary selection of services from cuts. Lastly she stressed that some circumstances making public sector provision inferior to contracted out services were amenable to change, and that this was a clear alternative for LMICs rather than further pursuing a policy of contracting out.

Circumstances where contracting out of non clinical services may offer advantages (of cost, quality, management convenience) were suggested to include those where:

- enough interested and capable private sector suppliers exist in sufficient number to ensure competition
- public sector funds are sufficient to fund a service of adequate quality
- public sector rates of pay are higher than private sector rates, and public sector rules make it hard to use labour flexibly.

Nevertheless Mills (1997) emphasises that when contracting is introduced, new skills need to be learned by public sector managers, the authority to monitor the contract needs to be clearly allocated, and contract specification should be sufficiently detailed that performance can be checked.

CONCLUSION AND UNANSWERED QUESTIONS

This review of economic theory relating to contracts reveals an interesting breadth of potentially relevant approaches for understanding their nature, although also some gaps, mainly in the traditional arguments in favour of contracting out as a tool to improve efficiency. Proponents of the New Public Management argue that efficiency is improved via any of three routes: increased competition, the beneficial effects of managerial decentralisation, or as a response to increased transparency and accountability by the use of a contract. Limited evidence, principally from hospital contracting in developed countries, indicates that the latter two routes may be more common. Instances of genuine competition amongst health service providers who require any significant level of capital investment has been found to be rare.

Equally, contracts for health tend to be incomplete and poorly monitored, with sanctions rarely specified and even more rarely invoked. Overall the limited empirical evidence available suggests that the operation of contracts is complex and determined by a range of factors better captured by an appreciation of the vital role of the broader institutional, organisational and social environment in which they exist. Such factors are stressed in the 'new' or 'modern' institutional economics literature.

Nevertheless, contracts are often still held up very much as a 'one size fits all' prescription. This review has highlighted some confusion between the policy prescriptions underlying many LMIC reforms, based on an idea of classical contracting, and empirical evidence of the nature of the contractual relationships emerging in countries such as the UK, which often appear to be more relational than transactional. Whilst policy prescriptions are filled with discussions of competition and choice, empirical findings on contractual relationships tell a different story, reflecting the existence of a variety of contract forms in a myriad of settings. Overall the need for a better understanding of the nature of contractual relationships and the factors which determine these is clearly required. In particular, this incomplete picture of the dynamics of contracting highlights the

need for more detailed information about specific contract design and management processes and how these operate in different contractual environments, especially those likely to characterise many LMICs. The channels or processes through which a contract does or does not influence the behaviour of different types of providers can only be understood by examining a range of different contracts and their operation in detail, and by giving consideration to the attitudes and perceptions of those involved in purchasing or providing the services in question.

In the case of contracts in developing countries, this review has stressed that very little is known about their nature or performance, or to what any differences in performance should be attributed. Factors concerning the role of institutions, market structure, social and environmental factors and individual motivations have been identified as influences upon the operation of contracting in recent literature from developed countries, but as yet not explored in the context of contracting for health in LMICs. The role of such factors in different LMIC settings, how they inter- relate and what their relative importance is in different settings are all subjects in need of more enquiry. For instance, a greater understanding of the interaction between reliance on trust, detailed monitoring and detailed contract specification as alternatives to ensure performance would shed light on the most appropriate manner to approach contracting for health in different settings. Alternatively, contracts may rely on entirely different operating mechanisms in LMICs from those identified in developed country literature. Either way, the types of conditions that must be present for different contractual arrangements to function effectively need to be understood to establish a coherent public private mix in LMICs. Unanswered questions of particular relevance in an LMIC context include a consideration of what constitutes appropriate contract design and management in a situation of weak institutional capacity and perhaps non-existent competition (highly relevant to the "export" of NPM ideas to developing countries); the implications of differing provider motivations (profit or non-profit) on the most efficient methods of managing contracts; and lastly the issue of how poor monitoring and regulatory capacity could be compensated for. For instance, can weak monitoring capacity be overcome by selecting providers with whom the level of trust is high or which are seen to have

motivations more in line with those of the government (for example NGOs)?. The complex phenomenon of how an individual contract operates needs to be examined from a range of angles, utilising the concepts suggested by developed country literature. A broad approach which takes in all facets of the contract's design and operation will allow a comprehensive exploration of the mechanisms that appear important in determining its overall nature.

FRAMEWORK FOR ANALYSIS

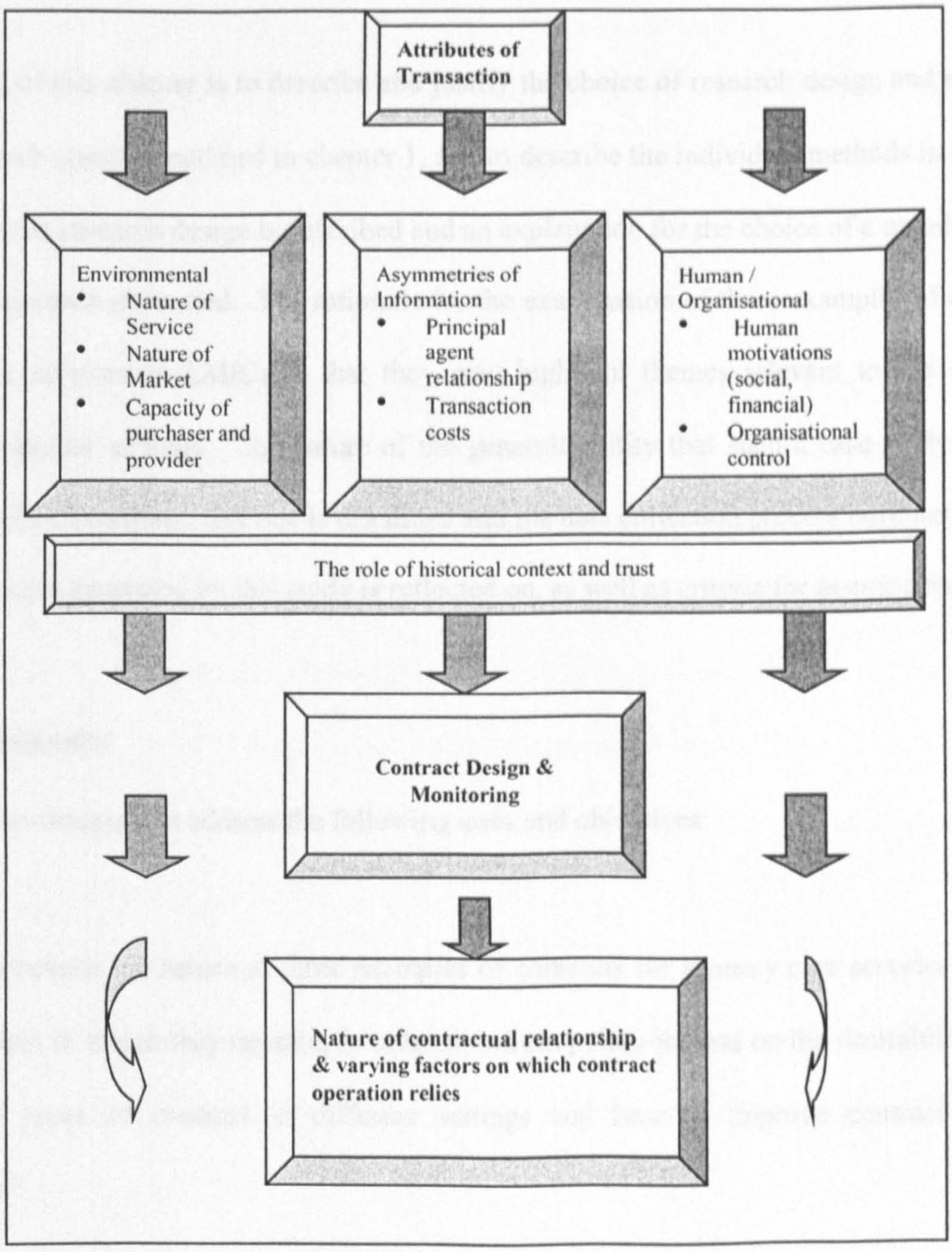
Several key concepts arise from the literature review presented. These have been grouped into a number of categories which form a flexible framework for considering the determinants/attributes of a contractual relationship, and are shown in figure 2.1. First, *environmental factors* such as the nature of the market in which contracts are to be let, the type of service that is to be specified in the contract and the capacity that exists within both purchaser and provider, are all influential. Second, at the root of any discussion of contracts are problems arising from *asymmetries of information*, although these will vary in their intensity and effect from transaction to transaction according to factors also discussed such as the nature of the service, the degree of opportunism amongst providers and the capacity of the purchaser to monitor service delivery. How any purchaser chooses to manage these problems is key to the nature of the contractual relationship. Third is the *human/organisational context* of the transaction. Some contracting literature attempts to address the question of the role of human factors in the operation of contracts, for instance the implications of a combination of bounded rationality and opportunism with asymmetries of information such as discussed by Williamson (1975). If opportunism or bounded rationality are assumed to be absent, asymmetries of information carry less sinister implications. The potential role of trust and historical context in determining many of the above factors must also be considered.

The literature review in this chapter suggests that such attributes of each specific transaction will also determine to a great extent the second set of key concepts, relating to the formal mechanisms of contractual control - contract design (and award and negotiation) and monitoring. In its turn, contract

design will directly influence the behaviour of those working under a contract via the package of incentives that is created. Incentives are determined by the manner in which provision is made for 1) specification of performance, 2) monitoring of performance, 3) method of pricing, 4) method of enforcement of performance and 5) method of dispute resolution. A key influence here is the extent to which inputs and outputs of the contract can be specified and provision made for monitoring them; again this is directly related to the nature of the service discussed above.

The third set of concepts centres on the nature of the contractual relationship and what drives it. This is clearly influenced by both the previous categories discussed. Relevant factors in considering the nature of the contractual relationship may be very broad but include the extent to which monitoring is possible and carried out, the types of sanctions resorted to, the role of trust, perceived dependence by either or both contractual parties, frequency of legal enforcement, and general perceptions and attitudes of each of the contracting parties to each other and to the contract. The literature from developed countries may underplay the importance of lack of choice in a contractual relationship in LMICs. It is conceivable that there exists a stage where neither trust nor monitoring are functioning sufficiently, but the contract remains due to a lack of any alternative to get the service provided. In this study the possibility of such a situation, as a form of a dependent, relational contract, is also recognised.

Figure 2.1: Factors likely to influence the nature of a contractual relationship



CHAPTER 3: RESEARCH DESIGN AND RESEARCH METHODS

The purpose of this chapter is to describe and justify the choice of research design and methodology for the research question outlined in chapter 1, and to describe the individual methods in detail. In the first section, the research design is described and an explanation for the choice of a mainly qualitative case study approach presented. The rationale for the examination of three examples of contracts for primary care services in LMICs is that they may highlight themes relevant to the operation of contracts in similar settings. The nature of the generalisability that such a case study design may offer is therefore important, and this is discussed and the data collection process outlined. Finally the status of the data generated by this study is reflected on, as well as criteria for assuring its quality.

RESEARCH DESIGN

The study was designed to address the following aims and objectives:

Aim: "To evaluate the nature of three examples of contracts for primary care services in an LMIC and the context in which they operate, in order to inform policy-makers on the desirability of the use of different types of contract in different settings and how to improve contract design and management"

Objectives:

- To describe and analyse contracts in terms of their award process, design and specification
- To describe the nature of the contractual relationship between purchaser and provider
- To identify and describe external factors and how they impact on the nature of the contractual relationship e.g. nature of provider, nature of service, degree of dependence, degree of trust
- To relate these factors to those which would be predicted to be important by theory supporting the use of contracts for health care

- To explore both formal and informal controls potentially determining the nature of the contractual relationship and the behaviour of the contracted provider
- To make recommendations on how policy-makers in South Africa and elsewhere could best approach a policy of contracting with the private sector, and what is likely to be appropriate for different types of service and different types of provider.

Research design provides the path from research questions to the research findings. In evaluating the nature of three examples of contracts for primary care services, the research aimed to address both the question of "what is the nature of the contractual relationship?" and seek answers to "why is this so?". By seeking to answer both "what" and "why" questions, the research described here was both exploratory and explanatory. To achieve the above aims and objectives, and following from the concepts highlighted by the initial literature review, a series of research questions were posed for each contract. Examples of these are given in Table 3.1 overleaf. A research design was chosen which was appropriate to answer these research questions.

The nature of the information sought was a mixture of facts and more subjective beliefs and perceptions and needed to take account of the context of each contract. The focus of the research was a naturally occurring social phenomenon, the contractual relationship. This, in addition to the small sample size of functional contracts available for evaluation, suggested the need for an emphasis on open-ended, qualitative enquiry.

Whilst the previous chapter reviewed theories and concepts which formed the basis for the collection of the data in this study, the final interpretation of the data arose from its analysis rather than any predetermined theoretical framework. Coast (1999) notes the usefulness of qualitative methods for this type of health economics research, in particular their ability to explore complex issues, their ability to allow for the role of context, and their applicability for developing theory grounded in real experience. This latter feature may be particularly applicable to 'alternative' approaches to

economics, such as institutional economics, where, in contrast to the neo-classical framework, the more piecemeal nature of explanation arising is less likely to be considered problematic.

Table 3.1: Key theoretical issues highlighted by literature review and related study questions

Influences on nature of the contractual relationship	**Research questions posed**
1. Contextual factors • environmental (nature of market, capacity, type of service) • human/individual (nature of provider and purchaser, motivations of provider)	What is the nature of the environmental factors potentially impacting on contract design and the contractual relationship, including the prior history of the contractual relationship?
2. Degree of asymmetries of information (information systems, capacity to monitor, degree of opportunism of providers)	What are the incentives and motivations of health service providers under each contract?
3. Contract design and award process	What form does the contract take, what incentives does it create and what factors can explain this?
--> Nature of the contractual relationship	**Research questions posed**
1. Formal and informal controls upon the behaviour of contracting parties 2. Factors on which the contract's operation relies	What appear to be the mechanisms (either within a written contract or external to it) which hold the relationship together and influence the performance of the provider? How does the contract operate? Under what conditions are different types of contractual form appropriate and desirable?

Choice of a case study approach

The research drew on Yin's work (1994) on case study design by paying attention to the need for a theoretical framework to underlie the research design, and to the categorisation of case studies which it employs. A case study is a study of an event which also includes its real-life context. Features of a case study are the attempt to measure multiple variables using a variety of methods, and seeking to triangulate findings from these different methods. Yin (1994) sees the case study as "all-encompassing" and a "comprehensive research strategy". In some ways a case study is similar to a history, except that it has access to methods such as direct observation and systematic interviewing.

Case studies have traditionally been looked down upon as a "weak sibling of social science methods" (ibid), accused of being a rather weak approach offering somewhat tentative conclusions and limited degrees of generalisability (Walsh et al 1997; Black 1994). However, Walsh observes that this

perspective derives from a highly positivistic conception of the nature of science, a stance made increasingly untenable by exploration of the philosophy of science, admitting that truth may not always be an objective set of facts waiting to be "revealed". Case studies are becoming increasingly commonplace and gaining recognition as valuable "where policy change is occurring in messy real world settings, and it is important to understand why such policies succeed or fail" (Keen and Packwood 1999). They are particularly appropriate in circumstances such as the following:

- where researchers have no control over events and so an experimental approach is not feasible (ibid).
- when it is desired to study policy implementation empirically
- where there are complex causal links between many variables to attempt to understand (when "how" or "why" questions are being posed (Yin 1994))
- where contextual conditions are a relevant issue for the study
- when the focus is on a contemporary phenomenon within some real-life setting- it allows an investigation to retain the holistic and meaningful characteristics of real-life events – such as individual life cycles, organisational and managerial processes, neighbourhood change, international relations and the maturation of industries (ibid).

In summary, case studies are good for analysing complex relationships and allowing for the importance of context. This is particularly relevant for the empirical study of the implementation of real-life policy. Given the importance of context, history and environmental factors in the key concepts summarised at the end of the previous chapter, a case study was clearly the most appropriate choice for being able to study the nature of contracting in the "real world" of an LMIC setting. This, combined with the small size of the sample of contracts available for study made the choice of a case-study method both suitable and inevitable.

Design of the case study

Yin (1994) provides a useful categorisation of case study design which is drawn upon here. In this research a multiple case, embedded case study was used. The unit of analysis was a contractual relationship and a total of three contracts were studied. One contract is presented in great detail and two others as summary cases. Within each case study, where more than one contractual relationship was reviewed, these individual contractual relationships were classified as a 'subunit' embedded in each case study. In the case of the Part Time District Surgeons there were 11 subunits examined and in the case of the Lesotho contract there were two. The private capitated scheme contract did not lend itself to the examination of specific contractual relationships, so this was examined as one generic contract.

The justification for using three case studies was that they would complement each other by demonstrating a range of contractual relationships over a cross-section of settings. This would shed light on the influence of different factors on the overall nature of the contractual relationship. The table below summarises the differences between the case studies with regard to some of these factors, such as the nature of purchaser and provider, and the setting of the contracts.

Table 3.2 Features of different contracts included as case studies

Contract	Purchaser	Provider	Setting
PDS	Public sector – provincial authority	Private sector -Individual GPs who are also engaged in private practice	Rural towns
Lesotho	Public sector -parastatal via contract with construction consortium	Private sector – commercial company whose key activities are not this contract	Remote rural
Private capitated scheme	Private sector companies - via medical scheme	Private sector – commercial company running a chain of clinics which are its main business	Urban

Site selection

For the PDS case study, eleven district surgeon practices were selected using purposive sampling. Practices were selected in two adjacent provinces, five in the Western Cape province and six in the

Eastern Cape[9]. Two provinces were used to allow for differences in provincial purchasing behaviour and capacity. These provinces were chosen because they had a strong history of using the PDS system and were using the same written contract, as they had originally both been part of the former Cape Provincial Administration. Sites were selected in consultation with Department of Health officials to give a cross section of regions and different types of town and contractual history. This was done in recognition of the need to minimise results that misrepresent the nature of the contractual relationship because they are consistently influenced by one external factor. Some of the district surgeons visited had been in the post for over 20 years whilst others were recently appointed; it was felt that this would allow for differences in the age and attitude of doctors as well as the effect of the history of the relationship on their current attitude to the contract. Care was also taken that towns differed in the number of other private doctors practising and the other public health sector services available and hence the degree of dependence on the services of the PDS.

For the Lesotho case study, two of the three clinics operating under contract were chosen. Again purposive sampling was used, choosing the contract which was most recent and that which was the longest established. The purchaser had attempted to lay more emphasis on public health issues during the award and design of the most recent contract and so it was felt that it would be useful to evaluate how this had influenced the nature of service delivery or awareness amongst the sub-contractor staff.

In the case of the private capitated scheme case study, two clinics (in Guateng and North West Province) were evaluated and these were chosen as typical examples of the most up to date service provision by the company. No specific purchaser was chosen as each clinic saw patients who fell under a range of contracts with different industrial companies.

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[9] In the Eastern Cape one practice was included at short notice to accommodate the concerns of the Department of Health that the sample would give a view only of the traditional contractual relationship and missed one practice that they saw as

As part of the performance evaluation in the larger project a number of public sector sites in rural and urban areas were also visited to gather comparative data. Data from some of these rural sites are drawn upon as comparisons to the PDS performance data presented in chapter 7. More details about the features of these comparison sites are given in Appendix 1.

Choice of principally qualitative methods

Qualitative methods are being increasingly used in health services research (Pope and Mays 1999) and some types of study naturally lend themselves more to qualitative methods, including those about which little is yet known. Qualitative data can give intricate details that may be difficult to convey with quantitative methods; they are concerned with the meanings that people attach to their experiences of the social world. They try to interpret social phenomena by studying people in their natural setting, rather than via means of artificially created experimental surroundings (ibid). Qualitative research can be about person's lives, stories, behaviour but also about organisational functioning, social movements, or interactional relationships (Strauss and Corbin 1990). Contractual relationships fall into this latter set of possible research subjects. In this setting, and similarly to case study research, qualitative research usually adopts multiple methods, based around watching people, talking to them and reading documents. With any qualitative approach however, these apparently simple tasks must be carried out in a systematic, planned and logical manner and then are subject to careful rigorous analysis (Pope and Mays 1999).

The value of qualitative methods in health economics research is also increasingly recognised (Black 1994, Coast 1999). Coast notes that health economics is in a unique position to learn from other disciplines in health services research and consider researching particular questions in what are generally considered to be unconventional ways, by using qualitative methods. She also stresses the importance of context in considering 'multiple realities' and summarises the basic aim of qualitative research as to try to:

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particularly innovative and interesting. As site selection was purposive, inclusion of this practice was not seen as

' grasp phenomena in some holistic way or to understand a phenomenon within its own context or to emphasise the immersion in and comprehension of human meaning ascribed to some set of circumstances or phenomena' (Lincoln 1992 p.376 quoted in Coast 1999 p.347).

Case studies are not synonymous with qualitative research and can use any combination of qualitative or quantitative methods, but the term case study is often taken to carry implications for the kind of data that are collected. Frequently, but not always, it implies the collection of unstructured data and qualitative analysis of those data (Gomm, Hammersley and Foster 2000). Methods used in these case studies were principally qualitative, that is, findings were not arrived at by means of statistical procedures or other means of quantification (Strauss and Corbin 1990). Strengths of qualitative research in a case study setting are suggested by Lincoln and Guba (1985) as:

a) validate and build upon the tacit knowledge that the investigator brings to the inquiry
b) allow for purposive sampling whereby informed choices of site or location enhance understanding of the process being investigated
c) incorporate the notion that the focus of the design can be adjusted as the process unfolds and issues of particular interest are identified.

Recent research using similar approach

Several recent studies have used qualitative methods, often in combination with a case study, to look at the operation of contracts:

- A study of the enforcement of commercial contracts in Ghana (Fafchamps, 1996) used interviews and highly qualitative approaches such as looking at respondents body-language whilst quizzing them on their motivations and beliefs regarding suppliers and clients – *"body language was an important part of respondents' answers – several laughed or shrugged" (p.434).*
- Mackintosh (2000) studied social care contracting in two health authorities to examine the discursive construction of social care contracting. Semi structured interviews were conducted

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problematic.

with staff, from departmental directors in a "slice" down to field level staff, and also with managers of contracting organisations. Analysis of the interviews was interpretative and identified shared and contested meanings of key words such as price/ purchase and contract.

- Allen (2000) used a case study approach for her doctoral dissertation, employing a combination of observation, document review and interviews to investigate and analyse the nature of contracts for district nursing in the NHS internal market.
- Walsh et al (1997) used case studies to provide an insight into the role of contracting in the British public services (health, social care and local government services), observing that *"the openness, unevenness and relative novelty of the research canvas confronting us suggested that a case study approach was likely to be most appropriate and most fruitful"(p.51).* These case studies were very similar to those reported here in their approach, using a combination of structured interviews, analysis of supporting documents and analysis of contracts themselves.
- Flynn, Williams and Pickard (1996) used a combination of interviews with patients and GPs, observation of meetings and document review in their study of purchaser provider contracting for community health services.

GENERALISING FROM CASE STUDIES AND QUALITATIVE RESEARCH

The degree to which case studies and qualitative research are able to provide a basis for drawing conclusions about some general type of phenomenon or about wider populations of cases is debated. Arguments outlined below include Yin's (1994) "replication logic", Mitchell's (1983) "theoretical generalisation" and the refutation of this type of reasoning by those who argue that case studies need not make any claims about generalisability of their findings and that it is their role in "naturalistic generalisation" that is crucial (summarised in Seale 1999; Hammersley and Gomm 2000; Donmayer 2000; Schofield 2000; Lincoln and Guba 2000).

The question of the generalisability of findings from a research design such as this goes to the very heart of the distinction between qualitative / case study type research and experimental or social survey methodology. Generalising from quantitative research is based on choosing representative

samples and using estimates of probability and chance to estimate the likelihood of events occurring in similar cases outside the sample. This is difficult in qualitative research, as generalising from a small number of cases on the basis of statistical probability is not feasible (Seale 1999). Mitchell (1983) paraphrases the most common criticism of the case study method as follows:

"The basic problem in the use of case material in theoretical analysis is that of the extent to which the analyst is justified in generalising from a single instance of an event which may be – and probably is- unique"(p.189).

Again, he comments that this criticism arises out of the common assumption that the only valid basis of inference is that which has been developed in relation to statistical analysis, whereas the process of inference from case studies is only logical or causal, and cannot be statistical. He responds to this criticism by introducing the idea of theoretical generalisation and warns against falling into the trap of criticising the validity of case studies because they are only based on one or two cases. Case studies need to be selected for their explanatory power rather than for their typicality as there is no attempt to seek statistical generalisability from a case study method. The basis of theoretical generalisation lies in logic rather than probability (Seale 1999) and typicality must be looked for in the "social morphology" rather than in the case (Mitchell 1983). Case studies do not seek to find events that are representative; the line of enquiry is from the event, back to a theoretical framework, which expands as a consequence of the case study. It is the theoretical framework that gains from each case study. Case studies do not stand alone as powerful analytical tools but only in conjunction with a body of theory generated by a series of case studies and other research. Extrapolation from each case study to theory is therefore based on the validity of the analysis rather than the representativeness of the events (Mitchell 1983).

Mitchell (ibid) makes the following points about the characteristics of the case study method:

1. No case study can be presented in isolation from the corpus of empirical information and theoretical postulates against which it has significance. Case studies can be used

ethnographically and analytically, but to be used analytically they must be embedded in an appropriate theoretical framework.

2. Predictions from an analysis based on case study techniques tend to be theoretical rather than empirical.
3. The validity of the extrapolation depends upon the cogency of the theoretical reasoning rather than anything else.
4. Impact of context features on the events being considered must also be incorporated rigorously in the analysis.

Seale (1999) rejects this notion of theoretical generalisability, commenting that it involves making *"unwarranted assumptions about the characteristics of populations not yet to be studied"*.... *"the attempt to generalise is, at least potentially, an act of violation"*(p.112). In order to generalise the researcher must attempt to ascertain the essential characteristics of a case and in social research these will always be *"somewhat speculative and refutable by further examples" (ibid).* Whilst he maintains that generalisation is a worthwhile goal for social research, Seale (1999) concludes more modestly that:

"thick and detailed description of individual 'sending' cases, chosen on the basis of evidence about the similarities with proposed 'receiving' cases, preferably bolstered by a study of several cases rather than just one, is a more secure basis for good work.... Theories generated by single cases should always be seen as fallible propositions that might be modified in the light of further experience"(ibid).

Lincoln and Guba (2000) whilst admitting that generalisation is an appealing concept, also advocate an intermediate position which does not involve deciding between *"nomic generalisations on the one hand and unique, particularised knowledge on the other"*(p.27). In a modified form of Mitchell's theoretical generalisation, Yin stresses that the theory provided as part of a case study design plays a key role in generalising case study results (Yin 1994).

The rationale for having more than one case study in a design such as that used here is what Yin terms "replication logic" rather than a "sampling logic". Replication logic includes both literal and theoretical replication. In this sense the basic objective of use of the case study method is again to

expand and generalise theories, and not to enumerate frequencies. A "replication logic" seeks to find similar results between case studies (literal replication) or different results but for predictable reasons (theoretical replication). In replication logic, theoretical replication takes place when different results are observed for predictable reasons, by relating the case study to a theoretical framework which analyses it differently and therefore would predict different results from the different cases chosen. Replication of results across sites helps to ensure that findings are not due to characteristics of particular sites, hence it increases external validity (Keen and Packwood 1999) or analytical generalisability if not statistical generalisability (Walsh et al 1997).

In the case of this study, three cases were chosen where contracts for primary care were operating in different contexts but within the same overall setting of an LMIC. The use of several cases acknowledges the difficulties of generalising from case studies and is not argued to strengthen the research design in terms of a bigger sample, but purely to reflect upon the same issues in a range of settings. Above all, this research was conceptualised pragmatically to "add meat to the bones" of theory about what types of contracts might operate in LMICs for primary care. At the minimum, substantive theory about each contractual relationship examined by the research reported here is generated. In addition, tentative generalisation can be made at the theoretical level, such as a typology of issues that are important to consider in LMIC contracting and how they might interact.

THE RESEARCH PROCESS

The Theoretical framework

A flexible theoretical framework of factors likely to impact on the process of contract design, letting and management were identified during the initial literature review prior to the development of study tools. At this stage the interview schedules were prepared (Appendix II) to reflect these. They covered a range of issues relating to the factors shown in figure 2.1 at the end of the previous chapter.

These different categories of factors that were considered initially should also highlight two characteristics of the phenomena being investigated. First is the complex and interrelated nature of the variables that the study seeks to investigate. Second is the importance of background, context and history in understanding the dynamic of a contractual relationship. A multitude of categories and possible influences and interrelationships needs to be understood in relation to one another. Whilst several concepts presented themselves as potentially important, part of the role of the research was to find which actually were.

Data Collection

Yin (1994) identifies six possible sources of data for case studies: interviews, direct observation, participant observation, archives, physical artefacts and documents. Specific methods used for the case studies reported here were semi-structured interviews, direct observation and document review. Results from the broader research project were also drawn upon to give further quantitative data such as cost and quality of care provided under each contract.

Fieldwork was carried out in four distinct stages between August 1998 and November 1999, covering the Western Cape PDS, Eastern Cape PDS, Lesotho contract and private capitated scheme contract consecutively. Each facility delivering services under a contract of interest was visited during this time. Over a period of two to three days data were collected for a comprehensive costing and quality

of care evaluation for each site, as part of the larger research project. During this time fieldwork for the case study was also carried out. In addition, further case study fieldwork consisted of interviewing purchasers and head office managers at their offices. This was done at regional, provincial and national level and any relevant documents were also collected from these sources.

To gain permission for the research, each PDS was contacted individually and asked whether he would be willing to participate in the study; all were keen to agree. The study was described as a joint undertaking between the London School of Hygiene and Tropical Medicine and two South African universities[10], funded by the UK Department for International Development. For the Lesotho and private capitated scheme case studies, the head offices of the service providers were contacted and both gave permission willingly. The clinics themselves were only contacted at a later date to make logistical arrangements, once they had been informed that the study would take place.

Data collected for the larger research project is also drawn upon for these case studies – in particular, transcripts of focus group discussions, cost data, utilisation data, timeflow data and data on the structural quality of care at each facility. Table 3.3 shows the methods used in the case studies, which aspect of the contractual relationship they addressed and what role the author played in the data collection and analysis of those parts drawn from the broader study.

[10] Centre for Health Policy, University of Witwatersrand and Health Economics Unit, University of Cape Town

Table 3.3 Methods used in case studies

Method	Aspect of contractual relationship method is assessing	Role of author in data collection and analysis (NP = author)
Semi-structured interviews with providers, purchasers, key informants	All aspects	NP
Document Review	Policy context. Nature of communication between purchaser and provider. Contract design.	NP
Direct Observation	Performance of contract : nature of service delivery / effect of incentives on service provision	NP
Structural quality assessment	Performance of contract : nature of service delivery / effect of incentives on service provision	NP
Costing	Performance of contract : nature of service delivery / effect of incentives on service provision	NP supervised data collection and analysis
Timeflow study	Performance of contract : nature of service delivery / effect of incentives on service provision	NP supervised and took part in data collection and analysis
Focus Group Discussions	Performance of contract : nature of service delivery / effect of incentives on service provision	NP was involved in drawing up guidelines for running groups and responsible for analysis of transcripts

METHODS

Each method is described in more detail below. Whilst a great variety of methods were employed to assess the performance of the contract, the bulk of the data used in this study are drawn from the semi-structured interviews and document review.

1. Semi-structured interviews

Semi-structured interviews were used with both purchasers and providers to explore issues around the contract design, award process, attitudes to the contract, the process of negotiation and the current contractual relationship, its history and the influences upon it. The interview usually lasted between one hour and one and a half hours. All interviews were taped and transcribed fully by the author. Forty six people were interviewed in total for all the case studies. Details of how these interviews were divided between the different case studies, as well as the race and gender of the interviewees, are given in table 3.5.

For each case study, the same themes were explored with purchasers and with providers but the nature of the interview and the way and order in which issues were addressed were not closely standardised (Silverman 1993). For instance, during the interview process for each case study it became clear that some questions were more relevant than others and attracted a more detailed or enthusiastic response from interviewees, whilst other questions met with uncertain responses. These areas were then pursued more closely as appeared appropriate. For instance, in the PDS case study, questions about what analysis had been done before the award of the contract to estimate payment levels or costs elicited a blank response from both purchasers and providers, suggesting that, whilst relevant, this was not a question that would be able to illuminate that particular contracting process. In contrast, in the Lesotho case study, both purchasers and providers were more able to engage with the question, even if they were still unsure as to the type of analysis that had been carried out. Key areas always explored with interviewees related to their motivations for being involved in the contract, the competitiveness of the contract award process, their perceptions of the contract design and their views on both the existence of the contract and the nature of the other party to the contract and the contractual relationship. The nature of the information sought was therefore a mixture of facts and perceptions, as summarised in Table 3.4 below. Some types of information are entered in both columns of this table, demonstrating the mix of fact and perception which makes up much of the interview data gathered.

Table 3.4 Factual and perceptual information sought during semi-structured interviews

Factual information solicited during the interview	Information based more on perceptions
Providers: • the history of their involvement in the contract • what proportion of total income the contract provided for their practice/company • the administrative burden that the contract represented and the types of skills required to manage it • number of potential competitors for the contract in the area • whether they knew of any competition for the contract at the time that it was awarded • the design of the contract and the incentives that they felt that it created • quality and level of monitoring by the purchaser • quality assurance systems • mechanisms for resolving disputes or agreeing revisions to the contract	**Providers:** • the history of their involvement in the contract • their motivation for taking on the contract • the nature of their relationship with the purchaser • whether they felt that the purchaser had many alternatives to get the service provided • the design of the contract and the incentives that they felt that it created • the distribution of risk in the contract • quality and level of monitoring by the purchaser • willingness to engage in legal disputes with the purchaser and their attitude to this
Purchasers: Interviews with purchasers covered similar topics but also explored: • capacity within their department to adequately manage and supervise the contract	**Purchasers:** Interviews with purchasers covered similar topics but also explored: • their attitude to the idea of contracting with the private sector in general • their beliefs about the motivations of the providers • how they felt these contracts fitted in with policy on primary care provision in general • their opinion of the quality of services offered under contract • capacity within their department to adequately manage and supervise the contract

Interviews with key informants covered more general aspects of the government's attitudes to contracting and their willingness to undertake new contracts, their capacity to manage contracts and to control the private sector, and specific detailed issues of the legal status of the PDS contract. Some key informants interviewed were private sector providers who potentially might contract with the government and in such cases they were asked about their perceptions of the government as a potential purchaser.

Table 3.5 Interviews carried out for each case study

	General background for study	PDS case study	Lesotho case study	Private capitated scheme case study
Interviews with providers		PDS were interviewed at their practices during the data collection visit. In practices where there was more than one doctor, the interview was conducted with the individual who was specified on the contract. In addition in each province the PDS who was head of the PDS' representative body was interviewed	In Lesotho, the manager and chief medical person at each clinic were interviewed in addition to the chief executive of the company which held the contract.	Interviews were held at head office and clinic level within the service provider company.
No. providers interviewed/ gender/race		11 PDS *Gender*: all men *Race*: all white	5 staff at two clinics *Gender*: 4 men, one woman *Race*: 4 white, one black (male)	5 staff at two clinics *Gender*: all men *Race*: all white
Interviews with purchasers		The regional manager responsible for each PDS contract was interviewed as well as managers responsible at provincial level.	Personnel from both the government level purchaser and the intermediate purchaser (engineering company) were interviewed.	None, due to the different nature of relationship. There was not one single purchasing institution - decisions whether to subscribe to the scheme were made by individuals.
No. purchasers interviewed/ gender/race		8 (4 in each province) In Western Cape: *Gender*: all men *Race*: 2 coloured, one Indian and one white In Eastern Cape: *Gender*: one woman (black) and three men *Race*: two black and two white	5 (3 Lesotho government officials and two from the consulting engineer) *Gender*: all men *Race*: 2 white, 3 black	0
Interviews with key informants	In Lesotho and South Africa, interviews were held with Department of Health officials, the South African Medical Association and other key informants in the private /NGO sector about the policy environment for contracting and specific areas relevant to some or all of these contracts. Many of these interviews were relevant to more than one of the case studies as they dealt with the environment in which contracting was taking place and also may have specifically discussed several different types of contract. These interviews are therefore presented as one block rather than divided between the case studies as has been done above.			
No. interviewed/ gender and race	12 key informants : *Gender*: three women (all white), nine men *Race*: one Indian, two black and nine white			

2. Document Review

a) *Contracts*:

Where possible, examples of each contract were collected from either the provider or purchaser.

b) *Policy documentation*:

Documents relating to policy on the public-private mix, contracting or the nature of the contractual relationship were sought. In Lesotho very little directly relevant policy documentation about contracting could be located. Documents relating to the contracts being studied were limited to statements of the desirability of providing health centres for all members of the population in sites of dam construction. In South Africa a range of policy documents ranging from 1994 to 1999 relating to policies on the public-private mix were accessed as well as some reports by academic institutions and special committees on the PDS system and suggestions for its reform. Finally, some PDS gave documentary examples of the type of communication that they received from the provincial Departments of Health.

3. Direct observation

Total fieldwork for the larger project entailed spending two to three days in each research site. The nature of data collection required most of this time to be spent in the clinic, around the areas where patients were waiting and the consulting areas. The author therefore was able to form a picture of how each facility operated and the characteristics of the service that it provided, as well as the atmosphere between patients and staff.

4. Structural quality assessment

In each facility a structural checklist was completed by the researcher. This included grading of factors such as the availability of drugs for standard treatment protocols, presence of a basic minimum standard of equipment and the cleanliness and state of repair of the buildings (such as the size of the waiting room, number of toilets for the patient load etc.).

5. Costing (including utilisation data)

Cost data were collected in each facility and a cost per visit and average cost per type of service calculated. Both recurrent and capital costs were included in the costing.

6. Timeflow

The time spent in the clinic and consultation time of 30 patients were recorded at each site.

7. Focus Group Discussions

Focus Group Discussions (FGDs) were used in the broader study to assess the perceptions of users of each facility as well as non-users, and reasons for their non-use. The objectives of the FGDs were to assess community opinions near to a study facility on access, equity and quality of alternative primary care services available. An external social research agency was contracted to run the FGDs according to guidelines drawn up by a number of researchers working on the project. For the PDS case study fourteen groups were run, two in each of seven of the towns where contracts were evaluated. For the Lesotho and private capitated scheme case studies, in each case two FGDs were run in the community near to one of the clinics. FGD participants were women aged between 20-30 or over 35 who had used a primary care facility in the last six months and did not have medical insurance.

Standard guidelines for moderators were developed and used in all FGDs. The guidelines covered discussion of all types of primary care facility available in the area where the FGD was being held, user perceptions of each type of facility, whether they had a choice of facility to use and if so, their reasons for using the one that they did. Issues around access, perceived competence of particular types of service provider, likelihood of referral, complaint mechanisms, quality of care, cost, drugs and cleanliness of alternative facilities were prompted for where appropriate.

Problems in data collection

In three cases the PDS was pressed for time. These three interviews were done either at several sittings, disturbed by telephone consultations or in a shorter space of time than was ideal. In these cases, an attempt was made to cover all the key issues in the interview even if it was not possible to explore them fully.

Accessing documents was often difficult. Some PDS were unable to supply a copy of the contract that they were working under because they had either lost it, it had expired or they had not been given a copy of the contract under which they were delivering services. This should also be seen as an important finding regarding the value placed on written contracts. Accessing policy documents was also problematic and there were fewer than had been envisaged at the research design stage.

ANALYSIS OF DATA

Analysis of interview data

Gahan and Hannibal (1998) observe that qualitative research always has three components:

- Data, which are messy, unstructured, usually textual and always rich
- Concepts, ideas or hunches about the data
- The researcher, who is the creator of the concepts, ideas or hunches about the data.

Transcripts were analysed using NudIST software, which should not be considered to detract from or remove any of the above elements, as the two quotes below emphasise:

"whilst NudIST provides the tools for a researcher to manipulate and interrogate qualitative data, these tasks remain researcher directed and implemented" (Gahan and Hannibal 1998).

"No computer can stand in for the ethnographer's discovery of emergent themes as fieldwork progresses, nor the final thinking and analysis" (Okely 1994)

NudIST facilitated the process of analysing qualitative data, but it did not enable anything to be done that could not have been done by hand, albeit more painstakingly. The decision to use NudIST was made because it was felt that it would lend order and rigour to the process and minimise dependence on analysis via the arrangement of pieces of paper, which could easily become muddled or lost.

Informal analysis of the interview data started early in the research process and well before the coding procedures described below, with constant thinking through and reaction to the interview data already collected. Even as the interviews were progressing, they became more focused on some themes which were emerging as important. Conversations with colleagues and my supervisor about what was coming out of the interviews also refined the process during the fieldwork stage. Opportunity for further reflection took place during time spent transcribing each interview, which usually took the best part of a day. By the time the interviews were formally coded their content was already known and reflected upon in considerable detail. Many codes had already emerged clearly as themes during these earlier stages of reflection.

A further process of interview data analysis then began by coding the transcripts using NudIST. The idea behind such detailed coding of the interview data was to ensure that the concepts discussed were:

> *"grounded in data on the page as well as on the conjunctive experiential data, including the knowledge of technical literature which the analyst brings into the inquiry"* (Strauss 1987 p.29).

Interviews for the different categories shown in the previous section were loaded onto NudIST, creating different analysis programmes for each type of interviewee, e.g. PDS, regional managers, national policy-makers, Lesotho purchasers.

For each set of interviews, a process of 'open coding' (Strauss 1987) was followed. Data were treated as empirical indicators from which analytical concepts could be derived. Preliminary sets of codes were applied to categorise indicators into different themes or under different concepts. At this

stage, links between these preliminary categories were not sought and, as Strauss (1987) observes, a number of categories were created which later were dropped as not very useful.

Text was coded to as many themes or categories as appeared appropriate. After this initial open coding, each set of codes/theme was examined in greater detail and re-coding, new coding and the introduction of new sub-codes took place again. Finally codes were grouped into key themes, in a process similar to what Strauss termed 'selective' coding. The grouping of categories and themes has influenced the way in which results have finally been written up and presented in this thesis. Quotes included in the results chapters were chosen as those which most articulately represented prevalent themes.

Document Review

Documents were summarised to reflect what they revealed about the nature of the existing contractual relationship or the government's policy towards contracting. Contracts analysis was based on the framework of form, focus and content used by Walsh et al (1997).

Direct observation

Observations of the way in which the practices visited were run or delivered services have not been formally analysed or separately written up. They have however informed the interpretation of much of the other data by providing a strong sense of the context in which the contracts being examined were operating and the nature of the service that they governed.

Structural quality

Structural quality at each site was awarded standardised scores divided into the following categories 1) general state of repair of facilities, 2) adequate toilets, 3) functioning refrigerator, 4) adequate emergency kit, 5) items of essential equipment, 6) lockable drug storage facility, 7) quality of waiting area facilities, 8) adequacy of patient records. A version of the score sheet is shown in appendix III.

Costing

Facilities were costed using a standardised methodology which is described in Appendix IV .

Analysis of FGD transcripts

Tapes were translated and transcribed. For use in this thesis, each transcript was analysed by the author.

COMMENTARY ON STATUS OF DATA AND CRITERIA FOR ASSESSING QUALITY OF RESEARCH

In the fallibilistic approach to qualitative methods offered by Seale (1999) there is still a need to critically evaluate findings, as the aim remains to reflect some truth lying beyond the text of the research report. This is complicated by the concepts of validity and reliability being to different degrees discredited as "*markers of an earlier now largely discredited (or at least no longer fashionable) 'moment' in the short history of qualitative research*" (Seale 1999 p.2 paraphrasing Denzin and Lincoln 1994). While some still argue that concern with validity and reliability is something that should be shared by all social researchers, the search for validity and reliability in research that allows for a belief in multiple constructed realities will always be compromised, and contradictory with the idea of judging the trustworthiness of an account (ibid). The idea of relativism and a single truth do not sit comfortably together and hence the idea of "quality" rather than validity in qualitative research becomes a more relevant, if still equally elusive, concept.

Since this research relies heavily on the interpretation of interview data, the status of that data is key in discussing the relevance of the research design. Due to the nature of the subjects being explored and the emphasis on interviewee's perceptions as a key variable driving the nature of the contractual relationship, the important role of the individual and how individuals interact with their situation was central to the conception of the research. This fits with a more interactionist view of interview data that: *"accounts are not simply representations of the world, they are part of the world they describe"*

(Hammersley and Atkinson 1983 p.107 quoted in Silverman 1993 p.95) and that interview accounts are both situated in context and "*compelling narratives*" rather than reports of any objective truth. In this case, interviews have given a snapshot of how people account for the contractual relationship being studied and in which they are active members. They are presenting their own interpretation, in interaction with the interviewer, not a report of an objective reality. The interactionist viewpoint furthermore stresses an interview as a social event – which must be interpreted in light of the people taking part, how they chose to interact and the context in which they were doing so:

" when we talk about the world that we live in, we engage in the activity of giving it a particular character...assign features and phenomena to it and make it out to work in a particular way...when we talk with someone else about the world, we take into account who the other is, what that other person could be presumed to know, "where" that other is in relation to ourself" (Baker 1982 quoted in Silverman 1993 p.86).

A recognition of the situated character of these interview data includes allowance for what would be considered a number of potential biases in a more positivist approach. These include 'response' and 'deference' effects where informants may tailor their responses to suit the interviewer or the identity of the interviewer influences the outcome of the interview. In this case, the interviewer's identity, as foreign, female, younger than most interviewees and non-medically trained, are potential factors to allow for in situating the interview data.

A number of techniques have been proposed to achieve 'quality' of research and analysis within a fallibilistic framework. Each of these and its limitations is described in turn. First is an attempt at *methodological triangulation*, or combining several methods to assess the phenomenon of interest. In this study, document review, interviews and observation all assessed different elements of the contractual relationship. Whilst document review revealed the "public face" of the system, interviews revealed the perceptions of those who took part in the contract and direct observation was able to show what the nature of service delivery and the attitude of the contracting parties was. There are weaknesses in triangulation however. First, the nature of triangulation available in this study design was not ideal precisely because these were different facets of the relationship accessed via

different methods. For instance, it was not possible to observe day to day interaction between purchaser and provider to triangulate findings on its nature from the interview data. Similarly, Seale (1999) and Silverman (1993) raise reservations about the use of triangulation in qualitative research, given that different methods and sources of data will tend to provide different sorts of insights rather than contribute to a single, accumulating picture. Second, this raises the question of how these different findings can be adjudicated between, once a recognition is made that none of them provides any guarantee to validity or representation of a single "truth".

The second technique proposed as useful for those working with a fallibilistic framework is *member validation*[11] but this was not deemed appropriate in these case studies due to the sensitive nature of the information which was given in confidential interviews, and the low chance of overstretched medical professionals and government officials being able to read and comment on the analysis.

The third technique is *deviant case analysis* or the search for negative instances in the data that help to guard against culpable error, arising from too great an attachment to the personal perspective or values of the individual researcher. Seale (1999) comments that:

"research is a process whereby the investigator should expect to change his or her mind about things which may currently be cherished, an event that is facilitated greatly if methods of data collection and analysis incorporate an active search for negative instances"(p.75).

The complexity of the data presented in this thesis provides a multitude of negative instances or deviant cases and these are an integral part of the overall analysis of the case studies.

Last some use of quantitative data is suggested by both Silverman (1993) and Seale (1999) to back up and give further form and shape to the picture arising from the interviews. This is done in all of the case studies by drawing on data from the broader research project, and also by using numerical frequencies to present some aspects of the interview data.

[11] The validation of the researcher's taxonomies and analysis with respondents

CHAPTER 4: BACKGROUND AND CONTEXT

Both the literature review and description of methods have noted the potentially important role played by context in the operation of health care contracts. The choice of a case study approach aimed to allow for this to be taken into account. This chapter gives some history and details of the context in which the contracts examined in this study were operating. It also highlights some of the historical factors which affect the current functioning and therefore capacity to contract of the South African government. Certainly for the PDS contract, which had been operating for several decades in an extremely complex and problematic political environment, it was likely that history and context would play a major role in explaining its current operation. For the other two contracts, which were newer and therefore less rich in the history and 'baggage' of their past, there was less of relevance.

None of what follows is intended to be a comprehensive review, but this chapter aims to provide some vital background and context to understanding the material presented from the case studies in chapters 5-8. The impact of apartheid on health service organisation and the huge task faced by South Africa's new government in overcoming the inequalities of the past, whilst faced with severe budgetary and human resource constraints, are discussed. South Africa's powerful private health sector and its predominance even at primary care level is described, as well as the government's ambivalent policy towards it, and some reasons for this. Last, some specific details about the history and context of each contract are given.

THE SOUTH AFRICAN CONTEXT

"for far too long this health system has been allowed to evolve along a path dictated by a combination of commercial interests and narrow, racial prejudice, and with every attempt to change it, we meet face to face with people who profited from this country's unsavoury past"
Chair of Portfolio Committee on Health (Gilson et al 1999 p.103)

This section briefly reviews the current context of health care delivery and health policy in South Africa, highlighting the organisational, financial and human legacy of the apartheid era, which has

left an under-resourced public sector struggling to meet the needs of the majority of the population, whilst the vast majority of resources for health care are engaged in a private sector which only serves a small portion of the population. The core context of this study is a public sector which cannot achieve adequate medical cover in many rural and per-urban areas without drawing on the private sector.

Separation and fragmentation dominate South Africa's history. The health sector is no exception. It is greatly affected by the country's past, from the way that services are organised to the way that people working in the health sector interact with each other. The PDS system in particular must be recognised in this context as a legacy of the "old" health system, but one which is still having to serve a role in the transforming health system. Some points are therefore particularly important for the context of the PDS contract. First is the continuing functional fragmentation of South African health services; second is the massive transformation that South African governance structures have had to undergo to redress the legacy of apartheid and the capacity problems associated with this; and third is the likely dynamics of a contractual relationship between an almost exclusively white group of doctors, many of whom rendered medico-legal services on behalf of the apartheid state, and the mainly black South African government, many of whom were detained by the same apartheid government.

LEGACY OF THE APARTHEID ERA

Between 1948 and 1994 South Africa was governed according to a policy of explicit racial discrimination. At the heart of the apartheid system lay four ideas (Thompson 1990), which determine many of the dynamics of post-apartheid South Africa. First, the population of South Africa was divided into four "racial groups" - White, Coloured, Indian and African. Second, whites were entitled to absolute control over the state. Third, white interests automatically gained precedence; the state was not obliged to provide equal facilities for all races. Fourth, the white racial group formed a single nation, with Afrikaans- and English- speaking components, while blacks were

forced to belong to several (eventually ten) distinct nations or so-called independent states - a formula which made the white nation the largest in the country in terms of geography and resources, but not population, of which they only represented approximately 12%. The legacy of apartheid is clear in all aspects of South African society. While its consequences have been most profound upon the welfare of individuals (including their health and education) there are also geographical and administrative factors which to this day shape the functioning of the new South African government and even a small feature of its administration such as the PDS system.

The organisational legacy of apartheid

During apartheid, state institutions were 'Afrikanerized', appointing Afrikaners to senior as well as junior positions in the civil service, army, police and state corporations. Medical and legal professional associations also came increasingly under Afrikaner control. Education policy was used to systematically disadvantage black South Africans. With the institution of the Bantu Education Act in 1953, government control of the quality of education for all racial groups was strengthened, resulting in expenditure ten times higher on the education of a white child than a black child (Thompson 1990). Segregation was imposed at all levels of education up to university. In 1980, 657 White, 52 African, 62 Indian and 18 Coloured medical students qualified as doctors (ibid).

At the same time, 'Grand Apartheid' in the form of "independent" or "self governing" homelands for black South Africans was established. The map of South Africa became increasingly confused, consisting of four provinces and eventually ten nominally or semi-independent "homelands". Often these "homelands" were not one consistent piece of land, but several poorer quality, scattered pieces of land amalgamated in name to make one territory. For instance, the homeland of Bophutatswana had nineteen fragments, some hundreds of miles apart (Thompson 1990). The establishment of "homelands" resulted in ten additional departments of health and a bewildering fragmentation of health services and authority structures (Van Rensburg and Harrison 1995).

The negotiated solution to the end of apartheid created nine new provincial governments out of the combination of the former Republic of South Africa and all of the "homelands". Provinces were faced with the task of amalgamating separate civil services from the old white provincial bureaucracies, whatever administrations may have existed for Indian and coloured people and the former "homelands", each of which had developed their own managerial styles and all of which lacked technical skills and professional integrity (Lodge 1999). The 18 health departments which existed in 1993 were streamlined into one national Department of Health and nine provincial health departments (Klugman and McIntyre 2000). Provincial health departments were also required to integrate staff from the former provincial administrations, the regional offices of the former Department of National Health and Population Development the former "homelands" (ibid). This meant that the health sector's problems all had to be addressed simultaneously with the challenges of creating, organising and staffing these nine new provincial structures. The example of the creation of the Northern Province demonstrates the sheer enormity of the administrative challenge, even before policy issues were tackled:

"the Northern Province.... is working to create a single health department out of five previous administrations. These include the former Department of National Health and Population Development, the previous Transvaal Provincial administration and the homeland health departments of Lebowa and Gazankulu and the once "independent" homeland of Venda" (Tollman and Rispel 1995)

The Eastern Cape province, one of the sites for this research, was formed by amalgamating the Eastern portion of the old Cape Province and its old administrative centre, Port Elizabeth, with the former "homelands" of the Ciskei (former capital Bisho) and the Transkei (former capital Umtata). The challenge of rapidly amalgamating these particularly disadvantaged former homelands' bureaucracies, each with its own managerial style and most of which were lacking in technical skills, management systems and professional integrity, was enormous (Gilson et al 1999). The Eastern Cape has struggled to overcome this challenge of amalgamation. Examples of problems that had to be tackled included the former Transkei's government accounts not having been audited since 1988 and a shortage of skills so extreme that it was estimated would require the recruitment of over 22,000

qualified personnel to make up the province's skills deficit (Lodge 1999). Capacity problems included poor information systems which even now have difficulty identifying the number of employees within the bureaucracy, and poor systems of financial control. For some provincial managers, getting even basic expenditure data is still problematic (Klugman and McIntyre 2000), and the lack of financial management capacity within health regions and districts has been noted in a number of reports in the past few years (Gilson et al 1997; Brijlal et al 1997, Makan et al 1997; Collins et al 1999; Engelbrecht 1999 all cited in Gilson et al 1999).

Transformation at provincial level impacted on the capacity and morale of South Africa's civil service, which in the health sector in turn influenced capacity to manage contractual relationships with the private sector, such as the PDS contract. In 1994 the public service employed 1.2 million people and accounted for 54% of the total government budget, excluding interest on government debt (Gilson et al 1999). At its inception, the new government faced the reform of a bloated public service which was sapping national resources and not delivering even the existing, racially biased services with anything approaching efficiency. This reform of the public service has itself run into numerous problems and has been acknowledged as not always effective. In 1999 a study found that "the system of governance in the new Republic of South Africa is in a number of crucial respects not working well at this stage of the transition process" (Gilson et al 1999). Lodge (1999) notes the huge and widespread shortages of technical and professional skills and the weaknesses of some administrative systems that new provinces had to inherit.

The new provincial structures also brought together competing political elites that still experience difficulties working with one another (Gilson et al 1999; Klugman and McIntyre 2000). In some cases, completely new people have been brought into senior positions, whilst in others many of the new positions were occupied by those who previously held positions in the old departments. The so-called 'Sunset Clauses' which protected the jobs of many old civil servants after the elections have further slowed down the pace of change within provincial bureaucracies. There is inevitable

suspicion on both sides, new and old, of the ability and motivations of the others. A review of health service organisation in 1995 muses of old civil servants re-appointed to new positions:

"They were responsible for implementing the fragmented centralised and discriminatory policies of the past.....only time will tell whether they will be able to rise above themselves and their history and boldly implement badly needed reforms" (Tollman and Rispel 1995)

whilst another study observes that:

"to some extent the barriers to collaboration in the restructuring process come from the difficulties of crossing the divides of the past. While few interviewees are willing to be explicit, it is clear that in many areas there is distrust across race lines" (Klugman and McIntyre 2000)

So called "old guard bureaucrats" were accused of being either apathetic towards change, or actively placing obstacles in the path of reform (Presidential Review Commission 1998 cited in Gilson et al 1999).

The financial legacy of apartheid

South Africa's new government also inherited a perilous financial situation in 1994. In response, the Department of Finance's current macro economic strategy, known as the Growth Employment and Redistribution strategy (GEAR), has the explicit objective of deficit reduction in order to improve business confidence and encourage foreign investment. Overall government spending limits are determined in a medium-term fiscal framework, which uses budget deficit and tax to GDP ratio targets set by GEAR (McIntyre et al 1999). In order to remain within these limits, the South African budget in real terms increased only marginally from R158 billion in 1995/6 to R160.9 billion in the 2000/01 budget (McIntyre, Baba and Makan 1998).

This means that the Department of Health was faced with the task of building up the capacity of public sector health services in the context of a budget that was shrinking in real per capita terms. Trends in real per capita provincial budgets for the two provinces focused on in this study are shown against the average for all provinces in the table below. In both the provinces focused on in the PDS case study, the decline has been considerable.

Table 4.1 Trends in real per capita provincial budgets 1995/6- 2000/01 (1995 Rand)

	1995/6	1996/7	1997/8	1998/9	1999/00	2000/01
Eastern Cape	2 149	2 500	2 183	1 879	1 734	1 651
Western Cape	2 257	2 415	2 281	1 958	1 744	1 642
Average for provincial budgets	**1 875**	**2 092**	**1 974**	**1 711**	**1 581**	**1 520**

Source: McIntyre, Baba and Makan 1998

Such a budget constraint has serious implications for the health budget. Whilst it is estimated that health will be consuming a slightly greater share of the total government budget (11%) in 2000/01 than in 1995/6 (10%), increases in the health budget have barely kept pace with population growth rates. There is evidence that within provincial health budgets a greater share of spending is being allocated to primary level services, although in both the Western and Eastern Cape provinces these relative shifts were insufficient to translate into real per capita increases in district health service budgets (McIntyre, Baba and Makan 1998).

Efforts to accommodate new policies while ensuring the continued provision of integrated primary care services (and other health services) of acceptable quality was particularly difficult in a context of static real health budgets. A study of the effect of transformation on the budgeting process quotes one regional manager:

"...80% of our money is tied in salaries. Another 10% is pharmaceutical services and sundries. ...at provincial level they ask what are your objectives for the year and to put money to your objectives but its hard to allocate money to these. Why are they bothering about the 6% of the budget we have manouvrability about and not asking about the 94%?" (Klugman and McIntyre 2000)

In the same study, some interviewees complained that their budgets were sometimes arbitrarily cut mid-way through the financial year. Such budgetary constraints are likely to have an impact on willingness to enter into contracts and the degree of flexibility there is to alter existing contracts.

The health sector legacy of apartheid

Apartheid health policy closely mirrored the ideology and social engineering of the white minority government. The health sector under apartheid was fragmented racially, geographically, and functionally; and a large, poorly controlled private sector was encouraged to develop in parallel. Services were concentrated in urban areas, and focused on curative, hospital-based, specialised care (Gilson et al 1999). For instance, in 1992/3 only 11% of public funds were spent on primary care delivered outside of the hospital setting (McIntyre et al 1995). Legislated racial discrimination and segregation affected not only the way in which health services were organised but also people's basic health, and the broader package of apartheid policies also contributed to inequity in health care use. McIntyre and Gilson (2000) show that health care utilisation patterns in South Africa were sensitive to race, household income level, employment status, education status, household environmental status, geographical area, and insurance status, rather than to health status. The only groups who achieved the target utilisation rate for primary care in South Africa of 3.74 visits per capita per year were the higher socio-economic groups and those with medical aid support (Gilson et al 1999).

A review of the management and organisation of the health sector in 1995 (Tollman and Rispel 1995) identified the following as particular legacies of apartheid health services:

1. The fragmentation of health services, with the former Department of National Health and Population Development having no authority over the ten "homeland" health services, which were in turn responsible for some 45% of the population. (In addition, there were approximately 400 local authorities involved in health service delivery (Klugman and McIntyre 2000)).
2. Highly centralised planning systems, both nationally and in the "homelands". Decision-making had been concentrated in a highly select group favoured by the prevailing political system.
3. Deliberate and long standing inequity in health investments. These favoured rural over urban areas, suburbs over townships, whites over blacks and the wealthy over the poor.
4. A large private sector, accounting for almost three fifths of total health care expenditure but used by only 23% of the population on a regular basis (McIntyre et al 1995). This sector employed

highly skilled medical and nursing personnel, trained in the public sector, while employers enjoyed tax rebates on their medical scheme contributions. The private sector was therefore benefiting from a major state subsidy.

THE HEALTH SECTOR AND PRIMARY CARE SERVICES

"South Africa has two parallel health systems - a system providing care for the poor majority, and a private system taking care of an affluent and /or employed minority" (Tollman and Rispel 1995)

The public sector

A key challenge faced by the public sector at all levels is the shortage of doctors, especially South African doctors, and the maldistribution of the existing limited number, who tend to cluster around large wealthy urban areas such as Cape Town or Johannesburg where the bulk of the medically insured population lives. The inequity between better off and worse off provinces is demonstrated by the difference between the two provinces examined in this research: the Eastern Cape had one doctor for every 3296 people and the Western Cape one for every 654, and the proportion of these doctors in private practice is estimated to be 58% and 81% respectively (Van Rensburg and Van Rensburg 2000). The government has adopted various strategies to overcome this shortage of doctors in key areas; first is the encouragement of a substantial influx of foreign doctors, in particular Cuban doctors on a country to country contract (20% of foreign doctors in South Africa are Cuban). Second is the introduction of compulsory community service for qualifying doctors who must now spend one year working in a public sector hospital before qualifying. In 1998/9, 45% of community service doctors were placed in either community health centres or district hospitals and visited outlying clinics regularly. Nevertheless the motivation to contract with the private sector remains strong, driven by the need to access the substantial human resources within it for the service of the public sector. This is particularly true in rural and peri-urban areas where it is most difficult to attract doctors into full time public sector employment.

Methods of primary care delivery vary from place to place, in particular between rural and urban areas and between former Republic of South Africa (RSA) and former homeland areas in South Africa. It is only in the former homelands that anything approaching a comprehensive model of primary health care (PHC) is well established. This is due to the existence of a split in service delivery in the former RSA between provincial administrations delivering curative services and local authorities delivering environmental and preventive health services established since 1910 (Naidoo 1997). This is still in place in many areas despite moves to establish a district health system delivering comprehensive primary care services under one roof. In areas where PDS traditionally operate, curative primary care would be their responsibility whilst local authority clinics delivered preventive care.

In President Mandela's first speech to parliament as President in May 1994 he made health care free for all pregnant woman and children under six. In April 1996 free primary care was extended for all South Africans without medical insurance. Both these policies were implemented with little warning for the health system. In both cases utilisation at public sector facilities rose rapidly, usually by between 20 and 60 percent, although it is unclear if these rapid increases were sustained across the country (Gilson et al 1999; McCoy 1996; Schneider et al 1997). The free care policies are also argued to have had unintended and negative effects on the quality of service provision. Concerns soon emerged that the system was unable to cope with the volume of demand. Overcrowded facilities, lengthy waiting periods, shortages of staff and drugs were all to some extent blamed on the new policy. Free health care also meant that the volume of patients attending PDS services rose dramatically - previously patients had been required to access the PDS via the magistrate and either pay R8 or get a certificate of indigence. This requirement was effectively removed by the introduction of free primary care services.

The private sector

Most health care professionals still work in the private sector, including the majority of general practitioners (GPs) (Tollman and Rispel 1995; McIntyre et al 1995) and the private sector cannot be ignored in any description of primary health care delivery in South Africa. In line with general apartheid policies to promote privatisation and service the interests of the elite, the private sector had been allowed to grow to substantial proportions by the mid-1990s (McIntyre et al 1995) and it is estimated to control over 60% of the health sector's resources. Its dynamism and sophistication allowed it to adapt to the changes in the market for private health care in South Africa in the last few years and are in startling contrast to South Africa's bureaucratic and somewhat archaic public sector.

The private sector offers the whole spectrum of primary care services. 1995 figures for expenditure on health care estimate that the private sector absorbed 61.1% of total health sector spending, and much of this is out of pocket expenditure at primary care level (McIntyre, Gilson, Valentine and Soderlund 1998). In the case of a key public health problem such as sexually transmitted infections (STIs), it has been estimated that private GPs in South Africa may treat more cases than are seen in the public sector (Schneider, Blaauw, Magongo and Khumalo 2000).

In urban areas there is typically a range of private GPs which are utilised as substitutes for or complements to public sector care by most income groups. The usual model for those without health insurance is to pay a flat fee for both a consultation and basic drugs. A new trend in urban areas are private clinics, such as those examined in the capitated private scheme case study, where patients pay a flat fee to be seen by a nurse clinician and where necessary a doctor, and to receive drugs. These clinics are strongly branded and are favoured by patients for their cleanliness, politeness and prompt service. In rural areas there are fewer doctors but they are more likely to practise in the private sector. They also provide care both to those with medical insurance and those paying a flat fee per consultation.

Private health insurance in South Africa has seen an explosion in costs since the mid 1980s. This has led to greater enthusiasm by employers for lower cost alternatives to provide cover for their workforce, encouraging the arrival of low cost insurance models based on managed care principles. For all levels of care, medical aid administrators have moved increasingly towards the use of contracts with provider groups which contain an element of risk-sharing as well greater reliance on the use of formularies and capitation payments to control costs. New chains of private clinics such as those described above (and used for the private capitated scheme case study) are moving into this market by offering, via medical aid schemes, low-cost capitated cover for primary care services. Medical aid administrators then purchase hospital cover in a similar manner from a different group of providers and create a comprehensive package of low cost cover to market to industrial companies for their workforce. Contracts often involve an element of risk-sharing by the primary care provider, who faces a penalty if too many patients are referred for hospital care.

Policy towards the private sector

One of the main points of contention in the discussions underlying the evolution of the African National Congress' (ANC) health policy in the 1980s and the early 1990s was the role of the private sector (Gilson et al 1999). At primary care level, the key issue was how to draw its plentiful human resources into the service of the public sector. Many commentators saw the central requirement of future financing policy as bridging the resource gap between the public and private sectors, for instance by using public funds to contract private providers. One commentator observed in 1994:

"The debates around the public/private mix in health care turn on whether one can counter the trend of decreasing equity and access to health care by drawing on financial resources currently being spent by the private sector through a national health insurance scheme, and by integrating private providers into the publicly financed health system" (Price 1994 p.50)

whilst others were more outspoken:

"It is imperative that private sector resources are made more available and accessible to the population as a whole. 62% of GPs are in private practice, and therefore accessible only to those with the ability to pay, they offer a prime resource to extend primary level care to the community at large" (Tollman and Rispel 1995)

The new Government was quick to acknowledge the importance of the primary health care approach and a district health system. At first this was combined explicitly with ideas of contracting with private providers, but both a lack of progress in developing this approach and an increasing reluctance to contract out clinical services to the private sector is noticeable.

Shortly after South Africa's first democratic elections, enthusiasm for contracts at primary care level was strong. In the draft policy for the establishment of a district health system (South Africa 1995b) it was suggested that district health authorities contract with individual or group private practices or NGOs. Several other policy documents in the mid 1990s, notably the report of the Committee of Inquiry into a National Health Insurance System, suggested using contracts to draw private practitioners into public sector PHC delivery (South Africa 1995). The Committee of Inquiry's report envisaged that ultimately there would be a complete purchaser-provider split, with accredited private providers competing with the public sector for contracts from public sector health authorities. These recommendations were incorporated into the White Paper on Health (South Africa, 1997). It stated that *"private health practitioners should be integrated with the public sector with regard to the provision and management of services*". However, very little progress has been made in this direction and more recent policy documents (South Africa 2000) suggest a more cautious approach. The most recent explicit statement on government policy towards public private partnerships appeared in late 1999, with a final draft released in March 2000. This report is the result of a task team established in the National Department of Health but also incorporating consultation with provincial officials. It shows that a quite clear shift has taken place in attitudes to public private partnerships (PPPs), placing a strong emphasis that they should:

"not limit the government's ability to guarantee public access to health care. The government must be able to provide, or guarantee provision of services to public patients and must be able to act as the insurer of last resort to private patients. At this stage, this means that the government would not wish to lose control of clinical services for public patients, since these are the core services. In future, however, it may be useful to review whether it may be able to control and guarantee such core services without necessarily being the provider"(ibid).

A dichotomy is apparent between the direction of earlier policy, and its slow implementation and growing scepticism of public private partnerships in more recent policy documents. At Provincial level, some frustration with mixed policy messages from the National department was expressed in the interviews with key informants:

(there are) *"great jumps from one policy to the other without having clarity or frameworks or anything"* Regional Manager

*"...On the one hand we are told to strengthen the public sector, get the referral system correct, but on the other hand if these people [*Accredited Private Providers*] can come in – how does that fit in? There were no examples of how it could work and we were extremely cautious of going that route."* Provincial manager

Several factors at both provincial and national level help to explain this lack of progress with tackling the issue of the private sector. These include an ambivalent attitude and occasional general hostility towards the private sector from some policy-makers, lack of capacity to write and manage contracts sufficient to control a highly sophisticated private sector, and budgetary constraints.

A general suspicion of the private sector has confused the formulation of policy towards it. One provincial manager tasked with a pilot of the accredited private provider system which did not materialise[12] explained:

"...within the group of my directors, my colleagues were ideologically against the private sector...they were outspoken against the private sector" Provincial Director

whilst other managers expressed the view that private doctors were:

"more interested in their incomes than the quality of care that they were providing" Regional Director

Post 1994 saw an influx of non-medically trained personnel into managerial positions and some policy-makers observed that there is a greater suspicion and hostility amongst non-medics to the idea of contracting with private providers. In the case of the PDS the following observation was also made:

"The district surgeons were the people who treated people in prisons – of which a lot were people of the struggle, people now in high positions so I think there is a stigma also to District Surgeons. I think that politically the whole environment was against them....The relationship was very poor to

[12] Following the report of the Committee of Inquity (1995) two provinces undertook to establish pilot schemes of Accredited Private Providers but no such schemes were ever established.

start off with. Because the PDS are chiefly male, white Afrikaaners who service the communities in the rural areas. They practice a back door front door[13] policy. There are allegations I have heard that they treated patients very poorly". Provincial Director

A further hindrance recognised at both national and provincial level is the issue of capacity to write and manage contracts. At the National Department of Health level one official was quite dismissive of some provinces' enthusiasm for the idea of trying to increase private sector participation, saying

"it's kind of like apple pie and motherhood...its just a good thing to do .....I don't think that they have thought it through logically". NDOH manager

and this lack of capacity for contracting is also acknowledged by some at provincial level:

"I don't think even in the province we have a person who would be able to really compile a contract" Provincial manager

Many provincial senior people commented that they thought that people were keen on the idea of contracting, its just that "*the nuts and bolts are more demanding than they realised*". Finally, one provincial director referred to 'corporate exhaustion' preventing them from making progress with accredited private providers whilst another observed:

"I think that generally people are quite open to the possibility of contracting. It's just that when you get into it it's a lot more, and sometimes it's easier to just run the service yourself".

The third hindrance to the development of contracts was budgetary. Many policy-makers interviewed expressed uncertainty regarding scope for contracting currently, given the budget constraints faced by the Department of Health. In particular, an intensive programme of clinic building has meant that the primary care budget has diminishing money for contracts and that the role for private providers within the system is increasingly unclear, although presently some clinics have neither staff nor drugs.

Other elements which would feed into the development of contracts, such as the definition of a standard package of primary care services have also been slow to be finalised[14], due mainly to a shortage of capacity. In addition, local government has been made constitutionally responsible for

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[13] A system where state patients enter the practice through the back door into a considerably inferior, separate waiting room and are seen in different consultation rooms, which are also usually much poorer quality than the private sector rooms.

delivering 'municipal health services' and this may include all primary care services. This would make local authorities the purchaser in any new contractual relationships but the policy is still mired in a lack of clarity over their specific role relative to other spheres of government, and uncertainty over what health services they are mandated to provide (Naidoo 1997; McCoy Buch and Palmer 2000). The operational status quo has therefore remained largely unchanged.

THE PART TIME DISTRICT SURGEONS (PDS) SYSTEM

In the case of towns where a PDS is working, the division of responsibility between clinic, hospital and PDS differs from town to town but is based along the following lines. The local authority or regional services council clinic in a town is responsible for delivering services such as ante-natal care, Family Planning, TB treatment and childhood preventive services. The PDS provides curative services and emergency care. His/her exact tasks will also reflect the capacity of the public sector services in a town. The PDS acts as a back up for sisters in local government clinics, usually doing sessions at some clinics as well as seeing referred patients at his practice. Referrals are also from PDS to clinic, with the PDS practice often referring TB and STIs to the local government clinic.

Policy on PDS since 1994

a) The De Villiers Report (1995)

Following the arrival of the new government, it was clear that the PDS system needed to be re-evaluated and brought into line with new policy initiatives such as the establishment of the district health system delivering comprehensive PHC. In 1995 the National Department of Health commissioned a report to prepare draft policy guidelines for reformed PDS services (De Villiers 1995). This report identified the following weaknesses with the current PDS system from the point of view of users, the Department of Health and the PDS themselves:

- Patients complained that the fragmentation of services caused them to be "shunted around" and that PDS did not have sufficient time to see to all their needs due to their huge workload.

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[14] Although an outline package was agreed in 1999.

- The Department of Health complained that the service was currently rendered outside of a comprehensive public sector health system, that there was inadequate monitoring and evaluation of service and that the PDS system used discriminatory practices (a type of back-door/front-door system with state patients often being seen in considerably less salubrious conditions than private patients in the adjoining room).
- PDS complained of having to be on duty 24 hours a day with no support from the primary care clinic, that there was a stigma attached to being the PDS which harmed their private practice, that they were required to provide all physical facilities at their own expense, that there was still major fragmentation in health services and that the remuneration system forced them to see patients very quickly and render a poorer quality service than would be possible if they were properly remunerated.

The report made a series of recommendations on how the PDS system should be transformed and brought in'o line with other ongoing policy reforms such as the establishment of a district health system and the recommendations of the Committee of Inquiry. Recommendations also included a name change, as the term district surgeon "has some negative associations" and the division of work into medico-legal and clinical functions. The newly titled 'Community or District Medical Officer/Practitioner' would have extended duties including:

- the rendering of comprehensive primary health care services including preventive, promotive, curative and rehabilitative services as envisaged in the district health plan
- training and support of primary health care practitioners
- certain public health functions where required (ibid)

It was also recommended that these posts must be advertised to all medical practitioners in a town, and that the duration of the PDS contract should be shortened. While it was recognised that PDS were reluctant to stop rendering services in their own rooms, the report recommended that:

- no discrimination must be allowed

- the service should form part of a comprehensive primary health care service rendered at district level
- the most feasible place for the service to be rendered, especially in the larger towns where practitioners from different practices will share the clinical functions, is the state health facility (ibid).

The report also observed that:

'continuing uncertainties amongst PDS regarding a new system are causing increasing discontent and a decline in morale and motivation..... The current fragmentation of health services continues to complicate the possible implementation of any new PDS system.'

However, it stopped short of making specific recommendations other than for discussion, or setting a time frame to the implementation of the type of new system that it recommended. It was concluded that 'a specific plan of action must be worked out and phased in' and that ideally this should be done at the National Department of Health level.

A pre-cursor to this report was a more detailed evaluation of the PDS system in the Western Cape (Western Cape District Surgeon Committee 1995). This report made more specific recommendations for the province regarding implementation of recommendations and time frames, and again stressed the importance of co-ordination with other policy implementation such as that of the Committee of Inquiry and the establishment of a District Health System. It was suggested that a phased approach to the new PDS system should be taken in the Western Cape, implementing it where a PDS resigned or was willing to change onto the new system. Those PDS who wished to continue functioning on the present system were to be allowed to continue for a two-year period. As with many of the others discussed above, the actual implementation of this policy has been slow and patchy. Over four years after the report was finalised, the majority of PDS in the Western Cape are still functioning on the "old" system, although they had been given a two-year notice period from December 1997. A

process of re-negotiation of contracts underway has been extremely slow and no PDS who wishes to remain in his post has had his contract removed.

b) Legal challenges to the contract: the Free State case

Provinces elsewhere in South Africa took a more abrupt approach to redefining the role of their PDS. At the end of 1996, as part of its restructuring towards a district health system, the Free State province gave three months notice to all its district surgeons. After consultation with the Medical Association of South Africa (MASA), some of these PDS decided to mount a legal challenge to this dismissal. The main question around which the case[15] revolved was whether PDS were independent contractors or employees of the province. The province claimed that the PDS were independent contract workers and that they were therefore not bound by the procedures laid out in the Labour Relations Act 1995 for a dismissal. MASA claimed on behalf of the PDS that they were employees of the State and as such their services could not be terminated summarily without following a fair procedure. The State, MASA claimed, was obliged to consult and negotiate with the doctors prior to terminating their services (Basson et al 1998).

The case was decided in favour of the Free State PDS, who were ruled by the court to be employees of the state. Arguments why the case went in their favour hinged around the following points (ibid):

- even though the doctors were professionals, the provincial administration did have some control over the way in which services were rendered
- the court viewed as 'neutral factors' the fact that the contracts could be terminated on three months' notice or on reaching the age of 65 years or summarily in certain circumstances; the provision for suspension or the holding of a disciplinary enquiry; and the non-membership of pension and medical aid schemes
- the dominant impression was therefore that the part-time district surgeons were more likely to be 'employees' as defined in the Labour Relations Act, 1995 as they had "placed their labour at the

[15] Medical Association of South Africa & Others v Minister of Health & Another (1997) 18 1LJ528

disposal of the Provincial Department of Health and the object of their relationship was the rendering of services rather than the end result of such services".

The fact that contracts were old, outdated and made provision for the payment of an annual honorarium were all elements which contributed to this judgement. The requirement on PDS to place their whole productive capacity at the disposal of the state ("*the district surgeon shall give preference to his official duties, except where serious emergencies occur in his private practice*") was also seen as suggesting the position of employees. This ruling in their favour meant that PDS were protected by the Labour Relations Act, which prevented them from being dismissed merely on notice and without reason. The Labour Relations Act specifies that the only reasons that employees can be dismissed are for misconduct, incapacity or because they are beyond operational requirements.

Despite the fact that the Free State province has subsequently terminated the contracts of all its remaining PDS (31 December 1998) in line with the Labour Relations Act's requirements (that the PDS were beyond operational requirements), this court case has affected the way that the PDS contract is viewed by other provinces, including the Western and Eastern Cape. It has contributed to the partial implementation of the recommendations of the De Villiers commission and the Western Cape District Surgeon Committee, due to concerns about the litigious inclinations of the PDS. Elements of confusion remain about the status of the PDS and the contract that they work under.

c) Policy to curb expenditure on PDS services

Before the introduction of free primary care services in 1996, PDS patients had been required to go via the magistrate in each town, where they either paid a fee of R8 or obtained a certificate of indigence. This acted as a barrier and a form of means testing, and reduced the risk to the province of too many patients attending PDS services. When primary care services were made free in 1996, the removal of this requirement meant that provinces faced an open-ended financial commitment to PDS, determined by how many patients chose to access their services.

In response, both the Eastern and Western Cape provinces brought in new ways to again limit access to PDS. From 1997, the Western Cape introduced a policy of "capping" expenditure on certain PDS practices. In a negotiated agreement with them, high volume practices were given a monthly payment limit beyond which they may not claim. This translated into an average number of patients per day and once a practice had gone beyond this they must either see patients without claiming payment from the province or tell them to come back the next day. In the practices reviewed in this study, this "capping" was in effect in two. In 1998, the Eastern Cape introduced a requirement that patients must attend the public sector clinic first to obtain a referral to the PDS and could not access PDS services directly.

THE LESOTHO CONTRACT

The Lesotho Highlands Water Project (LHWP) is a large civil engineering project based on an agreement between Lesotho and South Africa to construct a series of dams and tunnels for the transfer and sale of Lesotho's water to South Africa. The LHWP began in the 1980s and is now in its second phase. The historical context of the Lesotho contract is quite different from the South African cases, in that there is very little history relevant to what is a new, entirely commercial relationship, with a fixed time horizon. It has not been characterised by any contractual disputes or attempts to terminate the contract on the part of either party. However, geographic context is more relevant. Lesotho is a very mountainous and remote country, encircled by South Africa. Construction work for the LHWP takes place in the remote mountainous interior of Lesotho, which is bleak, cold and sparsely populated.

The project is governed by an international treaty signed between Lesotho and South Africa in 1986. In Lesotho the project's implementing authority is the Lesotho Highlands Development Authority (LHDA). The LHDA's mission is:

"*to efficiently and effectively implement and manage on a sustainable basis the Lesotho Highlands Water Project in accordance with the Treaty... to the benefit of the people, the environment and the economy of Lesotho*" (LHDA 1992)

Construction of the various parts of the project has been packaged up and put out to tender as different self-contained projects. A stipulation of all construction contracts has been that medical services must be supplied by the contractor to both the construction community and members of the local community who are resident in areas adjoining the construction site. LHDA adopted this policy for three reasons:

1. members of the local community are considered to be adversely affected by upheaval caused by the construction work of the LHWP and should be compensated
2. traditionally these communities have been remote, with poor access to health care facilities. The Government of Lesotho wished to used the opportunity of the LHWP to improve access to services for all its population.
3. the Environmental and Public Health Impact Assessment prior to the first phase of the project highlighted the adverse impact on health that the project would have; particularly it emphasised the effects of overcrowding, informal settlements and STIs on public health.

Public sector primary health care delivery in Lesotho is fairly typical of a poor rural African setting. Service provision is via a series of clinics which are not always open and characterised by frequent drug stock outs and low or non-existent staffing. The remote rural areas of Lesotho have no private sector allopathic medicine, although interestingly in urban Maseru the same trend is noticeable as in South Africa, with the opening of flat fee, branded private clinics such as those examined in the private capitated scheme contract.

In the case of LHDA's contract 129b, which is examined in this study, the engineering contractor sub-contracted the provision of medical services to a specialist for-profit health care company. Services required by the contract could be quite sophisticated, most importantly the running of 24 hour emergency medical cover and evacuation facilities was required. Sophisticated services have therefore been transposed onto a setting which is normally very poor in resources.

Whilst the Government of Lesotho suffers from more acute capacity problems than those described in South Africa, capacity within the bodies tasked to deal with contracting health for the LHWP is strong. The LHDA is a well resourced body supported by a combination of European Union, World Bank and bilateral donor funding and technical assistance, specifically focusing on areas such as contract writing. It employs a series of contracting experts, lawyers and engineers.

THE PRIVATE CAPITATED CONTRACT

The private capitated contract for primary care services, which is the third case study, is entirely within the private sector. A comprehensive package of primary care cover is offered by a single commercial company, via a medical scheme, to a range of industrial companies. Each company may have arrangements with several medical schemes to offer a variety of packages of health cover to their workers. The medical schemes' role is to package together alternative sources of cover for primary and hospital care to create comprehensive packages of cover. One of the options that they will offer is health cover at primary care level provided by this chain of clinics, in conjunction with hospital cover provided by different arrangements. When an industrial company elects to use this package, one of the contracts signed is a tripartite agreement between the industrial company, the commercial primary care provider and the medical scheme.

The commercial company offers a comprehensive set of primary care services in a number of clinics situated in low income, industrial settings throughout South Africa. All clinics offering services under this contract are part of the same company. The company was established in the mid 1990s to meet a perceived gap in the market for low cost, good quality private primary care services. Clinics are usually placed in busy parts of an urban area or near to industrial centres and factories. As with the Lesotho contract, there is very little relevant historical context to this contract, and government policy is of reduced importance because the contract lies entirely within the private sector. There is no history of legal disputes with any of the contracting parties. Also because the contract is within

the private sector, issues of weakness in public sector capacity are not relevant. How much capacity to devote to writing and supervising contracts is a commercial decision taken by both the purchaser and the provider, presumably according to the cost effectiveness of devoting resources to these activities.

The clinics all operate in a highly standardised manner, typically employing one doctor, two nurse clinicians and a number of "primary health care workers"[16] who are used to screen patients and take their vital signs before they are seen by a nurse or doctor. All staff in the clinics are paid on a salaried basis[17]. The company is run on a very strict system with strong, hierarchical, internal control. Each clinic has a full time manager and regular supervisory visits from an area manager, who is based at head office where he reports to an overall operations manager. The area manager typically has responsibility for four clinics, allowing quite a close degree of supervision. In addition to direct management supervision, each clinic is fitted with an extensive, specially designed computer system which is linked directly to head office, and all drugs are purchased and supplied according to a formulary common to the whole company.

As well as keeping control of finances, the computer system is used to control clinical practice. There is a computer terminal with a direct link to head office in each consulting booth and service providers are required to enter details of each patient as they see them. The computer then acts as an aid in diagnosis, and defines the prescription to be given for this diagnosis according to a set of over 2,000 primary care protocols contained within its programme. In effect this means that patients are being treated in a manner highly standardised and controlled by head office and variance in clinical practice according to the judgement of the service provider is much reduced. By weekly financial and clinical reports from the computer system, head office closely monitors the activities of each of the clinics.

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[16] employees without any formal medical training but who have undergone an in-house training programme in basic clinical skills such as taking blood pressure and testing urine

CONCLUSION

The importance of context generally, and different aspects of context (e.g. geography, history, capacity, policy) is likely to vary between the case studies. The PDS contract is particularly rich in relevant history and its current operation needs to be understood against this backdrop. In particular, this chapter has highlighted that the context in which this contract operates includes tension between the "old" and "new" South Africa which influences the attitudes of both parties to the contract, as well as having implications for the capacity of government. Budgetary constraints have also impacted on the attitude towards contracts for primary care in South Africa more generally. The Department of Health is faced with a legacy of fragmented services, inequity and a weak public sector human resource base which leads them to have to depend on the stronger private sector to meet the demands of even basic service provision in some rural areas. All these factors contribute to an ambivalent and rather suspicious atmosphere between public and private sectors at primary care level.

Both the Lesotho and private capitated contracts have less of a history, but in the case of Lesotho the geographical setting of service delivery is clearly an important and unique factor. In the case of the private capitated contract the recent growth of demand for private sector low cost primary care delivery and the context of strong internal control in which service delivery takes place in this company, as well as its setting in urban densely populated areas, must all be taken into account.

[17] with the exception of two clinics where the doctor is running his own private practice as a franchise for the commercial company

CHAPTER 5: ENVIRONMENTAL FACTORS AND THE OPERATION OF THE PDS CONTRACT

FORMAT OF THE CASE STUDIES : CONTENTS OF CHAPTERS 5-8

Chapters 5-7 present aspects of the PDS case study and in chapter 8 evidence from the Lesotho and private capitated scheme contract is explored. In line with the research questions highlighted in chapter 3 and figure 3.1 (adapted below to figure 5.1), each of the chapters addresses the following issues:

Chapter 5 - Environmental factors and the operation of the PDS contract

Chapter 6 - The PDS contract: award process and design

Chapter 7 - The contractual outcome : operation of an incomplete contract

Chapter 8 - Contracting experiences: the cases of Lesotho and a private capitated scheme

In the adapted version of figure 3.1 shown below, the way in which each of the issues identified is addressed in the following chapters is indicated:

Table 5.1: Map of results chapters 5-8

Influences on nature of the contractual relationship	PDS case study	Other case studies
1. Contextual factors • environmental (nature of market, capacity, type of service) • human/individual (nature of provider and purchaser, motivations of provider)	Chapter 5	Chapter 8
2. Degree of asymmetries of information (information systems, capacity to monitor, degree of opportunism of providers)	Chapters 5 & 7	Chapter 8
3. Contract design and award process	Chapter 6	Chapter 8
--> Nature of the contractual relationship		
What appear to be the mechanisms (either within a written contract or external to it) which hold the relationship together and influence the performance of the provider? How does the contract operate?	Chapter 7	Chapter 8
Under what conditions are different types of contractual form appropriate and desirable?	Chapters 9 and 10	

ENVIRONMENTAL FACTORS

The impact of contracts needs to be understood within the total institutional context within which they operate. Walsh et al (1997) observed that:

"a key feature of the external context will be the nature of the market, notably the degree of competition and the rate of change and stability....the nature of the service will have a key influence, through the impact on the degree to which the service can be specified, and the ease with which performance can be monitored".

This chapter describes these and other types of external influences as they impact upon the PDS contract. The term "environmental" is used here in the sense that these factors are "givens", at least in the short term, they are not defined by the type of contract chosen or how it is operated, whilst they may be influential in both these things.

The table below outlines the environmental factors which arose from the case study as potential influences on the way in which the contract was likely to operate. Each is then discussed in turn. At the end of the chapter, the role of asymmetries of information, which run through several of the factors described below, is discussed. The degree of existing trust within the contract, or more broadly in the contracting environment, should also be acknowledged as an important environmental factor which will underlie and influence the nature of the contract. It is however difficult to separate out different aspects of trust, for instance, what is of a historical or environmental nature and what is a manifestation of the condition of the current contractual relationship. All aspects of the role of trust in this case study are therefore dealt with in chapter 7.

Table 5.2 Environmental factors potentially influential on the nature of the PDS contract

Environmental Factor	Aspects potentially influential on nature of the contract	Direction of likely influence
Nature of the service to be contracted	1) Ease with which the boundaries or requirements of the task to be contracted can be defined 2) Asset specificity	More difficulties in specifying contract likely to lead to more incomplete, relational contracts. Greater asset specificity is likely to lead to more relational contracts.
Nature of the market in which service to be contracted	1) degree of current competition 2) barriers to exit and entry 3) existing substitutes for service 4) potential substitutes for service	Low competition, high barriers to entry to market, few substitutes (existing or potential) likely to make contracts more relational.
Capacity of purchaser	1) financial and administrative systems 2) resources- human and other	Shortage of capacity may lead to poorly specified or monitored contracts.
Human/ organisational context of contracts	Motivation of providers	Depending on importance of role of individual in defining nature of contract, their motivation will influence nature of service delivery. Hierarchical controls in companies may also influence this.
Cross Cutting Factors: *Asymmetries of information*	Combination of capacity, nature of service and motivation of provider	As asymmetries of information increase, the role of relational and trust based contracting becomes correspondingly more important.
Degree of trust existing in contractual setting	Trust between purchaser and provider arising from history of contract and context of contract	Existing trust or lack of trust influences environment in which any type of contract will operate.

NATURE OF THE SERVICE

Key dimensions of the nature of the service to be contracted for are the degree of asset specificity, and the degree to which the services required can be clearly foreseen and specified in a contract. Asset specificity is important as a determinant of the nature of the market (which is examined in greater detail in the next section) whilst the degree to which the boundaries of a service can be adequately defined and specified is important as a determinant of how easy contracts are to specify and whether they will tend to be complete or incomplete.

For the PDS contract, the issue of how easily a service can be adequately defined in a contract is examined via dimensions such as 1) whether all the factors that will influence the type of service to be required can be either foreseen in the contract or controlled by it, 2) whether this service can be adequately defined and specified separately from other inputs that would be required to deliver the

service successfully, 3) whether given any level of time or expertise it is possible to draft a fully comprehensive contract for the service (e.g. there is no uncertainty).

Asset specificity

Asset specificity reduces the competitiveness of the market by increasing the reliance of purchaser and provider on one another. Williamson (1975) identified four types of asset specificity - site specificity, physical asset specificity, human asset specificity and dedicated assets. PDS services are extremely site specific. They also require some degree of human asset specificity as the holder of the contract must be medically trained. Other skills are required which are specific to the PDS work, although these can be learnt relatively easily by any medical practitioner as long as there is time available. Physical asset requirements to hold the PDS contract are not high, and they are complementary to the assets private GPs must anyway possess to run a private practice.

Defining boundaries of the task

The nature of the service to be contracted to PDS is not easy to define absolutely. Whilst the services contracted out are only a part of all primary care services being delivered by the government, the overall responsibility that accompanies the role of PDS is large. South Africa has not yet corrected the historical division between the delivery of curative and preventive primary care services, so PDS form part of a highly fragmented system of PHC delivery, rarely being responsible for the delivery of all primary care services in a town. Nevertheless, the nature of the service which they are contracted to provide is diverse, consisting of:

- curative primary care services
- 24 hour emergency medical cover
- medico-legal duties
- ex officio duties

The requirement to be on call 24 hours a day led to a sense amongst the PDS interviewed of being ultimately responsible for all medical services:

"anything which is in the medical field has to be serviced by me, it has to be done, it doesn't matter what it is. Even if the ambulance isn't available, you have to make a plan. If there isn't a health care worker or the clinic sister has left, then its your responsibility" PDS, Western Cape

There are several instances where roles are likely to overlap or be confused between the PDS and the public sector. Many PDS are also the medical superintendents of the hospital in their town, or one of the part time medical officers at the hospital. In such cases they provide a continuum of services, from primary to hospital care. It becomes difficult to distinguish between what services are being delivered under the PDS contract and under other contracts with the state:

"a lot of the DS are also the medical superintendents of the hospitals where they are, and they are also the part time medical officers at the hospitals. So they run a continuum, from primary care they run the patient right through the system"
Regional Manager, Western Cape

Responsibilities are also likely to overlap and be confused between the doctor as PDS, Medical Officer or Medical Superintendent at the hospital.

Defining the requirements of the task

Three dimensions were suggested above as determining how easily a service can be adequately defined in a contract. Drawing on the context of this contract described in Chapter 4, each of these dimensions is examined with reference to the PDS contract.

1) *whether all factors that will influence the type of service to be required can be either foreseen in the contract or controlled by it* - the type of service required can be broken down into WHAT services are to be delivered and TO WHOM they should be delivered. At a macro level both of these factors are determined by policy and are subject to change which the contract cannot control. For instance, the removal of user fees for primary care services in 1996 led to a massive increase in the demand for PDS services throughout the country. On a more micro level, the time, place and nature of some of the services to be demanded cannot be determined because they are in response to emergency events or forensic work. Even the nature of standard primary care services that will be demanded is difficult to predict or control.

2) *whether that service can be adequately defined and specified separately from other inputs that would be required to deliver the service successfully* - the PDS services form part of the broader health system and rely on the functioning of other facilities such as clinics and hospitals within their referral network as well as services such as drug supplies and ambulance services. The operation of the PDS service is integrally linked to what is happening in these other parts of the health system, which means that their service must always be defined in the context of what is happening in the broader health system.

3) *whether given appropriate time or expertise it is possible to draft a fully comprehensive contract for the service* - as well as inputs, a comprehensive contract would describe what is to happen in each eventuality, methods of service delivery to be used and the outcomes desired. PDS services do not lend themselves to such specification for three reasons. First is the broad nature of the service to be delivered and the uncertainty of what will be required. Second is the inherent problem in comprehensively specifying how any form of medical service is to be delivered, but especially one as broad as primary care and in a situation where the circumstances of service delivery in each case are unknown. Third is the problem of uncertainty in linking services delivered to outcome in any health care setting.

NATURE OF THE MARKET

"one... big problem is whether you have only one doctor in the town, that's a big factor. ... the presence or absence of a hospital is another one. The presence or absence of more doctors (is another), because the big issue is that you have got no market competition and you have not got enough private work to keep the doctor. So the doctor in X [town]. *would not be in X. for private reasons. If he had to depend on private practice he would not be (there)....and of course it's also inconvenient to be in a small town. So we have got to compensate for that type of situation.....and if we press him too hard and he leaves, that is the end of medical care in that town..."*
Regional Manager, Western Cape

The nature of the market in which contracting takes place is a second key influence on the likely nature of the contractual relationship. The nature of the market will influence the degree of competition, the frequency of interaction between purchaser and provider, the history of their

interaction and the likelihood of continued interaction in the future. These all combine to determine the degree of dependence or competition which characterises the relationship. In turn, the degree of dependence between purchaser and provider is likely to influence the nature of their interaction under any contract, both in terms of their willingness to co-operate and their willingness to exit from the relationship. In situations where either or both parties to a contract are unwilling or unable to exit from a contractual relationship, it takes on a very different character from the shorter term, voluntary contracts likely to arise in a highly competitive market.

Indicators of the nature of the market examined below include the number of potential alternative providers, barriers to exit and entry of the market and the existence of real or potential substitutes for the services of a provider. Relevant factors for each town are summarised in table 5.3.

Table 5.3 Nature of market in PDS towns included in the case study

Practice	Number of doctors in PDS practice	Other practices in town? (Number)	Other doctors visit from neighbouring town?	Total number of doctors based in the town	Is there a hospital? How dependent on PDS doctors is it?
A - E Cape	3	No	Yes, part-time	3	Yes. 100% dependent
B - E Cape	5	No	No	5	Yes. 100% dependent
C - E Cape	1	No	No	1	Yes. 100% dependent
D - E Cape	1	No	No	1	Yes. 100% dependent
E - E Cape	3	No	Yes, part-time	3	No. PDS doctors must provide all after hours cover
F - E Cape	2	Yes, (2)	No	6	Yes. All doctors in town do sessions at the hospital
G - W Cape	1	No	No	1	Yes. 100%
H - W Cape	2	No	No	2	No. PDS doctors must provider all after hours cover.
J- W Cape	4	Yes, (2)	No	12	Yes. All doctors in town do sessions at the hospital.
K- W Cape	4	Yes, (1)	No	6	Yes. All doctors in town do sessions at the hospital
L - W Cape	2	Yes	No	not sure	Yes. All doctors in town do sessions at the hospital

Current competition

"... you must remember that with a lot of these [PDS] *we don't have options. It's not as if we have got 10 practices or 50 doctors where you say "you are not performing" and get somebody else. That is why most of the contracts in the rural areas just carry on."* Regional Manager, Western Cape

Of the 11 towns visited for the PDS case study, four had other doctors/practices resident who might potentially compete for the PDS contract, although it is not clear that they would want to. Two more towns had doctors who were resident elsewhere but visited the town regularly to see private patients, but these were unlikely to be viable alternatives to a resident PDS.

Contestability of the market - barriers to entry

The second factor which influences the degree of competition in a market is its contestability or the threat of other providers moving into the market. For PDS services, each of the towns included in this study resembled a separate market due to the distance to access health care in another town. There is little movement of doctors in and out of towns, and especially not where they are likely to face competition. Barriers to entry appear to fall into three categories:

- strategic behaviour by doctors already in the town to prevent a potential income for a second doctor/practice to enter their town
- reluctance by doctors to incur costs and disruption of moving to a new market when they are unsure of the income that it will offer
- reluctance of many doctors to become involved in PDS work, although there is some evidence that this situation is changing.

The market in each town appears to be quite aggressively guarded by its resident doctors, who see it very much as *"their patch"*, using phrases about other doctors such as *"he came and squatted here"*. They talked quite strategically about how they saw the market for their services in their town, and ways in which they might prevent other doctors entering the market:

"the reason that we kept it (the PDS work) in the practice was there was always just enough money in it to allow another practice to start up. So another doctor could move into town and if he gets the district surgeoncy, with his hospital job, other little jobs, then you could have two chaps working in opposition" PDS, Western Cape

Such blocking of access to a newcomer GP is made particularly easy by the 24 hour nature of the care which must be offered by a GP in a rural town:

"there is Dr X from Y. He came and squatted here about two years ago. He doesn't live here..... (but) he applied for permission to admit patients to hospital. We said no problem at all but the Medical Superintendent just insisted on a letter from this guy saying that he would give a 24 hours service, as he stays elsewhere. In other words that he doesn't admit patients and then we end up dealing with the emergencies . He never answered that letter...." PDS, Eastern Cape

The second type of barrier is due to the specific location of PDS work and its 24 hour nature. To successfully break into any town's market, the doctor must become resident:

"I have advertised for a partner...no one is interested to come because the contract is so temporary. You have to move house, buy a bakkie[18] etc....no one else wants to come here! Those who would want to come want a fixed income" PDS, Eastern Cape

In addition moving to a new town means building up a new private practice which is risky:

" it takes you 3 years to really build up a practice. The people [patients] *leave you and they still think of the old doctor so it still takes you about 3 years"* PDS, Western Cape

Such investment in re-establishing a practice suggests the need for a secure market to encourage doctors to take that risk; but by definition anywhere to which a doctor would move to increase competition will not be a secure market.

Asked about alternatives to his services, one PDS commented:

"you won't get a doctor in this practice again, because there is no private practice....if I go there is nothing that I can sell a guy...So I am sure that I will be the last private doctor in this town. There won't be another one." PDS, Western Cape

A further barrier to entry into the market is the need to be familiar with PDS work and to be willing to put up with its long hours and stressful nature, a point related to the human asset specificity discussed in the previous section:

"you also learn from years of dealing with the state that there are certain things that you can expect and certain things that you can't and you grow used to that.... the state doesn't always supply the best.... So the one problem the state would have if they would for instance drop us and take on another private practice, is that that other practice's doctors are not used to working with the state, I mean you sort of learn to do that." PDS, Western Cape

[18] Four wheel drive utility vehicle

Reluctance to get involved in PDS work is a related issue. Not all private doctors wish to compete for PDS work. In one town the PDS described how the other practice in town had previous experience with PDS work and had tried to take it on again:

"After 3 months they decided that they didn't want to do it anymore; it wasn't worth the income and they were losing private patients from their surgery because of the state patients turning up there"
PDS, Eastern Cape

This was echoed in another town in the Western Cape, which despite having 12 doctors, caused problems for the Province in replacing the recently retired PDS. The new practice which had taken on the contract commented that none of the other practices would do so. In a second town in the Western Cape the PDS described how before he took the contract the province had had to move a doctor up from Cape Town to cover the town:

"because nobody was interested in the job. There were doctors here but not interested"
PDS, Western Cape

This is partly due to the nature of the work, described by one regional manager as:

"blood and gore every Friday and Saturday night, people screaming through the window to come and help...it's extremely unpleasant" Regional Manager, Western Cape

Private practitioners are also reluctant to take on PDS work because they see a stigma attached to being the "state doctor" and this undermines their private practice. If they have a thriving practice they can also probably match the income from a PDS by seeing private patients, likely to be a less stressful and more easily controlled way of making a living:

".... in the towns where we have a reasonably high income group, the doctors are not really much interested in the PDS work.... because their private practices are so big that that is taking virtually all their time." Regional Manager, Eastern Cape

However, evidence from some towns, mainly in the Western Cape, suggest that this situation may be changing and that as private practice comes under greater pressure, PDS or any state work starts to look relatively more attractive. Several interviewees stressed the difficulties faced by private GPs in what is becoming an overly competitive market, leading them to become more interested in state work:

"things have changed lately....look at a place like V., nobody was interested in doing it now everybody wants to do it" PDS, Western Cape

This view was echoed by two of the three regional managers interviewed in the Western Cape:

"Private sector has reached saturation point in terms of the doctors that it can accommodate, so some doctors today are actually looking for another career in the public service"
Regional manager, Western Cape

"If you take the income that a doctor like X generates ....it is higher than he would get if he had a private practice in the city..... the private sector is quite over supplied in the cities and so a lot of private doctors in the cities are not earning a lot of money.....they don't earn as well as if they were a PDS in the rural towns". Regional Manager, Western Cape

To conclude, barriers to entry therefore exist both on the side of existing doctors blocking access to 'their' market and the reluctance of potential market entrants to uproot themselves to move to a potentially insecure market. There is also a reluctance by doctors with more successful private practices to get involved in PDS work, although this situation may be changing. Recognising considerable differences in this set of factors from case to case is important as the situation differed from town to town and doctor to doctor. However, overall there appeared to be little fluidity in the market described here, with difficulties for the free flow of capital or human resources in and out of the market represented by each individual town. As a result in most cases there is neither a high degree of existing competition nor the likelihood of new service providers easily entering the market.

Barriers to exit

Many of the factors described as barriers to entry were also barriers to exit - doctors were reluctant to leave a town where they have been established for a long time and face the risky prospect of establishing a new practice elsewhere. Fierce competition amongst private GPs in urban areas makes leaving PDS work for the city an unattractive prospect, and there are likely to be relatively few untapped markets in rural areas on account of the intense competition between GPs elsewhere.

Substitutes for the services of the PDS

Substitutes for PDS services would increase the competitiveness of the market by allowing the purchaser to replace a PDS with another service or combination of services. This section examines first the possibility of substitutes already in existence in each town and then possible alternatives to a PDS which could be introduced.

a) Existing substitutes

PDS contracts cover a range of services, so it is necessary to consider what services need to be substituted. Partly it is the services of a doctor (for which the only substitute is another doctor); but in many towns it is also 24 hour emergency cover (for which the substitute most obvious is a hospital) and delivery of standard primary care services (in which case the substitute could be a primary care clinic). It is likely that the availability of each of these substitutes will be influenced by different factors.

.....for the service of a doctor

The degree of existing competition between private doctors to deliver PDS services has already been described. A final substitute for a doctor's services would be state employed medical officers but posts for full time state employment do not exist in all small towns and where they do they are usually vacant, given the shortage of doctors working in the public sector and reluctance to move to rural towns. There are several potential policies to counteract this lack of public sector doctors in rural areas, these are examined in the section below on potential substitutes.

....for after hours/emergency care

Replacing key parts of the PDS service by sending patients to a hospital is dependent upon two factors:

1. that there is a hospital in the town, or that the Provincial Department of Health (PDOH) is willing to tell the community that they must travel to another town;

2. that the running of the hospital is not entirely or largely dependent on the same doctor as has the PDS contract as he/she cannot function as a substitute for themselves.

Table 5.3 reported how many of the towns included in this study had hospitals, and how much these hospitals were dependent on the same doctors as held the PDS contract. Two towns did not have a hospital and here the PDS was the only possible provider of 24 hours emergency care, i.e. there existed no substitutes, other than the province telling patients to travel to another town, a policy which has its own attendant difficulties. In five more towns the PDS practice were the only doctors running the hospital and were therefore also the only potential providers of 24 hour/emergency care. In the remaining 4 towns, the hospital was run by all doctors in the town on a sessional basis, therefore suggesting some basic element of competition in the provision of doctor cover for 24 emergency care. Here the province could at least in theory substitute part of the service offered by the PDS practice by referring patients to the hospital for after hours care, although the capacity of the hospital and other doctors to deal with this on top of existing work is an issue.

.....for primary care services

Primary care services delivered in a clinic by a nurse clinician is the most promising substitute for PDS services, as well as being the one most clearly preferred by government policy (South Africa 1995; 1995b; 1997). In all towns there are a combination of district council and/or provincial clinics offering a range of PHC services, often more comprehensively than many PDS practices although in some of the towns visited there was still a problem with some clinics not having nurse clinicians and therefore having to refer all patients in need of prescriptions classified above a certain level to the PDS .

However the clinic is less promising as a substitute for after hours emergency cover, due to restricted opening hours and the reluctance of staff:

"…. the primary care nurse and the primary care clinic have got a tendency to start at 9.30am and knock off at 3.30pm and what then? They are not prepared to do the after hours"
PDS, Western Cape

and cannot be substitutes where the services of a doctor are needed. Many PDS interviewed expressed scepticism about the ability of clinics to deliver primary care services adequately:

"the clinic system is simply not up to handling it... and the hospital isn't either because there aren't enough doctors there. So I see their alternative if we didn't want to do the job as having to put 2 or 3 permanent medical officers in the hospital"
"and how easy would that be[19]?"
"not easy!"
PDS, Western Cape

Regardless of the ability of primary care clinics to deliver, this demonstrates that most PDS do not see clinics as a viable alternative to their services and as such do not perceive them as a threat. In this sense, clinics are unlikely to increase the competitive pressure on PDS. Many clinics are overloaded and understaffed and unable to take on more work deferred from the PDS practice unless they are given more resources. For instance in one town, the clinic was the principal opponent of the idea of devolving all chronic patients from the PDS to the clinic, on the grounds that they did not have the capacity to see the new patients. In another case, the PDS described how he resented being made to be what he termed the primary care "gate" and had asked the PDOH when he took on the contract to put in some process of patient screening:

"the municipality and the Regional Services Council just simply stated 'we do not have the staff to sift 100-120 people a day'. I do understand that" PDS, Western Cape

In a town in the Western Cape with only one doctor and one clinic the PDS describes:

"the clinic isn't open after hours, it's not open on Fridays or on Saturdays or Sundays. In the past, if they go on leave for the whole December holidays it was closed. They just come here and bring a box of stuff and say 'will you look after the patients please?'" PDS, Western Cape

In addition, despite it being clear government policy, most patients and even some policy-makers are reluctant to see primary care clinics as a replacement for the services of a PDS. Community opinions on this were clearly expressed in the focus groups and show how difficult it is for the Department of

[19] Questions by interviewer are shown in bold throughout the text

Health to manage the expectations of patients away from the immediate access to a doctor that the PDS system has traditionally represented. This would take a concerted effort which has so far been lacking due to confusion over policy towards PDS services. Comments about the clinic system by service users in focus groups included:

" I am not even sure some nurses know how to read BP"/ "Since when is a nurse a doctor?"/ "the clinic is for babies, pregnant women and TB"/ "You can't really go if you are sick because there are no doctors"/ " I don't think that the clinic is equipped to deal with chronic illness"/ "its just for children and TB and diabetics"/ "if you go there, they just refer you anyway"/ "its best to go to the doctor, then you know that you will get medicines and tablets"/ "I don't think the clinic is much help, because in an emergency you will probably die first".

b) Potential substitutes

Regional managers and PDS doctors were all asked what they viewed as the most likely alternative for PDS services were these to come to an end. Their reactions were rooted in whether they believed that the regional or provincial DOH were willing to leave a town without cover by a doctor.

.....PDS in a neighbouring town

Many PDS knew of towns that have now been left without a doctor following the resignation of their PDS. Sometimes these were covered by PDS in neighbouring towns. This was not viewed as a politically desirable solution, but nevertheless one quite commonly resorted to, which demonstrated the scarcity of other practical substitutes for the services of PDS. When this system broke down, towns were left without cover. One PDS in the Eastern Cape described what they thought the response to their resignation from the DOH would be:

"they would say that they have an emergency room in X (approx. 50km) and that people must go there" PDS, Eastern Cape

Another said that he felt if he said:

" 'if you don't pay me more, I will leave' the DOH would respond 'OK, tough luck' - another town without a doctor"

....Cuban doctors

In the Eastern Cape, where there are many Cuban doctors already working, the possibility of using them to replace PDS was raised by both PDS and policy-makers but doubts were expressed as to how effective they would be working alone as community doctors as well as problems of communication, especially in areas that spoke mainly Afrikaans, where foreign doctors would struggle even with English:

"you must also remember that the amount of English being spoken here is about equivalent to the amount of Russian. Even if you speak English here, people don't understand" PDS, Western Cape

....Community Service Doctors (CSDs)

These newly qualified doctors doing a compulsory year's service in the public sector were also mentioned as potential substitutes for PDS. This is a relatively new scheme (legislation was passed in 1997 and the scheme commenced in 1998) and one regional manager clearly felt that it would change the dynamics of their relationship with PDS:

"now they know that the days when we had to fall on our knees and look for doctors are gone. This province had 220 applications for community service and so we will be able to fill our posts." Regional manager, Western Cape

However, other regional managers and PDS expressed concern about the level of supervision that CSDs needed and how that could be delivered in rural towns without another doctor. The likelihood of CSDs to stay in rural areas beyond their one year of duty was also questioned, meaning that expertise would constantly have to be rebuilt.

In the case of both Cubans and CSDs there were also concerns that there was a shortage of both types of resource and that there may not be enough to cover all the rural towns currently covered by the PDS system.

In conclusion, the market examined here has two key features. First, it is very segmented and highly varied. Each town represents a different flavour of the interplay between factors such as competition between doctors and the presence of a hospital. Second, most towns visited displayed an interesting combination of market power and dependence for both PDS and the DOH. For instance, many doctors enjoyed a strong degree of market power but also often a high degree of dependence on state work to provide income vital to their livelihood. Factors contributing to this situation of bilateral monopoly are that doctors tend not to move often between towns and when they do move they will tend to choose a new town with little competition. A further factor constraining competition is that the pool of doctors keen to become involved in providing primary care services for the state is only a proportion of all rural doctors. Last, whilst there do exist substitutes for all the services provided by PDS doctors, achieving the full combination of services which they offer by other means is not easy. Therefore many aspects of the market described do not resemble aspects of a competitive market. This is demonstrated by the attitude of one regional manager's description of their choice to take action against a doctor in breach of contract:

" Well it depends entirely on what is left over in the town. If there was just one single doctor then obviously we would at first try and convince him to stop it.
So the way that you exercise penalties against them depends on who they are and where they are?
unfortunately yes"
Regional Manager, Western Cape

GOVERNMENT CAPACITY TO WRITE AND MANAGE CONTRACTS

The capacity of the purchaser to write and manage contracts adequately is likely to influence the manner in which contracting can be approached. Poor capacity to write, monitor, manage and enforce contracts will lessen the ability of the purchaser to use specifications in a written contract as a tool to control the contractual relationship and this will make them more reliant on a relational form of contracting. Indicators of this type of capacity include the number of people available to manage contracts and their level of expertise as well as what financial and administrative systems are in place for managing contracts. Administrative capacity is needed in terms of expertise for policy formulation, contract letting and design and monitoring and enforcement of contracts as well as

adequate financial systems to process payments on time and financial capacity to pay for the services contracted out. Last, basic resources such as transport, telephones and computers are needed to facilitate the process of monitoring and communication with providers. Capacity problems faced by the South African government and their underlying causes have already been highlighted in the description of the organisational and financial legacy of apartheid in the previous chapter.

Financial and administrative systems

"we need an extra pair of hands before we can do the administration here"
Regional Manager, Eastern Cape

As was described in the previous chapter, South Africa's current provincial governments were formed following the 1994 elections and many government systems and policies are still in the process of being established. In this case study of two provinces there were marked differences in their respective levels of capacity. Whilst the Western Cape province was formed from a portion of the former well-resourced Cape Province and has maintained its administrative capital, Cape Town, the Eastern Cape was amalgamated from parts of the former Cape Province and the former homelands of the Transkei and Ciskei. The Eastern Cape therefore faced a harder task in establishing its administrative and financial systems, having to integrate the rump of the Western Cape bureaucracy and two additional more poorly resourced bureaucracies. In addition, the Eastern Cape did not inherit many of the core administrative units and skills necessary for it to function successfully in the new federal system.

The difference in financial and administrative capacity between the two provinces is demonstrated by the Western Cape's reliance on a computer system to monitor and process the claims of their PDS whilst the Eastern Cape still relies on forms to be filled out by the PDS and then checked by hand. The Western Cape has been able to both afford and administer the design of a computer programme specific to the PDS system, as well as the purchase and installation of computers for each PDS practice. As will be shown in Chapter 7, this computer system plays a key role in the monitoring

function of the Western Cape and acts as an important support for trust within that contractual relationship. In contrast an Eastern Cape PDS commented of that province's financial systems:

"Now at the moment the province isn't really aware of how much they are spending in each region. Because for instance in our practice we are getting a hospital cheque, getting a cheque from the regional council for the PDS, there might be others but I can't think... It's stacked, all of these are coming from the same Treasury, and their system won't allow them to know how much (in total) I am receiving" PDS, Eastern Cape

Further disruption was experienced in the Eastern Cape when the financial administration of the province was resumed by the National Department of Finance in 1997 following allegations of gross mismanagement. This impacted down to the level of PDS payments:

"one salary just disappeared, we never got paid. And we queried this, and the answer was that they were changing over from the DOH to the Department of Finance, and that those are the guys who in the future would be paying our salaries. And with the changeover, the October salary disappeared. It was never paid" PDS, Eastern Cape

The upheaval of decentralisation to the new provincial structures means that some systems are not yet fully decentralised. Administrative weakness in the Eastern Cape meant that the province was still processing the claims of the PDS at head office whilst their payments had been decentralised down to regional level. The region was unable to take on the monitoring task due to a shortage of personnel and was making payments independently of the monitoring function carried out at head office.

Poor capacity to formulate policy

"we are very concerned if that (contracting to the private sector) happens on a large scale because then the confusion between private and public becomes greater, in a situation which we haven't proper policies about where we are going to. What are the issues of private and public health in this country? and the issues of funding? I am scared of these patchy approaches to the public private mix. I think we need a much more global policy framework.....and until that is sorted out I think that a lot of PPM stuff becomes very fuzzy and difficult to control" Regional Manager, Western Cape

These basic administrative difficulties were taking place against a backdrop of confusion on basic policy towards the PDS, also partly due to a lack of capacity to formulate a coherent policy framework. At the time that the fieldwork was being carried out, the Eastern Cape was attempting to formulate a provincial policy towards contracting with the private sector. This was hindered by a

lack of basic data regarding issues such as an up to date census and information on the likely demand patterns for PHC services in different areas.

These problems are highlighted by the frustrated comments of regional managers:

"we don't have a problem with the contract just with the PDS we also have a problem with the contract with local government... we need to have a drastic review... How can you enter into contracts if you don't tell the people what it is that you want done? And that is our major problem at the moment, it's too loose" Regional Manager, Western Cape

"we have delayed in getting consensus on the kind of policy that we want in our Province"
Regional Manager , Eastern Cape

Lack of resources to manage and monitor contracts

"I am the only one left who knows anything or who is managing the district surgeons....the Eastern Cape, forming a new province, didn't have any infrastructure to fall back onto to manage it, whereas in the Western Cape they could still use their expertise from the previous time"
Regional Manager, Eastern Cape

Problem of a lack of resources appeared particularly acute in the Eastern Cape:

"we don't have the personnel to do the monitoring of the interventions"
Regional Director, Eastern Cape

One of the principal managers of all PDS in the Eastern Cape described how he is doing the job almost by default, despite his job designation and terms of reference being quite different than manager for the PDS services :

"I spend less than 20% of my time managing the PDS, I have stacks and stacks of work on my desk. There is too much for one person. It is an impossibility for one person to handle it. ....I am just fighting fires.....there is no one specifically engaged for that task. No-one specifically tasked with looking at, controlling and regulating the PDS services as they are at the moment"
Regional Manager, Eastern Cape

When asked whether he has time to spend contacting and managing the PDS the regional director said:

"no I don't have the time. I did before but I must say that in the past two or three years, no I don't have time" Regional Director, Eastern Cape

In turn the PDS complain that the people that they deal with in the Province are ill-informed:

"They don't even have an idea, when you speak to them they don't have any idea what we are doing here, what the situation is like. I mean the people that we refer to X and then we get letters back saying why don't we do certain things here, because they don't have an idea that we don't have a

hospital. .... There is a very great misconception of what is really going on in a rural area...they have got no inkling...." PDS, Eastern Cape

In the better resourced Western Cape the situation appeared less constrained and devolution of responsibility for management of the PDS to regional level had taken place smoothly.

HUMAN FACTORS: MOTIVATION OF PROVIDERS

Individual service providers may be an important determinant of the nature of service delivery under an incomplete contract, making the question relevant of what motivates individuals involved in the contracting process, and whether they are likely to behave in an opportunistic manner. This is likely to be determined to some extent by whether contractors are operating for-profit or not for profit, and whether they are self-employed individuals or part of a larger company structure, in which case both their own motivations and the way in which their behaviour is controlled by the company's internal controls and procedures must be taken into account. Whilst the overall motivation of providers will also reflect contract design, the role of the underlying attitudes of providers to their work and to state work in particular, can be important. During the interviews, these were explored along with the initial reason why the PDS became involved with the contract.

PDS interviewed for this research gave remarkably similar answers to the question of why they had become involved in that type of work. They had usually been in the town where they hold a contract for over 10 years. Their background was in rural practice, usually private, although in one case a doctor had moved from a public sector hospital in a former homeland. Most doctors mentioned a combination of altruistic and financial motivations. Examples of how they described these are shown in table 5.4 overleaf.

Table 5.4: Motivations of PDS

PDS	altruistic/ feelings of obligation	financial
A - E Cape	*"call it a sense of decency....if we didn't do it, nobody would do it"*	
C - E Cape	*"sounds very altruistic I suppose but it's part of the work in a small town to provide services to the indigent patients. In a way it's satisfying for me to work with the clinic sisters, not just seeing patients but also having a bit of a broader view as to the actual service and the quality of service"* *"personally I would find it very difficult to give up that part of the service"*	*"it's an income that we are dependent on, that's one aspect to it"*
D-E Cape	*"I always wanted to be a community doctor. I feel some sort of debt towards the community. They have looked after me at different stages and let's face it, nobody else wants to come! If somebody else wanted to come, I might feel different".*	
E - E Cape	*"first of all we stay here, that's one of the main things. But also primarily we all of us did this for the love of the job and the love of the people, that's how we all start out"* *"we have always accepted that we have to do all this doctor work because there is no one else available"*	*"the fact that we are still here in business shows that this is what we want to do and intend to do but there is a point at which if the province tries to cut your income below a certain level...."*
J - W Cape	*"it's part of my job...I have been involved with the state since I started working as a doctor...I see it as part of my life"*	*"It's a sure income every month that you don't have many overheads on"*
L - W Cape	*"you pay a price over the years to be a PDS (in terms of private practice). I thought at the time that I would like to be a PDS. I would like to service the community in that way. I have grown up here, I have been at school here, I know the community. I know especially the poorer community because I have grown up on a farm.....It is more interesting work. I also like medico-legal work. But I didn't know that it would influence my private work so much"*	*"firstly you must have a job"* *"of course money is important, but when I first started working here in 1962 I got R600 per month to do this job. That wasn't much money!"*
K - W Cape		*"one cannot avoid self interest, if this gets driven to the extreme, like in that your income drops by so much that its going to end up you having to leave the town..... I must have the income"*
H - W Cape	*"you can't do a service in a community like this without doing the district surgeon work as well. Otherwise you are not giving the community a service and the community is very much dependent on us"* *"the province knows it, they know that if you are not going to do your state work you are not going to have a practice"*	*"I think that there is a certain cut off point where a district surgeon will decide I can't work for this type of money, so you either get out of the contract or leave the town".* *"advantages of the contract to the province are both income wise and being able to give a good service to the community"*

Most PDS expressed a reluctance to uproot and move from where they were currently practising, having been there for a long time, and having a sense of identifying with the community in which they lived. These factors influenced their position, given that most acknowledged that they had little choice but to do the work if they wished to remain in that town. They also recognised that in many

cases provincial managers were aware of that and may be exploiting it. Rather than seeing the work as lucrative, interviewees talked most often of a level of pay below which they were not prepared to go; using phrases such as a "cut off point" down to which they were willing to go on rendering services, even if very poorly paid, although the increase in income since PHC was made free was also acknowledged. The best financial aspect of the contract was seen as the reliable nature of the work and income that it represented, as the demand from patients was consistently high.

In terms of altruistic motives, comments were very similar between all doctors. Only one did not mention a wish to serve the community or a feeling of obligation to the community in which he lived. The impossibility of living in a town and not doing state work was frequently mentioned. One doctor felt that he would probably have to do the work anyway, so he may as well receive some compensation from the state for it.

ASYMMETRIES OF INFORMATION

Asymmetries of information lie at the heart of any contractual (principal-agent relationship), both as a frequent cause for such a relationship and as a problem which bedevils its operation. They are particularly prevalent in almost any health care setting. It is not surprising therefore to acknowledge that several of the factors discussed above combine to create a situation of severe asymmetries of information in the PDS relationship. In particular the nature of the service, nature (or motivation) or providers and capacity to specify and monitor contracts all combine to create information problems. First, the nature of the service is varied and delivered in remote, scattered locations. The purchaser's exact service delivery requirements are unlikely to be easily specified in a contract or easily monitored. Second, the providers involved in this contract are profit-seeking and report one of their motivations as financial, which suggests that there may be a degree of opportunistic behaviour on their part. Third, capacity of the purchaser to tackle these information problems, either via monitoring or specifying the contract in any kind of detail, appears to be weak.

CONCLUSION

A review of the nature of the service, market, capacity and motivation of providers involved in the PDS contract reveals much about the environment in which the PDS contract operates, and how much this is likely to influence the way in which it works. The type of service that the contract governs is difficult to define both in terms of its boundaries and its exact content. The degree of competition or contestability of the PDS market is low and few direct substitutes exist. This, in addition to the nature of the towns in which PDS services are contracted, creates a situation of bilateral dependence between purchaser and provider. Capacity to specify, design and manage contracts at most levels of the South African department of health is under strain. The Eastern Cape, a formerly disadvantaged province, suffers from particularly weak capacity which severely compromises its ability to engage with the private sector. Last, the nature of the providers involved in the PDS contract is remarkably homogeneous. They identify a complex cocktail of motivations in their decision to do PDS work, which tend to contain both financial and more altruistic incentives.

The environment of the PDS contract suggests that it will be plagued by severe asymmetries of information. How the purchaser chooses to manage these information problems is key to the nature of the contractual relationship. Two options present themselves. One is to try and approach the problem through tight contract monitoring and delivery, despite the problems described above. The second is to accept that asymmetries of information will be too great to allow for such a classical approach to contracting and recognise the inevitable incompleteness and relational nature of the arising contract. The next two chapters examine how these problems are dealt with in the case of the PDS contract.

CHAPTER 6: THE PDS CONTRACT: AWARD PROCESS AND DESIGN

This chapter is the second on the PDS case study and gives information on the design of the contract, the award process and the perceptions of both purchaser and provider about the adequacy of the contract's specifications.

CONTRACT DESIGN

Both Eastern and Western Cape provinces still used the old Cape Provincial Administration's contract, the form of which was unchanged since the early 1970s. It was laid out as a memorandum of understanding regarding *"Part-time District Surgeons: the Conditions of Appointment and Duties to be performed."* Some of the PDS in the case study were not in possession of a written copy of their contract.

Duties specified

The PDS was appointed by the Deputy Director General: Health and Hospital services, and the contract stated that immediate control over his services was exercised by the magistrate of the town in which he was appointed. This referred to the system, out of date since the removal of fees for primary care services in 1996, by which patients had to visit the magistrate to either pay a user fee or gain a certificate of indigency before accessing the PDS.

The services to be rendered by the PDS are extremely broad. Their specification is shown in table 6.1 overleaf.

Table 6.1: Service specification in the PDS contract

SERVICES SPECIFIED IN THE PDS CONTRACT
i) ***Clinical duties***, including medical, obstetric and surgical[20] services for state patients[21] and tooth extractions for state patients where no dentist is available. Maternity services to other state patients and operations in hospital are excluded. *ii)**Ex-officio work,*** including the examination of a range of candidates for public service and apprenticeships as well as applicants for disability grants *iii)* ***Medical forensic,*** defined as *"required of district surgeons in terms of any act or provincial ordinance"* iv) ***Emergency services,*** the district surgeon is required to *"render any service that the Regional Medical Superintendant or any other medical official ... who was duly authorised .. may require of him".* *v)* ***Other duties*** are broadly specified as *"any other professional services required of him by the Deputy Director General: Hospital and Health services"*

In addition to the duties described in the table, the following parameters were also set on the way in which they will be delivered:

i) Geographic location

The PDS was obliged *"to render any service required of him in terms of this contract at any place in the above mentioned district surgeon area as ordered by the magistrate*". In the case of emergencies, he may also be required to render any service in any other area as ordered by the magistrate.

ii) Maintenence of records

The PDS was mandated to *"keep adequate records regarding his official services and render an annual report and returns on the prescribed form as the Deputy Director General: Hospital and Health services may from time to time require."*

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[20] "…which may reasonably be expected of a GP in regard to normal extra- institutional treatment"
[21] persons for whose medical care the Cape Provincial Administration has assumed responsibility

iii) Changes to the contract specification

Allowance was made for changes in the duties to be performed by the PDS in the following way: *"The district surgeon shall perform his duties strictly in accordance with the standing instructions of the Deputy Director General: Hospital and Health Services as he deems it necessary to issue from time to time".* In addition the Province retained the right to amend the contract or any standing orders, *"providing that the PDS is entitled to three months' notice in regard to -*

- *a reduction of his annual salary or an allowance or supplementary money named in the Appendix*
- *an amendment which brings about an extension of the PDS' area*
- *any other changes in the regional borders of the PDS area which may be detrimental to the PDS legal interests".*

iv) Availability

The contract specified that *"the district surgeon shall give preference to his official duties, except where serious emergencies occur in his private practice"* and that he *"shall be available at all times for the immediate and efficient performance of a service required of him in terms of this contract".*

v)Equipment

The contract specified that *"the district surgeon shall himself supply the means of transport and all the medical equipment required for the immediate and efficient performance of his duties in terms of this contract".* No compensation for any capital expenditure on equipment or upgrading of facilities was offered by the contract.

vi) Method of payment

Payment rates for services to be rendered by a district surgeon were not directly specified within the contract but laid out in an appendix. PDS services were remunerated monthly at sessional rates. In addition they received an honorarium payment and transport allowance per km. To calculate the sessional payment, a range of service options was specified, alongside the amount of time that it is

assumed each one will take; for instance a primary care consultation was assumed to last 10 minutes, or a post mortem 1.5 hours. This dictated the sessional payment that would be received. For instance, for every 6 PHC consultations a PDS would be paid the equivalent of one hour of work at the sessional rate. In addition PDS received a flat dispensing fee for each prescription that they supply. PDS practices are required to submit claims monthly, detailing the name of each patient seen, the diagnosis and drugs dispensed or prescribed.

The contract is therefore established to enable considerable demands to be made on the PDS where necessary. He or she is required to be available at all times to deliver a range of broadly specified services. Delivery of PHC services to state patients is just one aspect of this contract, although it represents the bulk of the work and therefore the income received for many practices.

DURATION OF CONTRACT/ CONTRACT TERMINATION

Duration of contracts varied between towns and differed from one month and indefinite (Table 6.2). Those contracts awarded before 1994 were valid until the PDS turned 65. More recently awarded contracts tended to have a shorter, fixed duration (e.g. one month) or be vague about duration - describing it as "open-ended" or "indefinite".

Table 6.2: Duration of various PDS contracts studied

Site	Duration of contract	Notice period
A - E Cape	Until PDS 65th birthday	3 months
B - E Cape	Monthly renewal	One month
C - E Cape	*"I happen to have seen the contract that I am supposed to have but I have never actually signed one".* If you don't give notice *"in practice it just runs on and on"*	3 months on either side
D - E Cape	Monthly renewal.	One month
E - E Cape	Until PDS 65th birthday	3 months on either side
F - E Cape	Originally was renewed monthly by letter from the province. Then made onto a three month contract which was faxed through every three months. Now they have not received faxes for several months. On the phone were told that the agreement was indefinite until they hear something.	Was 3 months. Now unsure as not received fax from Province for some time.
G - W Cape	Until PDS 65th birthday	3 months on either side
H - W Cape	Until PDS 65th birthday	15 days on either side
J - W Cape	No actual contract. Understanding is thought to be open-ended and indefinite. "*There is no end in sight*"	Not clear
K - W Cape	Until PDS 65th birthday	3 months on either side
L - W Cape	Until PDS 65th birthday	3 months on either side

The contract could be terminated by the province with immediate effect for any of the following reasons:

- breach of a material condition of the contract
- serious negligence or default in performing a duty assigned to the PDS
- misconduct calculated to discredit the medical profession or the PDS office.

Sanctions are also described in the case of a PDS leaving his post without having a locum in place. In this case, the Province was permitted to make arrangements for medical cover as they deemed fit and subtract the cost of this from the next payment to the PDS. Lastly, the contract could be suspended awaiting the outcome of an investigation into any breach of contract and any salary which would have been paid during that period withheld. Upon reinstatement, the PDS was entitled to receive this salary and any other payments due. In case of the termination of contract, the PDS was not entitled to any payments with effect from the start of his/her suspension.

THE NATURE OF THE CONTRACT

Walsh et al (1997) suggest several dimensions in which the nature of contracts can be analysed. In particular they highlight types of contracts as varying along three dimensions: focus, form and content. Practical issues such as methods of dealing with risk, problems of ensuring quality and the use of default to cope with problems of unsatisfactory performance are also highlighted. The nature of the PDS contract is illuminated by examining these dimensions.

First, the **focus** of the contract is revealed by whether it is specified in terms of inputs (what is required to do the work), methods (how the work is to be done) or performance (what are the results to be achieved?) None of these dimensions are particularly clearly specified in the PDS contract.

- In the case of *inputs*, only time and services of the PDS are mentioned. The way in which services are to be delivered is specified in terms of broad parameters such as place and time, but again little further specification is given. For instance, it is clear where services are to be delivered geographically, but whether they are to be delivered in the PDS private surgery or a clinic or another location is not mentioned. Broad parameters are set on timing, in that the PDS must give priority to his PDS work and can be called upon at any time. However, details such as hours of opening of the PDS clinic are not specified, nor what type of after hours services must be available.
- The *method* by which medical services of different types are to be delivered is not specified at all.
- Last, there is no focus on *results* in the contract. No mention is made of any type of output other than specific medical services, and it is debatable whether these constitute inputs, methods or outputs! Certainly no quantities of outputs or patients to be seen are defined in the contract.

The contract therefore has a superficial focus on inputs and methods but it does not clearly specify either the inputs required or the methods to be used to any useful degree. It also confounds Walsh's prediction that *"we would expect a closer focus on results where the nature of the work is difficult to*

specify" in that whilst the nature of PDS work is varied and clearly difficult to specify, results are not specified and indeed also would be difficult to specify. This incomplete focus of the contract reflects both the partial nature in which the purchaser chooses to define the service which they are purchasing, but also underlying difficulties in writing contracts for a service of this nature, as was predicted to be the case in the previous chapter.

Second, the **form** of the contract refers to the level of formality and whether the contract is based on a fixed or variable price. This contract is written in formal terms and is based on a series of fixed prices, but the quantity of services delivered can differ, with no upper limit on the amount of services that a PDS can deliver. Price per item is not altered by the volume of services.

Third, the **content** of the contract deals with issues of how the services are to be provided, how they are defined and the nature of contract conditions covering issues such as arbitration, variation and default. In the case of the PDS contract, content is quite varied. How services are to be delivered and how they are defined is a mixture of broad brush definitions, such as *"render medical services required"* and quite specific stipulations such as:

"perform tooth extractions on a state patient, a needy person or prisoner as required for immediate pain relief, but only in cases where the services of a dentist are not available".

Variation in the contract is dealt with in broad terms, giving the Province what appears to be the power to vary most conditions of contract. This power appears quite one-sided with no provision for the PDS to vary the terms of the contract from their side. The Deputy Director General is permitted to issue "*standing instructions...from time to time...*" in accordance with which the PDS must perform his duties, and the Administrator "*shall have the right to amend the contract...*" with only some requirements for notice to be given. Hence the contract is not "closed", in the sense that the nature of the relationship it defines could be altered quite radically by the purchaser. On the other hand, sanctions for default in some cases are quite detailed e.g. departure from town without arranging for a locum, but other issues of malpractice and the sanctions that could be invoked are not dealt with at

all, apart from termination. The contract does give an impression of the range of sanctions available: termination, suspension and deduction of money from payments due appear to be the main options which the province can exercise. However the manner in which they may do so are not specified in a comprehensive way by the contract.

How the contract deals with risk and the link between risk and quality supports Walsh et al's (1997) finding in the UK that *"the general tendency has been for the client, who is naturally highly risk-averse, to write the contract so that it is the provider who bears the greater risk"*. The PDS contract brings providers into an effectively open-ended commitment to the state - they sign an undertaking to give priority to state work the volume of which they cannot always control, and they can be called upon to perform a range of new functions at the wish of the DOH or the magistrate. The risk imposed on the PDS is that the volume of work generated by the PDS contract is so large that they are unable to maintain their own private practice and that the payment levels set by the Province will not be an adequate compensation for their time. On the other side, the Province now faces an open-ended commitment to pay the PDS for a volume of work which it may not be able to control, although prior to 1996 this risk was controlled by the mechanism that patients had to either pay a fee or obtain a certificate of indigency from the magistrate. The payment of the same fee per item of work suggests that quality of PDS services should not suffer as volume rises. However, setting payment at a low rate means that PDS are encouraged to maximise the volume of services that they provide, and the fact that there is a finite amount of work that can be performed by a PDS may mean that as volume is maximised, quality will suffer.

Lastly, methods of ensuring quality are suggested by Walsh et al (1997) as a practical issue that has to be tackled in specifying a contract. It is observed that this is:

"likely to pose particular problems where (quality) cannot easily be defined and may be difficult to observe: much depends on the character of the information available and the way in which access to it is distributed - whether providers have more information than purchasers."

The PDS contract appears to have found it least problematic to bypass issues of quality of services altogether. The word quality is not mentioned in the contract. It is specified that the PDS must submit all information in writing (*"claims, recommendations, reports and other official communications"*) and that he must *"keep adequate records regarding his official services and render an annual report and returns on the prescribed form"*. However none of these communications deal with the quality of services delivered or attempt to monitor quality.

A further dimension of the contract to be considered is the degree of its completeness, meaning the degree to which it has specified what is to happen in all possible eventualities. Whilst there is not an attempt to specify each possible eventuality in this contract the division of risk (in terms of service delivery to the provider and in terms of payment to the purchaser) is quite clear.

An analysis of the PDS contract according to the dimensions discussed above suggest that it offers more of a definition of a relationship between the Province and the PDS than any detailed specification of issues such as inputs, methods or outputs. Its focus and content both are quite varied, and range between highly detailed specifications and general 'catch all' measures. The contract relies on an open-ended commitment from the PDS to take on all work that is directed towards him. It also relies on an open-ended budget on the side of the province to pay for these services (although there used to be a filter in place in the form of the magistrate's office). Overall the general nature of the relationship suggested by this contract is one where all eventualities can be dealt with, but only whilst both of these points hold.

CONTRACT AWARD PROCESS

The PDS contract is awarded to an individual doctor rather than a group practice. The contracts examined here were awarded between 1973 and 1998. Features of the contract award process in each town are shown in table 6.3. Most contracts were not awarded as the result of any competitive process, most not even moving between practices, but just passed from an older doctor to a more junior one: five of the contracts were awarded when the incumbent PDS left the practice to a junior successor and in the other six cases, one doctor had joined a practice and taken on the PDS contract from a senior partner as he joined, three more doctors had bought practices which held PDS contracts and two practices had taken over the PDS work following the death of the town's previous PDS.

Four PDS were asked by the DOH to apply for the job in writing. The others had either been approached directly by the DOH or had simply taken over the work from a departing partner, with the change being followed up later by a change of name on the contract by the DOH. Of the four who had applied in writing, two said that the job had been advertised and two were not sure if this was the case. Only one of those who applied in writing knew for certain that someone else had also applied for the job.

In the case of the four most recently awarded contracts, no written contract had ever been provided, the contract having been only ever awarded verbally. Three of the PDS operating without a written contract were in the Eastern Cape.

Table 6.3: Features of contract award process in each town

TOWN	Year contract awarded	Awarded within same practice?	Reason for change in contract	Advertised? Did they have to apply?	Did others apply?	Do they have a written agreement?
A – E Cape	1983	Yes	Partner holding contract left the practice	Advertised. Applied.	No	Yes
B – E Cape	1982	No	Took over practice that did PDS work	Not advertised. Took on PDS as part of the work of the practice	No	Yes
C –E Cape	1998	Yes	Partner left. 8 months later made PDS.	No -instated after 8 months acting PDS.	No	No.
D –E Cape	1997	Yes	Partner holding contract left the practice.	Don't know if advertised. Applied.	Don't know	No
E –E Cape	1985	No	Old PDS died.	Advertised. Applied.	One other	Yes
F –E Cape	1996	No	Old PDS sold practice, including the PDS work	Don't know if advertised. Applied.	Don't know	No
G –W Cape	1993	No	Bought practice from old PDS who was leaving town	Not advertised. He applied for it as formality when taking over the practice and then did a 3 month trial period. Eventually worked as PDS for 6 months before receiving contract.	No	Yes
H –W Cape	1984	Yes	Partner holding contract left the practice.	No choice but to take the contract if wanted to practice in town.	No	Yes
J – W Cape	1998	Yes	Partner holding contract retired	No –approached directly by DOH.	No	No
K – W Cape	1973	Yes	Partner holding contract left the practice.	Passed on within the practice. No competitive process.		Yes
L – W Cape	1996	No	Previous PDS retired.	Not advertised. Agreed to take on work when approached by DOH.	No	"One line long"

PROCESS OF NEGOTIATION OVER CONTRACT

The contract appears to be viewed very much as a 'given'; around or outside of which various deals may be negotiated directly with the Province, but the outcome of such negotiations would not be reflected in the standardised contract document:

"*that was a standard contract. take it or leave it*" PDS, Eastern Cape

The contract's nature is standard across all PDS, and there was little negotiation about terms. Whether a practice took the contract was determined by whether they needed the work or felt that they could refuse it, rather than because of the attractiveness or otherwise of specific contract terms. Echoing some of the comments reported in the previous chapter, two PDS in the Western Cape described how the DOH were desperate to find a doctor in one town to be PDS, but even then did not mention that this created an opportunity to negotiate more favourable terms in the contract.

"nobody was interested in doing PDS work, it was really a very underpaid service, and not nice work to do..... I wouldn't have taken it if there was another PDS in this town, but you can't be the only practice and not be the PDS. These patients have to be seen" PDS, Western Cape

.... we just knew that the state needed us and we needed them so we had a talk and we realised that we would have to do it. We had no inclination of not doing it....we didn't actually need the pot sweetened, we just sort of drifted from the one situation into the next" PDS, Western Cape

Contract form was therefore not seen as a subject for negotiation. Even where practices were in a strong bargaining position there was little appetite to try and change the terms of the contract.

PDS AND PURCHASER OPINIONS ON THE CONTRACT

In the sections below both PDS' and purchasers' opinions about the specification of the contract are reported, in particular the adequacy with which contractual requirements are laid out, the payment mechanism and beliefs about what would constitute a breach of contract on either side and what sanctions are stipulated. These comments by both purchaser and provider highlight several points. First, whilst all of the doctors interviewed are effectively working under the same contract, it is interesting to see the variety in their opinions both about how well it is specified and even the details

of what it says. This suggests that the written contract is only marginal as a defining factor in the relationship between purchaser and provider. It is also important to note that in the case of four doctors interviewed there was no written contract; they were operating only with an understanding of what *would* be written in their contract, *if* they had one.

PDS views on contract specification

"the contract says that we have to do the work that they want us to do. That they can employ you basically in any way. The contract stipulates that you must see state patients. And they can stipulate which state patients you see..... So just as they increased the patients in 1994 and 1996.... the Lord giveth and the Lord taketh away! ...." PDS, Eastern Cape

Opinions differed between PDS as to whether the contract was well specified and what services they were expected to deliver. In many cases the attitude to the contract was one of tolerance rather than seeing it as a guide to the contractual relationship. Some PDS referred to it as if they were humouring the province by continuing to work under a document that in many respects no longer had any relevance to the work that they do:

"well it (the contract) ...is just not being adhered to by the state, so whether it's specified or not doesn't really make any difference, at this time." PDS, Eastern Cape

Another said:

"well those old contracts are irrelevant for the present situation. The nature of the practice has changed too much.....is that really a contract? It's more a job description of what you must do" PDS, Western Cape

About the degree of detail with which services were specified by the contract the following comments were made:

"we haven't got a very fixed contract, we have the contract that I signed 14 years ago, it hasn't changed, it's a very basic and very loose type of contract. It's not binding any of the parties, it just sort of asks the practitioner to give a decent service and if he doesn't comply with that he is to be dismissed. But it doesn't give you a timescale or any sort of insurance of how long or what your income will be, what your services will consist of. and they can decrease it or increase it as they see fit"
".....(services to be delivered) aren't spelt out in any clear way." PDS, Western Cape

" It was broadly put. It basically had different clauses in it, for instance...that DS patients would have priority over my private patients..... that I should do medical and forensic services, that's it" PDS, Eastern Cape

"it has got a broad framework. It says that you must look after the poorer part of the people, those that can't afford private health care. That's your job, a broad description. And you must provide medico legal services" PDS, Western Cape

No mention was made by any PDS about quality in contract specifications. One doctor offered a negative definition of the quality that they were expected to offer:

"in the old contract I think it said that you have to give a service to such an extent that there won't be any complaints" PDS, Western Cape

More exasperation was expressed by one PDS about how poorly the services were specified by his contract:

".....my contract is one line long. It says "you are hereby appointed district surgeon for the month of February". And I think that was about 3 years back! So basically there is no contract."
PDS, Eastern Cape

Interestingly, two PDS that were happy with the detail of contract specification were both working without a contract, although they both have prior experience of working in practices where there were contracts. This almost suggests that they find it easier to operate as PDS and understand the nature of the service without any recourse to written form.

Specifications such as the types of inputs to be used, or the level or quality of output to be delivered were thought by all PDS to be entirely absent from the contract specifications. One regional manager pointed out how this was also to the advantage of the PDS, allowing them to make unlimited use of state support services such as laboratory services.

When asked to name what they saw as the main responsibilities of a PDS, doctors' descriptions were very similar; stressing their role in curative primary care for state patients and medico-legal services:

"basically I render primary and curative services to indigent patients and I do forensic work as well." PDS, Eastern Cape

"I have got to provide curative health services during office hours to state patients. PLUS I have to do medico legal work like drunken driving and rape cases after hours as well as in office hours. and then we also have to do the disability grants, certifying of mentally ill patients etc."
PDS, Western Cape

Most PDS said that they had learned what was involved in the job from their predecessor:

"*(I learnt it from) ...the guy who was DS when I arrived in Jan 1983"* PDS, Western Cape

" *(I learnt it from)...time and Dr X...what do you call that? in- service training.*" PDS, Western Cape

At one extreme, one PDS had never seen a copy of his contract or of any PDS contract, having learnt the whole system from other doctors in practices where he had worked.

PDS were also confident that the services they were delivering were all broadly in line with each other. The chairman of one of the PDS committees described how he saw the system operating:

"Everybody does what he thinks.
and do you think that everybody does the same?
I daresay that you will get a great variance in terms of quality.
But if I lined up 10 PDS and said "please describe what it means" do you think that I would get roughly the same answer?
probably roughly the same answer, depending on whether the town has a hospital or not".
PDS Western Cape

PDS saw their professional opinion and discretion playing a considerable role in determining what services they will provide. Therefore despite feeling that the contract was poorly specified, most PDS were happy to have this left to their individual discretion:

"*they say "be a doctor to our patients" and that's what we do"* PDS, Western Cape

"*it's just that we all do what we think is our duty"* PDS, Western Cape

whilst another explained:

" *the specification is vague is because they know the services that we have been providing all the time so we are not new to this"* PDS, Western Cape

and another said:

"there is a certain standard of medical care and of humanitarian care, which I don't need the province to tell me." PDS, Eastern Cape

One regional manager also echoed this preference of doctors to define their own working practices, saying that he felt that the new capped payment system was preferred because it gave them greater autonomy to decide how to deliver services.

Whilst most PDS practices visited did operate along remarkably similar lines, one practice was an exception. They were using sisters to screen patients and only referring a small proportion to be seen by the PDS. Given that they were working under the same contract as all the other PDS visited, this variation suggests an interesting breadth to how the contract can be interpreted, or alternatively that they are breaching their contract by using sisters and the Province is choosing to overlook this. The province acknowledged that they knew that nurses were being used to screen patients but said this had not been agreed. However, they took no action to stop the practice. This was a curious anomaly. If it is permitted under the contract it is strange that other PDS practices do not do the same. This again suggests that the true definition of the service to be offered lies outside of the written contract.

Purchaser views on contract specification

Purchasers in the Western Cape felt that some aspects of contract specification were of limited importance. For instance:

"the fact that the contract might be for a defined period doesn't influence the relationship with the doctors...because there aren't a lot of options" Regional Manager, Western Cape.

There was also some confusion as to which contract PDS were working under, as they had agreed subsequent capping of their services which was not included in the original contract. The contract document was clearly out of date but the subsequent agreement was not seen as a contract:

"I didn't give them a contract. We were sort of agreeing on terms that they consented to...." Regional Manager, Western Cape

This is further complicated by the Free State court case which ruled that PDS were employees of the state. Regional managers complained of not knowing whether to treat them as state employees or not:

"they adopt the ruling when it suits them" Regional Manager, Western Cape

In general regional managers in the Western Cape also were of the opinion that contracts were poorly specified:

"the original DS contract, the services aren't specifically specified, or adequately, except for the subdivisions e.g. primary care, forensics, ex-officio work etc" Regional Manager, Western Cape

Overall there appeared to be a general frustration with the contract. Regional managers stressed that the contracts were an inheritance, both from the previous Provincial authority and from 'Head Office' (Provincial Administration of the Western Cape). One regional manager's office was not even in possession of copies of the contracts;

"...so we don't know the contracts too well" Regional Manager, Western Cape

This view was echoed in the Eastern Cape, where one regional manager said of the contract;

"I can't remember the contract. I have just forgotten about it" Regional Manager, Eastern Cape

PDS opinions on breach of contract and sanctions

Table 6.4 summarises PDS' views of what would constitute a breach of contract. Their understanding of the different sanctions which could be applied against them is also shown. Fraud, and failing to deliver services either through absence or some other reason were the main areas that PDS identified as breaches of contract on their side. One PDS mentioned rendering poor quality services to patients. Another said it was impossible to say what a breach of contract could be, given that he was operating without a written contract anyway.

What would constitute a breach of contract on the side of the DOH was less easy for PDS to define, suggesting that it is not something often considered as a possibility. Most frequently mentioned was any way in which the DOH could suddenly reduce the PDS' income, for instance either suddenly taking away the work, allowing a competitor in to the market or reducing the volume of patients by changing the terms of the contract at short notice. Essentially, threatening the PDS income was interpreted as a breach of contract, suggesting their reliance on that guaranteed income.

In terms of the sanctions that could be brought by the DOH, termination and suspension were the main ones expected by the PDS. Sanctions or penalties which the PDS could exercise against the DOH were much more difficult; a general lack of choices "outside of common law" and the difficulty of tackling such a huge institution were both mentioned.

Purchaser opinions on breach of contract and sanctions

Defining a breach of contract was seen by one regional manager as:

"something that you have to use a lot of common sense in deciding...any doctor makes mistakes in his career" Regional Manager, Western Cape

In both provinces there was a strong perception that terminating the PDS contract would be problematic. Managers in the Eastern Cape were at pains to stress that once a PDS resigned or left, they took care not to replace him with the same type of contractual relationship, careful not to give what they called "*a contract*" but only an "*agreement*". One Western Cape manager described how there were several PDS that he would like to dismiss, and the only problem stopping him from doing that was the contract:

".... I can't do anything with the contract".

Frustration was expressed by some managers at what they saw as the impossibility of terminating contracts with PDS:

"we must have some means of terminating the contract" Regional Manager, Western Cape

"we feel that it's too difficult to get rid of them" Regional Manager, Western Cape

"all the provinces have been trying to get out of their existing contracts but they found there is no way in which these contracts can be called up" Regional Manager, Eastern Cape

"we wanted to stop the contracts but then we withdrew because we couldn't"
Regional Manager, Eastern Cape

Table 6.4: PDS opinions on what constitutes a breach of contract

Town	Breach of contract on PDS side	Breach of contract on side of DOH	Type of Sanctions.....
A- E Cape	*"well basically not delivering the services that I am supposed to be delivering"*		
B – E Cape	*I don't think that anybody can answer you that because there is no contract*		
C-E Cape	*"The one thing that I have seen in that contract that I haven't signed, I mean the original thing, is that we have to be 24 hours available. So I certainly think that unavailability would be a breach of contract."*		**what is the sanction if they find no Dr available?** **"**that *would be a question of termination of contract. but if they can't, obviously they would come and talk to you and find out whats the problem and if it keeps on recurring I think that there would be termination."*
E-E Cape	*"I haven't read my contract lately but there are certain stipulations that they have in terms of certain periods of time that you are not available in your practice and whatever. but at this time I don't know what we can do to breach our contract"*		
F-E Cape	*"me? either stop doing the work or just apply to get fired! on our side, we can only really stop giving the service"*	*"Breach of contract from them would be them taking away the income. Saying, "you have got to go and see all the patients in the clinics", that is NOT what is stated in our original contract. If they alter it and then they don't pay us properly to see the patients in the clinic then from their side that is breach of contract. If they don't pay us within the normal time that is stated than that also can be breach of contract. If they give some of my state work to any other doctor who is not employed as the DS, that is breach of contract"*	
H-Western Cape	*"if you are creating figures or patients that don't exist. Fraud. Or if there is something personally wrong with you like you are turning into an alcoholic or something so that patients start complaining or you are not available for the services needed, or you are prescribing certain drugs totally out of bounds with normal practice.."* ***"are any of these things in the contract?...*** *I think that it is broadly specified"*		*"sacking is about the only type of sanction"*
J-Western Cape	*".....(long pause)...I think fraud ...and that would be quite difficult in the case where you have got this cutting* [capping] *that we have got now, because why would you then? Its pointless!"* *"for us to tell them that "from the end of this month you are on your own", that would be a breach of contract, although it wasn't written like that it would still be.... Its a gentleman's agreement and with everything that goes with that"*	*"the state telling us 'from tomorrow, you aren't needed anymore', without any valid reason"*	*"I don't think outside of common law you would have much...."*
K-Western Cape	*"Rendering poor service to patients. the same things you would be punished for by the medical council. If I do my job well...although you always get dissatisfied people when its a free service - I think if I steal drugs or something like that, you might make a mistake on the computer but if you in anyway, like, steal drugs or anything then you must be out. Or charge for patients that I have never seen"*	*"you see, if you continue capping, if this year its 17%, next year its 35% and so on, in effect in a year or two, from a practical point of view, you have been rendered redundant. You've been rendered redundant, and you are going to leave, your practice is going to collapse, but you don't get a package, you don't get paid out. So you have been sacked, in a subtle way, without being renumerated in some sort of way. And we think this is unfair labour practice"*	*"well, they used to just willy nilly suspend you within three months. That's when our contract started. .... Since this new labour act of 95, they have to have very good reason.. . If I am caught stealing I must be sacked, if I did it on purpose. But I would basically expect to be sacked"* ***"and if they breached the contract, what sanctions would you have against them?" "*** *well, because they are a huge body. I don't know where to tackle them"*

However this widely held view was contradicted by one regional manager, who echoed very closely how the Free State eventually approached the termination of their PDS contracts:

"I think that it's extremely simple to get rid of them. In terms of the existing contract and the (Free State) court case and in terms of the Labour Relations Act, we just tell them that we don't need them anymore in terms of our operational requirements...I can't see why it needs to be so difficult to get them out of the system" Regional Manager, Western Cape

Whilst this would involve the payment of redundancy pay, termination of the contracts was nevertheless possible. This opinion is borne out by legal experts who have followed the court cases relating to this contract. It is not clear what had given rise to the widely held view that termination of contracts was not possible and it is interesting that this was such a consistently held view, despite being of questionable validity. This may possibly be due to an aversion to the idea of having to pay redundancy to private sector doctors, or a recognition that in effect the health service's degree of dependence on some PDS in remote areas made it better to do nothing. This argument serves as a convenient smokescreen for a government that would ideally like to terminate the contracts but feels that this is not practical (this is discussed in greater detail in the next chapter).

One manager in the Eastern Cape who felt that the contract was very clearly specified:

"it details everything, pages and pages, absolutely, a)b)c)d) and e) etc. It just goes on and on about all the cover that they are supposed to provide to the indigent, to the community, 24 hours service, 7 days of the week, emergency calls, etc." Regional Manager, Eastern Cape

felt that it had also been clearly breached on both sides: on the side of the PDS by using nurses to screen patients, and on the side of the province in not giving the pay reviews and salary increments to the PDS that they were entitled to. Judging by his description, this manager obviously knows the contract well. He felt that failure to take sanctions against PDS who had breached the contract was not a result of vague service specification but a lack of resources and capacity to adequately monitor and police the contract.

Opinions on payment mechanisms and financial incentives

The payment mechanism of the contract created a clear set of incentives. First there was a clear incentive to see as many patients as possible under the fee for service (FFS) arrangement. It was recognised by both regional managers and PDS that the time allocations contained in the contract for different services overstate the actual time spent with a patient. In reality the incentive is to see high volumes of patients much more quickly, thereby increasing the hourly salary dramatically:

"R54 an hour...that's what we get paid. Theoretically, that's if we spent 10 minutes with every 10 minute consultation. The bottom line is that if I saw only 6 PDS patients an hour, I would die of hunger. Which is why we have got this conveyor belt method..." PDS, Eastern Cape

"what you do ..is you make up the discrepancy between the private patient and the state patient by spending less time with the state patient" PDS, Western Cape

"many of these guys just look at the patient and then let them go out and say that was 12 minutes" Regional Manager, Western Cape

In areas of the Western Cape where the capping of payments was operating, for these PDS the payment mechanism was more resembling a salary, with the incentive becoming to see a set limit of patients in as little time as possible.

Generally PDS preferred the idea of fee for service payment to any alternative and justified it as follows:

"the doctors feel that they are being paid well for what they do now. So the patients also get a good service. Because you actually think of this man as being a patient of yours and not as being a hassle....I know that this government is completely against fee for service but it works well, and it's not just me. The other reason why it works is that we have a better income, so we prefer to stay here. I don't want to go away, why should I?" PDS, Western Cape

The second incentive created by the system of payment of the contract was competition with other primary care providers. Because doctors were being paid on a FFS basis, if they wished to increase volumes of patients they may chose to do this by "stealing" patients from the clinic, rather than working in a co-operative relationship with them. One regional manager expressed his reservations about the contract design:

"one of the key issues is that with the present system the PDS function independently of most of the primary care team and the more patients that they see the more money they earn. So there is a perverse incentive to run down the primary health care services and to try and see as many patients as you can" Regional Manager, Eastern Cape

Payment for different parts of the PDS services were very varied and for some services such as forensic work, felt to be unrealistically low. One PDS described that if he spent a whole day driving to appear in court he would still only be paid for the time that he was in court. Payment for out of hours work is the same as if it were in working hours, also making this type of work relatively more unattractive.

PDS described a trade-off between the straightforward, high volume "easy" money provided by daytime PHC work and the more demanding and relatively worse paid after hours work:

"what we always said in the past was that the volume of patients that we saw during the day, what you might call the easy work, like BP reviews etc, that made up financially for the after hours work. After hours work you get paid the same whether it's 3 minutes or 10 hours" PDS, Eastern Cape

"what we don't get paid for is being on duty. We are on duty 24 hours. ....we are not going to be paid. We are only going to be paid for any service that we might render, and then it is going to be at a daytime rate" PDS, Western Cape

Therefore, the payment mechanism and the contract are seen as functioning as a whole rather than each service component of the contract standing alone. There is cross-subsidisation between different parts of the contract, with the primary care work being used to sweeten the poorly paid and unpleasant nature of the after hours and medico legal work.

Cross subsidisation from one section of the contract to another was also clearly recognised by the regional managers:

"the PHC is the one that makes them happy as far as the income is concerned" Regional Manager, Eastern Cape

"It's not the medico legal work where they get their money. They get their money from the primary care services. And we want to take out the primary care services" Regional Director, Eastern Cape

The contract works as a package with one set of services dependent for their delivery on the financial rewards for a separate package of services. The system is also dependent on the PDS not choosing to do the more financially rewarding aspects of the work and neglecting the other parts of the contract.

One regional manager was of the view that given that PDS are remunerated on a fee for service payment the lack of detailed specification of the contract was not a problem as:

"there is no risk of underservicing in a FFS system" Regional Manager, Western Cape

This was seen to be an advantage, but one to be weighed up against the risk of over-servicing. Another regional manager complained that such an open-ended fee for service contract:

"can't establish a ceiling" Regional Manager, Western Cape

This problem could also be reflected in the writing of unnecessary prescriptions for patients to receive the dispensing fee.

CONCLUSION

This chapter has described the design of the PDS contract, its award process, variations in its duration and the fact that some PDS did not have a copy of the written contract. It has also described the views of both PDS and policy-makers on how well the contract specified the work expected of the PDS, what constituted a breach of contract, and the incentives created by the payment mechanism. These comments have also highlighted the role of other factors in shaping the nature of PDS services.

Data presented in this chapter show the contract to be incomplete and that it was not usually awarded as part of a competitive process. These factors signal a clear departure from many of the assumptions of the classical contracting model described in chapter 2. The PDS contract served to distribute risk between purchaser and provider but left the specific nature of either commitment quite open-ended. The service provider faced a wide range of possible claims that could be made on his/her time and were open for definition in the future by the government. In return the nature of the contract design allowed her/him to manipulate the income that it generated, and this in turn constituted a risk faced

by the purchaser. The contract was also quite out of date, referring to systems and personnel who were important in the functioning of the system when this contract was drawn up, but who were no longer relevant.

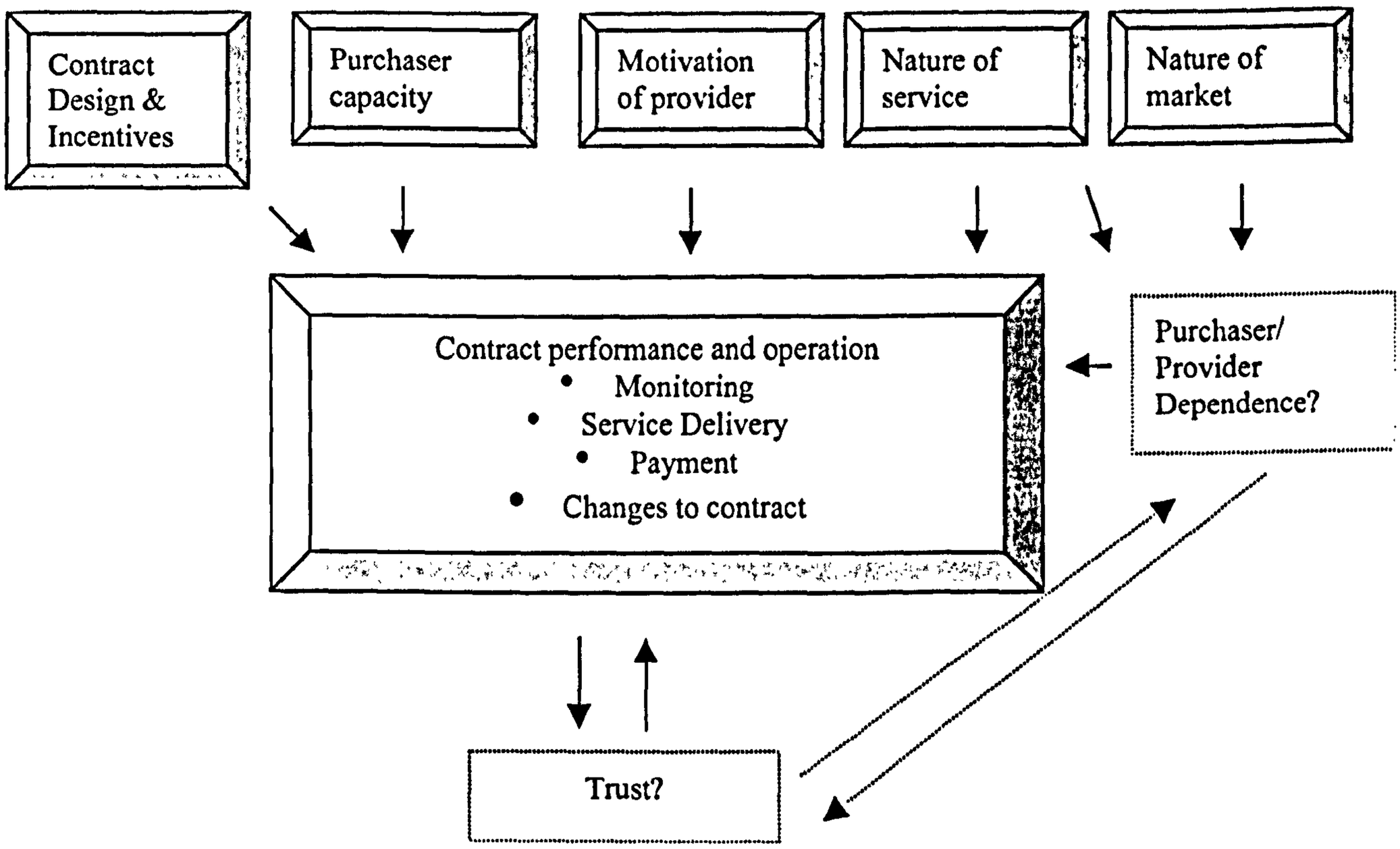
In the interviews with purchasers and providers, there was general agreement that the nature of service delivery was fairly standardised, although largely determined by the PDS themselves rather than what was specified in the contract. PDS were happy feeling that service delivery was left up to their professional discretion and not overly specified or interfered with by the province, although some of them expressed frustration with having no copy of their contract or being unsure whether it was still valid. Purchasers interviewed also expressed frustration with the out of date contract and the perceived difficulty of amending or terminating it. This created a tendency for them to by pass written agreements and make verbal arrangements.

Overall the impression emerges of two contracts- the written contract, which is perceived as incomplete and problematic by both purchaser and provider, and the 'operational' contract, which exists almost independently of the written contract (in some cases PDS had no copy of a written contract) and is defined by a combination of circumstance, history, verbal agreements and professional judgement by PDS. Such elements external to the contract document *per se* appear to be effectively the driving force in shaping this contractual relationship. The next chapter will examine both the nature of operation of the contract and some of these external factors underlying its operation in greater detail.

CHAPTER 7: THE CONTRACTUAL OUTCOME - OPERATION OF AN INCOMPLETE CONTRACT

Previous chapters have reviewed aspects of the five factors shown in the top row of figure 7.1. This chapter focuses on the issue of how the contract operates, seeking to explain both how the contract design described in chapter 6, and other external factors described in chapter 5, influence this.

Figure 7.1: Influences upon contract performance and operation



In the first section of this chapter, contract operation is explored via the examination of four contractual functions shown in the centre of figure 7.1: service delivery, monitoring, payment and changes to the contract. An exploration of how each of these operates is followed by a brief discussion about what each reveals about the nature of the contract and its operation. In the second section, the importance of two informal controls (trust and dependence) on determining the contract's operation is highlighted. To differing degrees these are argued to underlie the operation of the contract, acting in this case as the "glue" which holds this incompletely specified and monitored

contractual relationship together. They act as less formal contractual mechanisms and substitutes for the stipulations of a complete contract.

SECTION 1: OPERATION OF CONTRACTUAL FUNCTIONS

SERVICE DELIVERY

An important clue to the influence of any type of contract on behaviour is the nature of the services that are delivered under it. This, to some extent, will reveal how much the design of the contract is controlling the behaviour of providers, although assessing which aspects of service delivery are attributable to contract design and which to some of the other factors shown in figure 7.1, especially individual motivation, is problematic. This is particularly true in the case of a contract where the requirements of service delivery are so vaguely specified. The data presented below describe features of service delivery in the PDS clinics visited in comparison with public sector clinics in similar settings. The inclusion of public sector clinic data is an attempt to aid comparison with services which are not influenced by a contract. However, conclusions on the influence of the PDS contract design or other factors on the way in which they deliver services are still cautious as a result of the multitude of influences on service delivery.

The previous chapter described the PDS contract's fee for service design and subsequent incentive to increase volumes of patients, and reduce the resources spent on each patient (with the exception of drugs, which are supplied by the province). The nature of services delivered can be examined in terms of the volume, the type and the quality. Data presented below describe some features of the services that PDS deliver in comparison with public sector sites. Data on the volume and type of service delivery seek to demonstrate to what extent PDS are responding to the financial incentives in the contract. The quality of services delivered are difficult to assess objectively, but some perceptions of users and non-users of the service are presented from focus group discussions to give a sense of the impressions of quality of care of PDS services.

However as well as the incentives contained in the contract, there may be other, external influences on the nature of services delivered, in particular their quality. For example, to the extent that they are left to determine the services they will deliver, one provider may simply chose to deliver a higher quality service. As well as contractual incentives, providers' individual motivations and the demand for their services will therefore also influence the nature of services delivered.

Volume, cost and structural quality of services[22]

Table 7. 1: Type of services delivered (% of total patients)

Provider	Curative	Chronic	Antenatal care and family planning	Total
WC PDS (n=4)	68.0%	30.0%	2.0%	100.0%
EC PDS (n=5)	46.0%	49.0%	5.0%	100.0%
Public sector: rural facilities[23] (n=4)	67.0%	25.0%	8.0%	100.0%

Table 7.2: Patients seen per full time equivalent (FTE) consulting professional

Provider	Average annual workload per FTE consulting (range)
WC PDS (n=4)	19184 (14602-23360)
EC PDS (n=5)	13162 (36117 – 2736)
Public sector: rural facilities (n=4)	9722 (7237-11490)

Table 7.3: Mean and median consultation time and time spent in clinic (minutes)

	WC PDS (n=4)	EC PDS (n=5)	Public (n=4)
Mean consultation time	3.0	5.1	7.6
Median consultation time	3.7	5.2	6.8
Mean time in clinic	115.0	127.0	136.0
Median time in clinic	92.0	75.0	103.0

Table 7.1 shows that the public sector clinics delivered a higher proportion of preventive services such as antenatal care and family planning. High volumes of patients seen per PDS practitioner is reflected in the figures of average annual workload per full time equivalent (FTE) consulting staff

[22] The data presented in tables 7.1 to 7.6 are drawn from the results of the broader research project 'New purchaser/provider relationships in health care: the desirability of contracts with primary care providers'

[23] Details of some elements of PDS performance are presented in comparison with an average for 4 rural public sector sites. More details of these sites are given in appendix I.

member, shown in table 7.2. Table 7.3 shows that PDS facilities had the shortest consultation times[24]. In the Western Cape, where access to the PDS is not restricted by a need for referral, the consultation time was particularly brief. PDS in the WC were seeing over double the volume of patients per clinical staff member than public sector facility personnel in the same province. They were therefore seeing high volumes of patients in short periods of time, which makes sense in terms of the incentives created by the contract, but could also be a simple reaction to demand from the community. Such high volumes of patients and short consultation times are likely to have negative implications for the quality of the service being delivered.

Table 7.4: Average cost per clinic visit (Rand)

	WC PDS (n=4)	%	EC PDS (n=5)	%	Rural public sector with sessional doctors[25] (n=3)	%	Rural public sector average (n=4)	%
Internal admin and management	1.13	2.7%	1.27	3.0%	1.43	3.7%	1.58	4.2%
Building operating costs	1.74	4.1%	2.99	7.2%	3.19	8.2%	2.94	7.9%
Diagnostic tests	0.94	2.2%	0.59	1.4%	1.05	2.6%	1.02	2.7%
Transport/vehicle running costs	0.17	2.8%	0.23	0.6%	0.56	1.4%	0.67	1.8%
Recurrent cost excl. staff & drugs	**4.98**	**11.8%**	**5.08**	**12.2%**	**6.23**	**15.9%**	**6.21**	**16.6%**
Clinical staff	17.28	41.1%	20.44	49.0%	14.84	37.8%	13.58	36.3%
Medical and surgical supplies	15.58	37.0%	10.14	24.3%	12.03	30.6%	11.80	31.6%
Total recurrent cost	**37.84**	**89.9%**	**35.66**	**85.5%**	**33.10**	**84.4%**	**31.59**	**84.5%**
Building costs	0.58	1.4%	2.55	6.1%	3.71	9.5%	3.90	10.4%
Medical Equipment	0.11	0.2%	0.10	0.2%	0.25	0.6%	0.22	0.6%
Furniture and equipment	0.03	0.1%	0.11	0.3%	0.10	0.2%	0.10	0.3%
Vehicle costs	3.55	8.4%	3.29	7.9%	2.08	5.3%	1.55	4.2%
Total capital cost	**4.27**	**10.1%**	**6.05**	**14.5%**	**6.14**	**15.6%**	**5.77**	**15.5%**
Total cost	**41.11**	**100.0%**	**41.71**	**100.0%**	**39.24**	**100.0%**	**37.36**	**100%**

Table 7.4 shows the average costs for PDS practices in the EC and WC and the four public sector rural clinics as a comparison. Spending on items that are reimbursed by the contract (staff costs and drugs) is in line with or higher than the public sector. When it is considered that PDS are operating

[24] PDS had the shortest consultation times of all the facilities evaluated in the research project

[25] Three of the rural public sector clinics had doctors visiting the clinic on a sessional basis and therefore had a staff complement which was more comparable to the PDS practices in terms of cost. One of the public sector rural clinics did not have any doctors employed.

with lower staff per patient ratios (see for instance table 7.2 for patients per FTE), spending on clinical staff costs is relatively very high. Meanwhile, spending on other recurrent items is consistently lower, presumably reflecting the fact that they are not reimbursed by the contract. Capital spending, in particular building costs and medical equipment, is also low. Vehicle costs are relatively high because they are calculated as a portion of the PDS' private vehicle costs. There was considerable variation in the cost structure between PDS practices, a breakdown of costs per facility visited is shown in Appendix V.

Drugs were supplied directly from the provincial drug depot, and for this area of expenditure the PDS are in line with other public sector services. Table 7.5 shows some more detailed drug use indicators. The PDS prescribed roughly the same number of drugs and antibiotics as their public sector counterparts, although their use of generic names was lower.

Table 7.5: Drug use indicators (high and low range between facilities shown)

	No. of drugs per script	% antibiotics	% generic name used
PDS range	2.0-2.3	24%-35%	11%-28%
Public sector range	1.7-2.5	22%-48%	33%-37%

Finally, the results of an assessment of structural quality shown in Table 7.6 below also suggest that PDS spend little on areas of the service for which they will not be reimbursed e.g. purchase and upkeep of facilities and equipment. Each PDS facility was scored on a standardised checklist for structural quality. This included the categories of: infrastructure, access, management and staffing, patient environment, drug supplies and equipment, tracer drugs and diagnostic tests and lab services. Out of these categories the indicators shown in the table below were chosen as those most likely to be influenced by contract design. The percentage of PDS practices that scored adequately in these categories is again shown in comparison with the same public sector clinics.

Table 7.6: Indicators of structural quality of care

Structural indicator	WC PDS	EC PDS	Public sector
General state of repair of facilities	Adequate/poor	Poor	Good/adequate
Adequate toilets	0%	20%	90%
Functioning refrigerator	100%	100%	100%
Adequate emergency kit	25%	40%	45%
Items of essential equipment	75%	80%	100%
Lockable drug storage facility	75%	60%	75%
Waiting area: large enough and under cover	75%	40%	65%
Adequate patient records kept	75%	80%	100%

That PDS practices may minimise expenditure on structural facilities for their state patients, as a result of a contract design where these costs are not reimbursed, appears to be borne out by the general state of repair of their rooms and the adequacy of simple facilities such as toilets. All but one PDS practice had either non-existent or grossly inadequate toilet facilities for their state patients. Facilities were far more cramped and in worse states of repair than for the public sector. PDS did not purchase new equipment for the PDS side of their practice or put money into improvement of its facilities. One practice did not keep patient records for their state patients. Although generally on the low end of the spectrum, other structural indicators are not greatly out of line with the weaknesses and strengths of other models that were investigated.

Data presented so far suggest that PDS were delivering a low cost, high volume service but little can be concluded about its quality. Inference from the evidence presented would suggest that the quality of the services will be reduced by the short time spent with each patient and the low structural quality observed. Further evidence from FGD discussions run in five of the towns where PDS practices were evaluated sheds light on the opinion of users and non-users within the community about the quality of the services.

Perceptions from FGDs

Extracts of these FGDs are presented below. The opinion of users and non-users of the PDS services was largely negative, with the separation of services from private patients, the waiting time, attitude of personnel, lack of privacy, adequacy of examination and medicines all criticised. The limitations of this type of evidence are then briefly discussed.

Long waiting times and short consultation times were a common cause of complaint, with PDS being perceived as only issuing drugs without giving a proper examination:

"you are not even fully in the consulting room yet, and he is done with you"

"all he does is sit down, look at you, and start to write"

"all he did was write medicines on a piece of paper...he didn't even ask me to lie on the bed"

"all the people get the same medication, irrespective of complaint"

"sometimes we have to come back the next day if they cannot attend to us"

"you go to the doctor in the morning and you come home at 7 in the evening. The doctor comes, he drinks tea, he has a cigarette, walks around then he helps the people in front (private patients) then he has another cup of tea....."

Comments on the interpersonal quality of the consultation, or the doctor's apparent level of caring and motivation, varied a great deal from practice to practice.

"at the state doctor, it isn't really about the patient's well being, its about the money that he is going to get at the end of the month from the state...he just neglects the sick people"

"you can see that this man doesn't care less"

"they really have a way of making you feel like rubbish"

Positive comments were made about two doctors specifically:

"I must say that he always gives me a regular examination, a good examination...he won't be aggressive or anything, he is all right"

"I cannot say whether he is good or bad but he does have some care"

"he is friendly and active"

"he listens to what you have to say. Everyone understands him because he speaks isiXhosa like us, which makes it easy for us to explain to him what the problem is. That's what we like about him"

"he usually takes a lot of time, checking thoroughly so that you are also satisfied."

In most focus groups the issue of racial discrimination was raised, as well as the lack of privacy at some PDS where they use a "conveyor belt" method of seeing the maximum number of patients in minimum time:

"he is too concerned about the whites and the medical aid patients"

"if a white person comes, then they are treated first"

"all the people were sitting in a row and the doctor examines them starting from one side to the other....and later on the sister came around and the people said what's wrong with them"

Whilst this data from FGDs adds a useful perspective to understanding the way in which PDS deliver services, it must be treated with some caution. First there is a tendency of FGD participants to focus on "atrocity" stories and therefore give an unduly negative picture of the service described (Silverman 2000, Schneider and Palmer forthcoming) and second because these FGDs were at least as negative about other services, particularly the public sector. For instance it was said of nurses in the public sector clinics:

"she doesn't examine you, she just gives you medicine and sends you home" and also of hospital services:

"they just give you pills and ask how you feel, then write down your response"

Again, separating out the influence of the contract from other factors is problematic. Problems of poor quality due to large volumes of patients being seen may be attributed to contractual incentives but could equally be a consequence of the under-resourcing of the health system, as is demonstrated by many urban public sector health facilities being equally over-crowded.

Evidence on service delivery suggests behaviour that would be predicted if PDS were responding to financial incentives in the contract, but cannot rule out other influences and explanations. In particular, whilst it is difficult to capture this in any of the data presented here, it was clear from direct observation at the different PDS practices that there was considerable variation in the way that each practice was run, how patients were treated and their level of satisfaction with the service. This suggests a considerable role is played by each individual's motivation in determining the type of services that get delivered under an incomplete contract.

MONITORING OF SERVICE DELIVERY

This section considers the operation of the contract in terms of the process of monitoring. The degree to which the purchaser is able to know what is taking place under the contract and the degree to which the provider sees the threat of monitoring as a control on his/her activities are examined. Due to a lack of capacity at provincial and regional level and the nature of the service, monitoring was recognised by both purchaser and provider to be both imperfect and incomplete. There was a complex mixture of justifications presented for this, ranging from an unwillingness of the province to monitor, through their lack of capacity to do so, to the opinion that monitoring of services such as the PDS deliver was simply not feasible.

The degree to which PDS services are monitored depends both on the feasibility of monitoring this type of service and the capacity in the province to carry out the task. Several levels/degrees of monitoring, varying both in formality and the degree to which they were practised, were mentioned by managers and PDS, these are shown in the tables below:

Table 7.7 : Types of monitoring

Types of monitoring commonly used by both provinces	**Type of control exercised by this type of monitoring**
Monitoring of global financial target	*Are the claims by the PDS within the budget limit set?*
Administrative monitoring/ monitoring for irregularities	*Do the claims add up? Is the province paying for services that it received?*
Drug use monitoring	*From the drugs used, what volume and type of services appear to have been delivered?*
Types of monitoring mentioned as a good idea, but not practised	
Monitoring of the service profile	*Is the service pattern a)realistic? b)appropriate?*
Monitoring of quality of services delivered	*Are good quality services being delivered?*
Monitoring of outcomes	*Are health indicators in the district improving?*

In addition, table 7.8 shows that the following more informal controls on service delivery were suggested:

Table 7.8: Informal monitoring and control on service delivery

Informal methods of monitoring	**Likely effectiveness**
Monitoring by other health professionals in town e.g. other doctors, pharmacist, clinic sister	*differs from town to town according to individuals involved*
Complaints from patients/community	*These are described as seldom – one manager gave an example of receiving 2 complaints per months for all services in the whole region (1800 people and 14 hospitals)*
Other controls on service delivery mentioned	**Examples**
Policy	*e.g. restricting access by requesting a referral from the clinic provides further way of checking if volumes are realistic*
Incentives	*e.g. make payment too low for incentive to increase volumes of patients really seen : "the time it takes to see these patients and (their) increasing sophistication .. means that you don't have time for your private work. So you will lose. If you have to physically see all those patients you will lose" PDS, Eastern Cape*
Control drug use	*e.g drug procurement via central drug depot to allow monitoring of what drugs issued/prescribed*
Threat of sanctions	*e.g. existence of bodies such as the Heath Commission which investigate fraud*

Strength of monitoring function in each province

Opinions on the effectiveness of basic monitoring differed between the two provinces. Whilst in the Western Cape there was some confidence that basic financial monitoring was effective, in the Eastern

Cape this was doubted. It was clear in both provinces that quality of services delivered was not being effectively monitored.

Monitoring procedures - Western Cape

The Western Cape system of monitoring relies to a large extent on the computer supplied by the province to each practice. This records details of each individual patient's visit – name, date of visit, diagnosis and what drugs were prescribed. At the end of every month each PDS sends these details to the Provincial head office. Here figures are processed and then claims passed to the regional office for payment. Regional offices monitor monthly claims to ensure that they are within the budget limit set for each PDS practice. They expressed little interest in monitoring beyond this level of detail:

"The head office is looking at the procedures that they are doing. I pay no attention to what they are doing at all! We just monitor the expenditure and inform them if they are going to overspend" Regional Manager, Western Cape

Drug use is also assessed as an indicator of the volume of service delivery.

"I think that our office takes more seriously the monitoring of medicines. ... We have excellent or better than average pharmaceutical control...." Regional Manager, Western Cape

Monitoring procedures - Eastern Cape

In the Eastern Cape there was no computer system. For each individual patient a form recorded the date, name, address, diagnosis, medication prescribed and length of time spent with the patient. Each form was signed by the PDS and sent to the regional head office monthly. Here they were checked for any obvious numerical errors but further problems were unlikely to be picked up as checking was done by a junior clerk, described by one provincial manager as having *"no insight into what she is doing"*. Once this review is completed payment proceeded. Although there was no formal review process by which this would happen, if the province believed that there was a problem with the claims of a certain practice, e.g. there seem to be high volumes of patients relative to the population or someone has complained, then all claims from that practice were entered onto a computer and

more thorough analysis of the service patterns carried out. An Eastern Cape manager described some of the abuses of the system which they tried to pick up:

- PDS seeing a large population compared to the size of the town
- Doctors writing 5 items on a prescription and then claiming for 5 prescriptions on consecutive days
- Claims for additional services such as X-rays that do not contain the name of the patient

Effectiveness of monitoring

In the Western Cape there was a belief that basic financial monitoring was effective and likely to pick up inconsistencies in claims, even if unable to address broader issues such as the accuracy of claims and the quality of care delivered. This belief was shared by both PDS and regional managers. Western Cape PDS felt that the figures that they submitted were rigorously checked and that inconsistencies would be picked up:

"... if you are up or down with your consultations or if you do more surgery than they think is necessary then they will pick it up, so they do monitor. That was started mainly.... after the computer system was brought in" PDS, Western Cape

".. I saw a patient about 5 times in one month. I had an explanation and I was very pleased that they picked it up. It takes about a month for them to come back." PDS, Western Cape

"They monitor exactly what we do" PDS, Western Cape

In contrast, in the Eastern Cape neither PDS nor managers felt that even basic administrative monitoring was taking place. One manager commented:

"Monitoring? - There is nothing going on" Regional Manager, Eastern Cape

Whilst a PDS said:

"Oh we can get away with murder...up to about 1992 we were under the impression that all statistics were monitored, but since then, nothing. I remember one month the sister forgot to send in the practice's claims, and we only realised it about 6 weeks later, and no one inquired ..why all of a sudden these statistics weren't there" PDS, Eastern Cape

Another PDS observed:

".. it's quite easy to use some of the PDS medicines for your private patients. I don't think that, I mean I don't get the impression anyway that, supposedly they have to tally the medicines that we have ordered from those forms. Apart from the numbers I don't think there is much monitoring" PDS, Eastern Cape.

In both provinces there was little expectation that quality of care was or could be actively monitored:

"I don't think we have good monitoring. It depends on what you want to monitor, administrative monitoring the system is good at doing...If you talk about clinical monitoring then that's a different ball game" Regional Manager, Western Cape

"I think they monitor the amount of work. In all the discussions that we have had the quality of care has never been discussed. It's always been about money...we have never discussed what we are doing or how well we are doing." PDS, Western Cape

Regional managers and PDS expressed doubt about the feasibility of monitoring either the type or quality of services that a PDS delivers:

" monitoring medical practitioners ..is a very very tricky business, under the best conditions" Regional Manager, Western Cape

"I don't have any control over what they do, many just look at the patient." Regional Manager, Western Cape

"Unless you are there how can you see if a guy spends 12 minutes or whether he does a procedure or whether... I personally feel that there is no ways that you can police that kind of a system" Regional Manager, Western Cape

Whilst PDS echoed this opinion from their side:

"quality of care I don't think they really know what is going on. They don't even have an idea...I don't see how they can do it." PDS, Eastern Cape

"... they don't know, with the amount of patients that we see, whether we see one patient ten times or ten patients once" PDS, Eastern Cape

In the Eastern Cape the overall failure to monitor was also blamed on a lack of resources and capacity to monitor. A manager commented that his department used to visit every PDS every 3 to 6 months, nowadays PDS practices were only visited *" to put out a fire"*. Others said

"it was very easy to do that when we had the staff and the vehicles and the time"/ . "we haven't got the staff to do that work anymore" / "if they could just appoint someone to visit and inspect these part time district surgeons, it would immediately eliminate all those kinds of things happening" Regional Manager, Eastern Cape

PDS also appeared to think that monitoring their activities would be relatively straightforward if the capacity was there:

"it would be very easy to audit us. A clerk with a matric education could walk into this practice and say "please give me the stuff" and he could physically count and look at it. Alternatively for every patient I see I have to have a letter of referral. So its actually a very simple but very foolproof system. It's very easy to monitor. They just don't do it" PDS, Eastern Cape

But the view of regional managers that currently such capacity was lacking was echoed:

"when Bisho[26] took over the admin, everything just fell flat. We haven't had reviews of our figures for I think three or four years." / "they are doing crisis management"/ "I don't know if they have got the manpower to read all those things every month. But hopefully they do" PDS, Eastern Cape

Whilst monitoring was generally acknowledged to be weak, and the risk of being penalised by the Province small, the Department of Health's ultimate sanction, an investigation for fraud was still seen as an unpleasant deterrent. One PDS described their experience:

" we had a very intense investigation because my previous partner was quite confrontational... it was very embarrassing for us. Loss of face in front of the whole town. The police turned up, seized our records. They gave us no warning. .... they took one month and then they went through that whole month and they went to individuals and asked. They went to a lot of people....." PDS, Eastern Cape

Data presented in these two sections on service delivery and monitoring beg the question of what is determining the behaviour of PDS in delivering services. First it seems that the design of the contract has some effect and that PDS to an extent are responding to financial incentives by seeing high volumes of patients, keeping consultations short and minimising some elements of expenditure on their PDS practice. Second there appears to be some deterrent from outright fraud provided by the formal monitoring mechanism, but this is not able to ascertain and therefore influence the type or quality of services delivered by PDS. This leaves more informal mechanisms to explain the remainder of influences upon service delivery.

[26] The provincial capital of the newly created Eastern Cape Province

Forms of informal monitoring/control

One of these mechanisms may be a form of informal monitoring by people within the community. The manner in which this operates is linked to issues of the motivation of PDS, in this case the preservation of their reputation. Particularly in the Western Cape this was perceived by PDS as playing an important role:

"... The incentive in the contract is this: every patient you see is related to somebody else. It's often likely to be a private patient. So you cannot afford to mess up your practice by giving bad service. So you have to be reasonable, you have to be decent, otherwise you can lose your private practice. It's a great thing combining public and private practice, it will keep both to a decent standard" PDS, Western Cape

Another doctor described how his reputation as a doctor applied regardless of whether he was treating state or private patients:

"patients don't make a difference between state and private patients, they say its Dr X who does this and does that. So in areas like this the state patients is always going to receive a first world service if it is rendered by a private practitioner because he can't service one patient on a third world basis and the next one on a first world. There is no way you can do that" PDS, Western Cape

Monitoring by other health professionals (*"My peer review is my chemist in town..."*)

as well as patient complaints were also mentioned in the Eastern Cape but doubts were cast as to what extent these mechanisms could be relied upon. One PDS observed that in many years in that town not one patient had complained:

"*Short of deliberately killing someone. Then somebody might complain*". PDS, Eastern Cape

Monitoring of the contract does not therefore appear to provide great control over the services delivered. In conjunction with a vaguely specified contract it appears that to a large a degree the PDS work is open to interpretation by the individual.

PAYMENT

Many PDS had experienced late or inadequate payment by the Province. Four of the five PDS interviewed in the Eastern Cape said that they had experienced 3-4 month delays at least once and often payment was incomplete. In some cases, debts were still outstanding. In other cases, whilst payment for clinical services was made, the dispensing fee was not included:

(*'it's not a sure thing, you can't bank on it'* PDS, Eastern Cape). Obligations by the province to review the contract payment levels were also felt to be neglected:

" .....there are shortcomings and there are things that the government hasn't changed. for instance our travelling fees, that hasn't been increased in almost 10 years. In the meantime petrol has gone up by almost 400% so if you look at the figures of the AA now..... I am making a loss with every clinic that I travel to, and I am spending a lot of time on the road which I don't get paid for, so every call out and every clinic is an expense and that they are not willing to change." PDS, Western Cape

In the Western Cape there were also quite common experiences of delays in payment but there were no references to cases of money outstanding to be paid. One practice described how if their cheque was late they would go to the provincial offices and *"stand there until it gets written"*. PDS responded to late payment in a variety of ways, but never by stopping service delivery. On one occasion one practice both went to the chairman of the Democratic Party in that area and threatened the DOH that they would stop rendering services before they received their payment. On another occasion the representative for the Eastern Cape PDS association consulted lawyers and informed the province that they were doing so. In both these cases payment was eventually received without the threatened action having to take place.

Some PDS also cited examples of delivering services for which they already knew they would not be paid by the province. In one case a practice in the Western Cape that had been capped at an average of 100 patients per day was seeing 118 on average. *"I have never asked them to pay me for the extra 18, they haven't paid me for the extra 18 so I have done it for nothing"*

Overall the payment function relies on toleration by PDS of late or inaccurate payment. PDS are unwilling to use the ultimate sanction of withdrawing services but use many other methods to secure

payment by approaching officials, threatening the withdrawal of services or indirectly threatening legal action. One PDS who did approach a lawyer over issues of non-payment explained how legal action worried him:

"Yes it did. It did worry me. That's why I waited so long" PDS, Eastern Cape.

NEGOTIATIONS OVER CHANGES TO THE CONTRACT

A long standing contract such as that for PDS services will inevitably have to adapt to changing circumstances. How this is done is a good indicator of how the contract operates.

There are various areas in which the terms of the PDS contract have changed or are still changing, and this has implications for the income of PDS. They can be grouped into issues of a) how patients access the system (PHC made free, referrals from clinic) and b) changes to what services PDS are expected /permitted to provide (services for chronic patients, drug dispensing). This section analyses the way in which the change to the contract is introduced and the reactions of PDS.

a) Changes to how patients access PDS services

The introduction of free health care (described in chapter 4) saw a 40% increase in demand for PDS services which led provinces to seek to control expenditure on these services. As was outlined in chapter 4, in the Eastern Cape this was achieved by a requirement for referral from the PHC clinic and in the Western Cape by capping the total numbers of patients that can be seen by some high volume PDS practices. This combination of policies meant that PDS first had to adapt to a huge increase in demand for services and then a sharp reduction.

PDS in both provinces complained that subsequent controls on access to their services were introduced with no negotiation and very suddenly. Both policies of capping (WC) and requirement of clinic referral (EC) were introduced at very short notice. In the Western Cape there was some agreement by PDS that they were willing to be capped, but they felt that this was then violated by the

province making a further unilateral decision to increase the degree by which their budgets were cut. In the Eastern Cape the policy of clinic referral was introduced with no negotiation. This meant that practices which had had to expand quickly to cope with the sudden increase in demand following the introduction of free primary care, had to again contract and staff had to be laid off at very short notice. In the case of the Eastern Cape, PDS were given two weeks notice that they may only see patients who had a referral letter from the clinic:

"*the letter just pitched up here.. They just sent us this and we had to make choices and determine what we were going to do, and the clinics knew nothing and we had to tell them that they were taking on the outpatient load from now on.*" PDS, Eastern Cape

For the Western Cape, one PDS describes how patient numbers increased and then capping was introduced:

" from 800 patients a month to 4000...we adapted and coped and people were happy. I think this was a tremendous service, it surely should have made Mandela[27] *and Zuma*[28] *happy...they wanted to give medicine to the people and we achieved it at a very fair price....and yet at the end, you don't get thanked, you get capped... suddenly, in the middle of this year, without fair warning, they capped us"* PDS, Western Cape

The capping system was viewed by some WC PDS as effectively a slow form of dismissal by drastically limiting their income. One PDS described the wish to take legal action against the province, but feared for the consequences of such action:

"you've been rendered redundant, and you are going to leave, your practice is going to collapse, but you don't get a package, you don't get paid out. So you *have been sacked, in a subtle way, without being renumerated in some sort of way. And we think this is unfair labour practice. We feel we should take this to dispute, but these things are way above us, it just frightens me, personally, to death. I don't know how those things work...I don't know enough about it. It's uncertain times, you want to look after your job, you have got a lot of overheads.and your own family etc...and you don't want to risk your job. Say you lose a thing like this, after you are without a job, or they bear a grudge..."* PDS, Western Cape

A regional manager described how the terms of the written contract did not play a huge role in this type of negotiation. He dealt with the PDS' discontent as follows:

"saying to the PDS 'just take us to the constitutional court', I was playing with fire a bit, luckily I haven't burnt my fingers. The negotiation with the PDS is not a legalistic negotiation, it's a negotiation that basically appeals for common sense and for sanity to prevail. I was saying to them "I can't lose you but you have become unaffordable". Regional Manager, Western Cape

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[27] President Nelson Mandela
[28] Minister of Health for South Africa 1994-1999

b) changes to what services PDS are expected /permitted to provide

Issues such as PDS' right to dispense from their practice (and earn a dispensing fee) and which types of PHC services they should deliver (e.g. whether chronic patients need to visit the PDS for each check up) were also subject to change. This was again felt to be at short notice and unnegotiated by the Provincial DOH. Comments included:

"one day, out of the blue we were told that we were giving up dispensing" PDS, Eastern Cape

"it hasn't been officially stated, but the message that we get through the grapevine from Bisho is that they plan to do away ...with us dispensing" PDS, Eastern Cape

It was also felt by some that salary reviews were random, at the whim of the province and according to their ability to pay:

"the last time they reviewed our salary it actually dropped, that was in 1993 or 1992. They actually applied that unilaterally" PDS, Eastern Cape

"So when we approached them on the situation (lack of increments) *they said well there is too much fraud going on and they need to audit and review everything.. But we know that the province hasn't got any money, and they are using it as a delaying tactic."* PDS, Eastern Cape

Other PDS expressed feelings of defencelessness when they talked about the way that the terms of their contracts were altered:

"Without my consent they have now capped me by 26 or 30%. And this now sets a precedent, it means next year they can cap me by 50%. We cannot allow that precedent to continue. It's just that precedent I don't like" PDS, Western Cape

But this PDS when questioned about how he could stand up against such a precedent admitted that he had very little recourse, other than legally, and the idea of that again 'frightened him to death':

"I am scared of going through this whole legal process which I know nothing about. It's too unfamiliar for me. It might cost me a lot, it might cost me my job. I don't want to be seen in the paper. I don't want to go through this whole rigmarole. I am a doctor" PDS, Western Cape

However, more fundamental change to the contract design did not follow this pattern and appeared to require greater negotiation and agreement. There was an ongoing attempt by both the Western and Eastern Cape to fundamentally alter the nature of the contract:

"we want the doctor to go and visit the clinic as such and see referrals...be available for after hours emergency work and do medico legal work. ...the contracts that the province has devised so far and offered....they are not lucrative enough to retain them in these places."
Regional Manager, Eastern Cape

They appeared less able to proceed with such a major revision without the co-operation of the PDS.

The approach to this major change to contracts has been more consultative, with policy documents circulated for comment and several meetings between PDS and provincial officials. At the time of the research no consensus had been reached in either province, but there was a generally more positive attitude towards the process of negotiation. PDS commented:

"I think that they will write a new contract that will be negotiated with us as well. There has been a promise to us that we will negotiate it...they must be reasonable...it's totally unfair to go to the clinic." PDS Eastern Cape

"you used to just get a letter and it was just from the top. Now we have a committee and we have discussions every 6 weeks. It's much better." PDS Western Cape

It is possible that provinces are adopting a more co-operative approach to this change in the contract because it is clear that they cannot introduce such radical changes unilaterally. The dependence which increased the willingness of PDS to adapt to small changes in contractual terms appeared to be mutual - radical changes to contractual terms cannot be made unilaterally by the purchaser for fear that they may lose their service provider altogether.

The manner in which both PDS and the purchasers react to solving problems of weak monitoring, payment problems and changes to the contract was heavily influenced by the lack of competition within the market and the reliance of PDS on continuing their income from the province, as well as their perception that the community that they lived in relies on them to continue rendering services. This last point is clearly illustrated by the example of the PDS rendering services to more patients than he will be paid for. Again it appears that the operation of the contract is being as much determined by factors which are not contained within its formal structures as by those that are. The

next section turns to some possible explanations of the nature of the contractual relationship arising in this context.

SECTION 2: SUBSTITUTES FOR A COMPLETE CONTRACT

Data presented in the previous section suggest that PDS are influenced by the incentives contained in the contract, and that in such an incompletely specified contract many areas are also left to their discretion. In addition, late payment and abrupt changes to the contract rely on the PDS' willingness to co-operate for the contractual relationship to survive.

In discussing each of these features of the contractual relationship, the role of external or "residual" factors in determining how individuals act under an incomplete contract were identified. It is clear from the interview data that each contractual relationship was to some extent determined by how the individuals concerned chose to interpret it and chose to act and this in turn was influenced by the context in which the contract was operating. In recognition of this, the final section of this chapter examines two potential influences upon how individuals chose to act, namely trust and dependence. To some extent, such informal controls arise from the context and combination of factors described in chapter 5.

TRUST

As was shown by the review of the literature in chapter 2, trust between parties has been highlighted as a possible determinant of how contractual functions are carried out. In the context of many long-running, incomplete contracts, resort to trust as a method of co-operation is common. Its role in the PDS contract was therefore explored during the semi-structured interviews with purchasers and PDS.

The setting in which trust is discussed is one in which the prevalence of fraud under the contract was acknowledged by both PDS and provincial managers. For instance, provincial officials often refer to

"*the kind of fraud taking place under the PDS*" and the fact that PDS are "*bending the rules – we know that it's happening.*"

PDS also referred to:

"*... district surgeons who (are) cheating. I suppose statistically there always will be one or two*" PDS, Eastern Cape

and that:

"*cheating...happens a lot in the other districts - guys would claim for the same patients twice a day...*" PDS, Eastern Cape

Against such a background of acknowledged fraud, unsurprisingly the role of trust in PDS relationships was varied.

Different levels at which trust could play a role in the operation of the PDS contract were between PDS and individual government officials at regional and provincial level, between PDS and regional and provincial government, and between PDS and the National Department of Health. Different types and degrees of trust were reviewed in chapter 2, for instance the distinction between competence, goodwill and contractual trust, and types of inter-personal trust. In explaining the workings of the PDS relationship it appeared that inter-personal trust and competence trust were the most important. The nature of each relationship between an individual PDS and their regional manager was highly individual, correspondingly as the relationship became more distant, for instance, between the PDS and the National Department of Health, trust was lessened. Competence trust was important because the nature of the services being contracted are professional, raising professional competence as a key issue.

Where positive statements were made about trust, its nature tended to be interpersonal, based on a history of successful interaction:

"*That is why our monitoring and our relationship depends more on our inter-personal, and our relationships, that's the defining things, not the contract. .... We haven't depended very much on strict legal definitions of what we expect of people. And the rest is very much a gentleman's agreement if you want, or an understanding amongst peers that that is what we should be doing*" Regional Manager, Western Cape

Provincial managers spoke about PDS on an individual basis "X is OK, I don't trust Y" and PDS also appeared to feel that they could rely on certain individuals, being able to say with more confidence about one individual: "he won't dish us" than they were willing to comment on any level of the Department of Health more generally. One PDS said of the provincial manager in charge of restructuring the PDS;

" I basically trust him, that he wouldn't come up with a thing that would totally do the DS" PDS, Western Cape.

When asked questions about trust, the response was often given for an individual level:

"a lot of it is to do with Dr X. I mean you ask me if I trust this man, I have to, but from what I have seen of him, I will trust him" PDS, Western Cape

whilst many comments stressed the individual nature of evaluating trust, along the following lines:

"well the only person who really does much for me is Mr X...." PDS, Eastern Cape

In response to a question about trust in the provincial level of the Department of Health, many PDS also picked out an individual and said "*well, I trust him*".

or for example:

"now this gentleman's type of agreement works much better. I have no idea how much of this is because of the personality of Dr K that it works so well. I think that if somebody else might come into his place it might change, but at the moment this works very well" PDS, Western Cape

Regional managers responses to questions about trust were also often brought to an individual level. One regional manager explained that he trusted some PDS and some he trusted not at all. He said that he had a specific opinion about each one and behaved according to that.

The role of prior experience and history was important in establishing such individual trust. Practices which saw themselves as having a trusting relationship with the province often based that on close interaction in the past. For instance:

"where we differ from quite a few other practices is that I think that we have quite an open relationship with the state because we were the pilots for the computer system so we have been working closely together for a long time. So we don't really have a problem." PDS Western Cape

At the other extreme, an impression of a complete breakdown of trust was reflected in comments by PDS in the Eastern Cape:

"they don't trust us.....I think that there is massive distrust from Bisho" PDS, Eastern Cape

"there are a few rotten apples in the bag...so they have decided that we are all taking them for a ride" PDS, Eastern Cape

This was echoed by the comments of provincial managers in both provinces:

"there is deep seated mistrust amongst some of the managers in the Department"
Regional Manager, Eastern Cape

" there is a lot of corruption you know...you can't trust any doctor, they are crooks.... It's a struggle to trust. Maybe it's the situation that people are working in that is not conducive to trust "
Regional Director, Eastern Cape

"I can't believe that all those drugs are only used for state patients"
Regional Manager, Western Cape

As well as the importance of an individual dimension in the type of trust characterising some parts of the PDS system, a second noticeable feature is that trust was fostered by the impression of shared beliefs and motivations. Comments about why there was little trust in many of the PDS-purchaser relationships usually included some reference to suspicion of the motivation of the other party or historical experiences of unreliability.

For instance, as distance increased and the degree of personal experience or interaction decreased, the more sinister the plans and motivations of government departments were assumed to be. PDS clearly considered it easier to trust the regional and provincial government than the National Department of Health (NDOH). There was widespread mistrust and even fear of the motivations of national policy-makers and the influence that they could wield over a local situation. For instance:

"They [the province] *could be stringing us along.* [getting rid of all PDS] *might be part of a National Initiative. They have no control over it, they just get simply told that this is the end".*
PDS, Eastern Cape

"I trust them, but I realise that they are at the beck and call of the ministers and the politicians and the budget. They can be told that their budget has been cut by 50% and they have got no choice"
PDS, Western Cape

In some comments it almost seemed as if the PDS found it easier to blame the NDOH for aspects of policy with which they did not agree. They made the NDOH into a scapegoat because it was further away and easier to blame and they did not have to interact with it:

"the health system as it is now has just been posed onto them (the WC province) *by central government. They have got to cope with it. They don't really agree with it but they have got to cope with it."* PDS, Western Cape

"they (the province) won't stop the contract if it is in their hands because they are grateful for the service that we are rendering but the central government suddenly decides another system is going to be implemented, no matter what the cost is then they have no control" PDS, Western Cape

Where there was feeling that the motivations of PDS and the province did not coincide this further exacerbated feelings of distrust. PDS constantly expressed doubts about the motivations of the provincial and national governments. For the PDS, a general lack of confidence in the underlying motivations of provincial decisions was coupled with a belief that decisions were being implemented for political rather than practical reasons.

PDS also believed that the province held similar suspicions about their motivations, commenting on being allowed to employ nurses to screen patients, it was said:

"they wouldn't pay the salary. because they are afraid that we might use that person for our own, devious purposes..." PDS, Western Cape

and this was echoed by one regional manager commenting on their basic motivations:

"If you don't monitor (PDS) and you don't get them to review themselves.... Then they are going to milk the system, everyone is going to milk the system" Regional Director, Eastern Cape

Trust was diminished by the presence of great uncertainty about the future of the contract, again closely linked to a fear of the motivation of the Department of Health and a feeling of powerlessness. Uncertainty took a variety of forms, most noticeably about how much longer the PDS system would run for and the DOH's plans for restructuring the system:

"I know that they will sack me if there is a black doctor who wants the job" PDS, Eastern Cape

"Sometimes you feel that, ..., because you are white and you are Afrikaans you can very easily become a victim of a system. What is being done to me I will do to you" PDS, Western Cape

"...the impression that we get, that they would love to keep this system going for as long as they can and then sort of phase you out when they like. So there is certainly a lot of uncertainty concerning motives on both sides" PDS, Eastern Cape

"the way that we read the situation is that Bisho would like to get rid of a lot of us and start a new system of their own making, preferably with darker skin personnel..." PDS, Eastern Cape

Uncertainty led to frustration amongst PDS as expressed by one doctor:

"I have a responsible job, it is difficult, the PDoH relies on me, so why do they only give me one month contracts? If it's responsible there should be some permanence. This is the kind of thing that makes me nervous." PDS, Eastern Cape

The second important form of trust in this contractual relationship appeared to be what Sako (in Goddard and Mannion, 1998) defined "competence trust", or the belief that PDS would do a good job because they were trained professionals and therefore competent and would behave ethically. Again this is linked to the ideas of motivation and preservation of reputation discussed earlier. PDS also seemed comfortable with this idea that they would behave appropriately and be 'self policing':

"I hope that the relationship is one of trust. I hope they rely on me to be a good doctor. And it is very unethical not to be one" PDS, Eastern Cape

"many of them [the PDS] *are outstanding medical officers"* Regional Manager, Western Cape

"he is causing us a lot of grief, but I think that as a clinician he is a good doctor"
Regional Manager, Western Cape

A belief in the strength of professional accountability also underlay WC provincial officials' expressions of confidence in the efficacy of a system in which PDS had to sign their claims personally.

Whilst the PDS appeared to be trusted to be competent by regional managers, the reverse was not always true i.e. PDS did not appear to think of the DOH as competent. At one Eastern Cape practice the short notice for policy requiring that patients be referred from the clinic as well as bad

experiences with late payments and non-existent salary reviews were used as examples of the poor management that they had come to expect from the province:

"I trust them what I read from them, that's basically all the trust that we have; so I trust them to send me that sort of letter at short notice, that's all....I mean I don't trust them because my contract says that it should be reviewed and they don't do that. I speak to them, they don't do it. There is always hitches with the payments. So what trust is that?" PDS, Eastern Cape

Comments about the way that health policy was formulated, again reflecting a lack of competence trust as well as suspicion as to motivations, included:

"I trust them to be inefficient. I trust them to further their political aims without being too practical about it" PDS, Eastern Cape

" some services are just started whether it is cost effective or not, it is just started, and that sort of thing goes on over our heads all the time. If you just look at the impact of these free services, it was a disaster really". PDS, Western Cape

One doctor expressed his frustrations with the apparently confused policy of the NDOH more broadly:

"I don't trust them [the NDOH]. *You never know. Maybe AZT, maybe not*[29]*. Maybe this hospital, maybe not. Now from Cuba, now not from Cuba*[30]*. Isn't that the impression that you get? That's the impression that the citizen in the street is also getting."* PDS, Western Cape

The following conclusions about the nature of trust within the PDS contract can be made. First, trust was not always present in the contracts examined. Second, the most common type of trust apparent was interpersonal. Third, belief that the other party shared motivations and values seemed to increase trust and vice versa. This appeared to be linked to the perceived similarities and closeness between the contracting parties and hence the quality of their relationship. In both provinces trust was lessened as distance increased and frequency of interaction decreased between purchaser and provider. Greater levels of trust in the Western Cape were an example of this. The higher administrative capacity in the Western Cape contributed to closer management of the PDS system, most notably via the computerised monitoring system. This greater capacity and sophistication or the monitoring system itself may have contributed to the higher degrees of trust present, by creating an

[29] referring to a slow decision by the Department of Health on whether to adopt a policy of giving short course anti-retroviral treatment to pregnant HIV positive women

atmosphere of greater confidence for contracting to take place. For instance, the ongoing reassurance provided by an effective monitoring system may have contributed to further establishing trust. It is interesting to note that if trust was bolstered by more effective monitoring, or more frequent communication, this would contradict the commonly accepted idea that trust acts as an efficient substitute for monitoring or that the more transactional aspects of contracting, such as monitoring, may actually erode trust in relationships. These findings may suggest that trust needs to be seen as a dynamic rather than a static element in contractual relationships, and higher levels of capacity and communication will contribute to its renewal. Last, competence trust appeared to play a role in the use of contracts to govern the delivery of professional services. This is likely to be strengthened in contracting with a profession, and is linked with ideas of professional motivation and reliance on doctors' feeling that they wish to safeguard their reputation.

DEPENDENCE

"You duck and dive, because some of the district surgeons they have got a bit of racial tendencies and the communities are unhappy. But I always tell the communities "let's go easy" because there are two choices, either I chuck this guy out, but then, what am I going to do? How am I going to replace the guy? And the other choice is to.... I tell the communities go easy..... " Regional Director, Eastern Cape

More than trust, the key factor which arose from this research as underlying the nature of the contractual relationship was a recognition of mutual dependence by both parties. This was determined by the context and appeared to play a major role in determining how the PDS contract operated. As was discussed in chapter 5, a lack of competition for PDS services and a lack of substitutes to deliver the broad package of services that they provided made provinciai purchasers dependent to differing degrees on the existing PDS. The PDS was also dependent on continued provincial work. About their dependence more generally on the services of PDS, regional managers commented:

" if some PDS resigned, we are not going to have any medical cover in the rural areas. Because we haven't yet found an alternative that makes it lucrative enough for a medical officer to go to the rural areas" Regional Manager, Western Cape

[30] referring to the implementation of a policy to bring doctors from Cuba to staff rural hospitals

"How do you provide a 24 hour emergency service 7 days of the week and a medico legal service in a town without having the PDS do it for you?" Regional Manager, Eastern Cape

Equally, most PDS relied on their incomes from this role to substitute their limited private practice and to ensure the viability of their practices. In particular they value the PDS income for its reliability and ability to give *"a feeling of permanence"*:

"I think that there are very mixed feelings among district surgeons, because at times they feel very frustrated by the work that they do and about the problems that they have, but they also realise that they can't really be without it" PDS, Eastern Cape

"to a very great extent I think that we are trapped. We are leaning on the good relationship with the government a lot. It has always been like that. I think that there is a way out but it will be very drastic. I have to fire people." PDS, Western Cape

This dependence was sometimes recognised by PDS as a tool to be used strategically in negotiations with the province:

"It's lucky to be the only guy in town. That's the one strong point that I have." PDS, Eastern Cape

"...they wanted to change the system and then they realised that they didn't have the clinics in place and so they kept the system going..." PDS, Eastern Cape

"..they said that they didn't want to cut our salaries because if they cut our salaries then the town would simply lose doctors...they have to keep a certain amount of doctors in the area"
PDS, Western Cape.

"It's difficult for the government to make a radical change, they are also trapped. If you are trapped you want to do things to help each other" PDS, Western Cape

As described in chapter 5 on the contracting environment for this case study, factors influencing the degree of mutual dependence differed from town to town. Each PDS practice's reliance on the PDS income was determined by the wealth of the town in which they were based, and hence the size of private practice which could be relied upon. One doctor in a poorer rural town (who said that he spent 90% of his time seeing PDS patients) explained that in the case of practices in larger towns:

"if they take the DS completely away they are not going to lose a lot. Because they are still going to have a lot of private patients, a lot of patients who can pay R60. We haven't got one, not a single one." PDS, Western Cape

Dependence for the province on particular PDS also varied from town to town. Often in smaller towns, the departure of the PDS would often signal the end of comprehensive medical cover for that town:

"there are lots of areas where if the DS came tomorrow and said "I want to go" I would have problems....you must remember that a lot of the DS are also the medical superintendents of the hospitals where they are, and they are also the part time medical officers at the hospitals" Regional Manager, Western Cape

"For the first time in our history we have got 5 towns without any medical officers.....You can't stay in a town where you don't earn enough money to survive" Regional Manager, Western Cape

The effect of this mutual dependence by the contracting parties altered the terrain of the contract dramatically, lessening the power of either party and increasing the tendency to co-operate. The willingness of PDS to continue delivering services when not paid or in situations when it was unclear whether they were still employed as PDS demonstrates this. PDS referred to "*being in good faith*" and "*even if there is no salary we continue rendering a service*". As described earlier in this chapter, a feeling of powerlessness in dealing with the provincial purchaser was reflected quite clearly, for instance in this comment about late payment:

"I just waited, I didn't threaten anything" PDS, Western Cape

About the sense of powerlessness on the re-negotiation of a future contract one PDS representative commented rather dramatically:

"I think that the people in general are more apathetic than anything else. They are like the scene of the Jewish people going to the gas chambers. They just think that whatever is going to be is going to be. ....many of them would just like to see the thing drag on and let's keep our heads low and hope that it carries on" PDS, Eastern Cape

The nature of the dependence between province and doctor in many rural towns goes beyond the PDS contract, with several PDS recognising that even if these contracts terminated they would still have to work for the state in one form or other, making the maintenance of a good working relationship even more fundamental:

"in the end we will probably still work for the state but in a different capacity.....so we realise and I think the state realises too that we will always be linked to the state in some or other way" PDS, Western Cape

Several examples of PDS extending their services beyond their direct duties were found in the case study. As well as the example of continuing to see state patients even after monthly faxes confirming their continued appointment as PDS had stopped arriving; (*"we continued the work, even though we weren't certain that we were going to get paid"* PDS, Eastern Cape) there were cases of PDS offering support to the local clinic's nurse or a newly arrived community service doctor in a neighbouring town. This may be a result of their recognition of the need to make themselves indispensable to the province, or their recognition of the unavoidable nature of their relationship with the province. Equally however it may be a result of their own professional or personal view of what their duty as a community doctor was.

CONCLUSION

This chapter has reviewed the manner in which a variety of contractual functions were carried out under the PDS contract. The examination has sought to shed light on the nature of the contractual relationship and what its determinants may be. Whilst the difficulties both of measuring and explaining the nature of service delivery were acknowledged, a key determinant of the nature of service delivery seems to be the financial incentives contained in the contract. The monitoring function was shown to be incomplete in either province but particularly weak in the Eastern Cape due to problems of capacity. Late payment for services and abrupt unnegotiated changes to the contract meant that the provinces to some extent rely on the goodwill of the PDS for the contract to continue.

This examination of the way in which contractual functions were carried out highlights the variability of how each individual may respond to the contract, begging the question of what determined the behaviour of different individuals under similar contractual conditions. Three main determinants were identified. First is individual motivation, explored briefly in chapter 5, and second and third are the contextually determined factors of trust and dependence. The nature of these two factors and the

impact that they may have on the way in which individuals behave under the contract was explored in this chapter. In the case of trust, interpersonal trust and competence trust were found to be important but not always present. Mutual dependence between parties to the contract was finally highlighted as perhaps the core explanation for the features of the contractual relationship observed in this case study.

CHAPTER 8: CONTRACTING EXPERIENCES - THE CASES OF LESOTHO AND A PRIVATE CAPITATED SCHEME

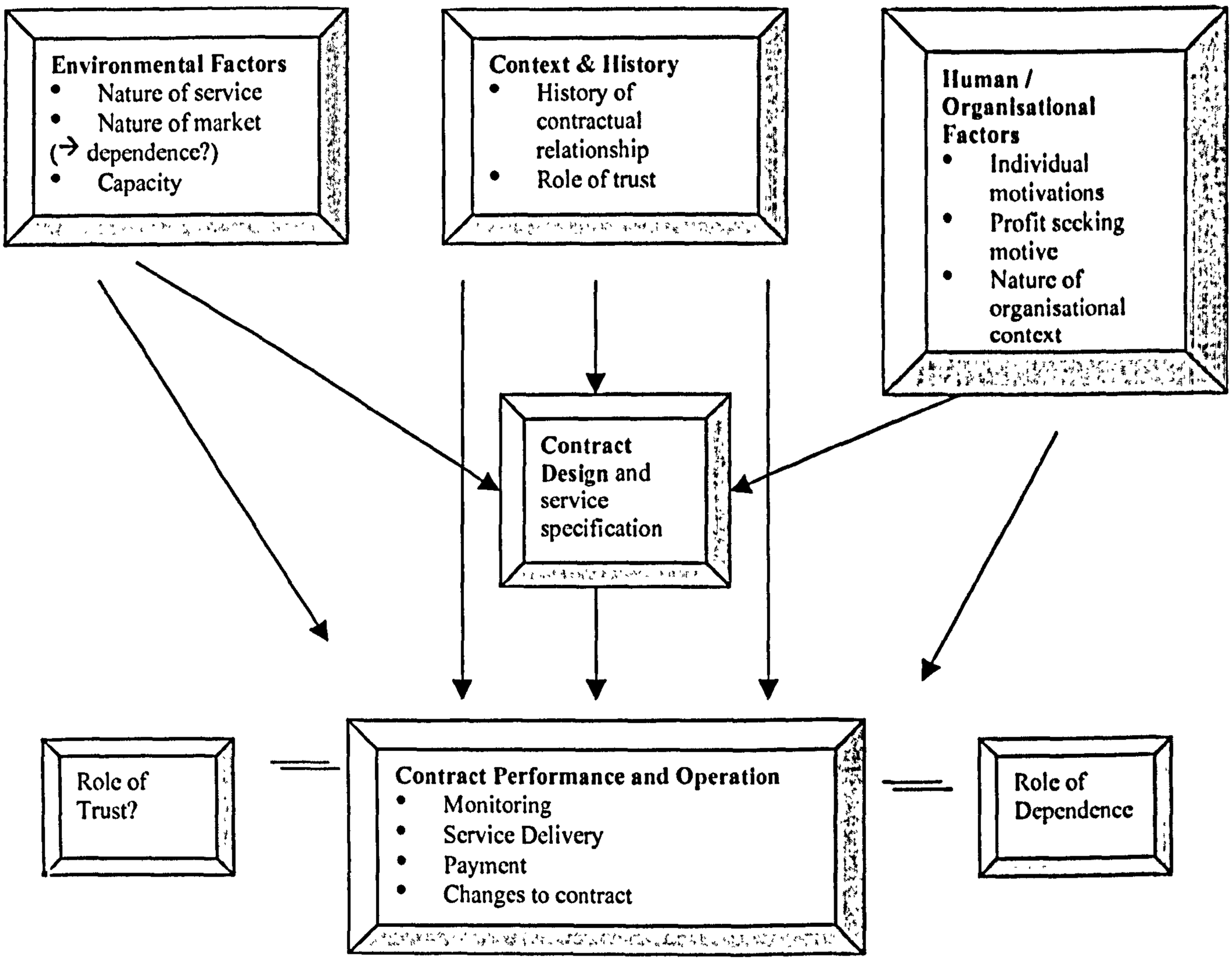
The previous three chapters have described the case study of the PDS contract in South Africa in detail. This chapter summarises the key features of two further case studies in order to draw out their differences and similarities with the PDS contract and to facilitate further interpretation of contractual relationships. For each case, the environmental factors and context and history of the contract are highlighted and the contract design and outcomes of the contractual relationship reviewed. The inclusion of these two brief case studies broadens the research and strengthens the framework of analysis employed in the PDS case by using it to examine similarities and differences in other situations. In each case the combination of factors and the contractual outcome is different, making it possible to reflect on the possible role of the different factors used to analyse the PDS case study.

Figure 8.1 (overleaf) summarises the factors that were analysed in previous chapters and their potential interaction to determine the nature of contract operation and performance. These factors will again be used in summarised form for the analysis in this chapter.

CASE NUMBER 2: THE LESOTHO CONTRACT - DESCRIPTION, BACKGROUND AND CONTEXT

This contract governed the delivery of general medical services (including emergency services) and occupational health services by a South African company at a series of construction sites in Lesotho. As part of this contract, two clinics adjacent to construction sites were equipped and staffed to offer services both to the construction workforce and members of the local community. In the case of the services offered to the local community, the Government of Lesotho reimbursed the contractor. It is this part of the contract which was of interest for this research as an example of the state reimbursing a private for-profit company for delivering primary care services to state patients.

Figure 8.1: Framework of factors useful in analysing nature of contractual relationship



Responsibility for running these clinics was contracted by the Lesotho Highlands Development Authority[30] (LHDA) to the engineering consortium responsible for the overall construction contract, who then sub-contracted this medical service provision to a specialist. The specialist was a commercial South African company, who was given a "back to back" [31] contract, making this health care contract a three way agreement between the purchaser, the engineering contractor and a specialist medical sub-contractor. To access the services offered by the contractor clinics, members of the local community were required to pay a user charge of 15 Maloti (R15), which was then passed on by the contractor to LHDA.

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[30] Lesotho Highlands Development Authority is the ultimate purchaser of all services for the Lesotho Highlands Water Project.

[31] meaning that the section of the contract dealing with medical services is simply passed on to a sub-contractor.

This contract for the delivery of health care provides a second perspective on the different conditions under which contracting for health in a low income country might occur. In particular this type of contract is a relevant example for many LMICs where the possibility exists to take advantage of commercial private sector activity in remote rural areas (typically mining, commercial farming and construction work) to benefit the public health of the surrounding communities. In addition, for this study, this contract provides an example of contracting with a commercial company in a situation of increased capacity to at least write, and potentially monitor, contracts. It also provides an alternative example of the way in which a contract for primary care services can be specified, and of a contract where there is a lessor role played by history in defining the nature of the contractual relationship. Other conditions remain more similar to the PDS case study. In particular, the nature of the service remains broadly similar and there was limited competition for the contract.

In contrast to the PDS contract, this contract had very little relevant history or background and all of it was recent. It had been operational for one year at the time that this research was carried out. The service providers were outsiders to the community to whom they were expected to deliver services and would only remain there for the duration of the contract, although some of them had worked in different parts of Lesotho before. In addition, the remote setting, the temporary nature of the services to be provided by the contract and the fact that the contractor was an "import" to the area all lessened the role of any historical context in defining the nature of the contract.

The outcome was a contractual relationship more reliant on the formal channels of the contract, but, despite its different setting and context, it still faced the problems of monitoring and therefore to some extent reliance on interpersonal relationships found to be common in the PDS case.

CASE NUMBER 3: THE PRIVATE CAPITATED SCHEME - DESCRIPTION, BACKGROUND AND CONTEXT

This final case study looked at a new and rapidly expanding model of capitated primary care provision available in the private sector of urban areas in South Africa. Branded, standardised primary health care services were offered via a chain of clinics by a for-profit provider to industrial companies, as part of a package of medical scheme cover for their employees. It is the provision of these services under a capitated contract that are examined in this case study. In this case the contract was a tripartite agreement between the company purchasing cover, a medical scheme (which provides a comprehensive package of cover for all levels of care) and the primary care service provider. The services offered and operation of each clinic were strictly controlled by standards established by the head office of the company, who likened the product to the "McDonalds of health care". Payment was on a capitated basis, with subscribers pre-paying a fixed amount per month for cover, whether they used the services or not.

Over 20 clinics belonging to this provider are situated around South Africa, offering a highly standardised service. The company was organised in a tight hierarchical structure as described in chapter 4. All staff in the clinics were paid on a salaried basis and each clinic had both a full time manager who reported directly to head office and regular supervisory visits from an area manager, who was based at head office. In addition to this direct management supervision, each clinic was fitted with an extensive, specially designed computer system which was also linked directly to head office. There were computers in each consulting room/cubicle which carried an extensive range of treatment protocols. Clinical staff were required to enter details of each patient and their symptoms into this computer system and then follow the recommended action according to the company's approved protocols. Via this method, the effectiveness and appropriateness of service delivery was closely monitored by the company's head office. Drugs dispensed were drawn from an approved company formulary.

Similar to the Lesotho case and in contrast to the PDS, this type of contract had very little context or history. Multiple purchasers and providers rendered the idea of the contract being governed by any recourse to established interpersonal relationships unlikely.

This case study thus provides an example of a contract operating under quite different conditions from the PDS or Lesotho case, and demonstrates the different nature of contracting for primary care services possible within the private sector. Key factors that are different in this contract are the degree of competition in the market, the ability to have a capitation payment mechanism (due to the ease of defining the population eligible to be treated as those who have subscribed), and the lack of any type of personal relationship between purchaser and provider. In particular, the urban position of the clinics provided a more competitive market setting whilst the nature of the contract meant that there were many potential purchasers for the package of services offered by the clinics at any one time. Very little monitoring was carried out by subscribing organisations, who relied on each user to judge the quality of the service and whether they wished to continue subscribing to it, and on controls/procedures internal to the provider company. Via a standardised clinic system, the well defined nature of the service being contracted and the lack of emphasis on monitoring made capacity less of an important issue. The differences in these factors build a quite different contractual picture.

The same structure as for the PDS case study is used below to offer summarised descriptions of each set of factors and features of the contractual outcome for the two case studies.

ENVIRONMENT FACTORS

NATURE OF SERVICE

Lesotho

The service was highly asset specific. Site specificity, as was observed in the case of the PDS, was joined with a high degree of physical asset specificity and human asset specificity as equipment and personnel had to be brought into the area specially to deliver the total services required by the

contract (which included high tech services for construction site workers such as 24 hour emergency/trauma services and occupational health screening).

As with the PDS case, there were problems of defining the content and boundaries of the service to be delivered and it was unclear how the services provided under the Lesotho contract should complement or substitute existing public sector services. There was some confusion over the respective roles of the contracted clinics and the public sector in delivering the full range of primary care services. Whilst the purchaser expressed the wish that the contractor should provide a comprehensive range of services, the contractor said that they did not wish to duplicate the services offered by the public clinic as this may lead to problems when their contract ended. They also expressed concerns about having to refer local community patients into Lesotho's weak public sector, where the treatment they would receive would be very poor or non-existent, whilst private patients requiring referral were sent straight to the South African private sector.

Private Capitated scheme

This contract simply offered access to all services provided by any clinic in the branded chain. As described, all clinics were run on the same protocols and strict guidelines, meaning that in the case of each type of service demanded, its nature was already well defined. Last, because this contract lay entirely within the private sector there was no confusion how the services delivered under this contract should complement or substitute existing public sector services.

Asset specificity of the service was lower than in the other cases, due to the urban setting of service delivery. This meant that for clinical staff their current livelihood was not invested in the success of this particular contract as they would be likely to easily find employment elsewhere in the same area. Equally, the physical assets of the clinic were not there purely for the service of the contract and were also serving patients who paid fee for service, or could be put to another use relatively easily, given their urban setting.

NATURE OF MARKET

Lesotho

As with the PDS, the Lesotho market was found to be uncompetitive, both as a result of the remote geographical area and the complexity of the total package of services required by the contract. There were few contractors in this market able to provide this type of service and none of them were based in Lesotho. Neither site where clinics were evaluated had any potential substitute to provide the relatively sophisticated services required; there were no doctors in practice in the area, no other facilities with any diagnostic equipment and the nearest facility operating a 24 hour service was several hours' journey away.

Given that there was no direct competition within the existing market, providers would have to enter the market to contest it, making barriers to entry highly relevant. In a situation of geographical remoteness where foreign firms were the only ones with appropriate capacity, these were high. Equally, appropriately skilled personnel willing to work in remote areas in this politically unstable country were in limited supply.

Whilst the lack of competition or contestability of the market is similar to that described for the PDS contract, the nature of the provider meant that the same issues of dependence did not arise for both parties to the contract, but was more one-sided for the purchaser. For the medical services sub-contractor this contract represented only a small part of their overall business, which was based in South Africa. In contrast, the purchaser remained quite dependent on this provider, due to the lack of providers with the capacity to offer the combination of services that they demanded. The engineering consortia were themselves operating under considerable time pressure and so from this point of view a change of sub-contractor was also undesirable:

*"the contract is too complicated. There are too many demands. Just say that they kick [*the current sub-contractor*] out and they bring in new people. How much time do you think they will allow those*

people to settle in? There won't be any time because the project is running. Then they stand a chance to lose money then." Purchaser, LHDA

Private Capitated Scheme

The dynamic nature of the private sector in urban areas of South Africa was highlighted in chapter 4.

Consequently the nature of the market for the services offered by the private capitated scheme clinics was strikingly different from the two case studies already presented. Various providers, principally other networks of private, for-profit clinics and private GPs / Independent Practitioner Associations competed to offer similar services to potential patients either on a fee for service or capitated basis. Competition was based on price and the perceived quality of the service. Competition was greater due to the urban setting and secondly because subscribers were themselves directly choosing which type of primary care service to subscribe to[32], which made the number of purchasers in the market high. Therefore the private capitated scheme was not limited to dependence on the government as a purchaser but could independently offer services to a range of individuals and company subscribers. This market structure meant that each purchaser and provider was less powerful, due to the possibility of their replacement, which in turn had implications for the likelihood of sanctions such as exit being invoked in the relationship.

GOVERNMENT CAPACITY TO WRITE AND MANAGE CONTRACTS

Lesotho

Overall technical capacity for contracting in Lesotho was far greater than in the case of the PDS. Ultimate responsibility for contract management lay with LHDA, a centre of technical expertise, supported by a combination of World Bank, European Union and bilateral donor funding and employing a range of experts on various aspects of contract specification and management. In addition, LHDA employed a consulting engineer to further aid the overseeing of contracts. There was no specific expertise in contracting for health services within LHDA but there were public health

[32] each industrial company may offer its workers a range of medical scheme packages

specialists, including Lesotho's previous Permanent Secretary for Health as chief of the Environmental Services Division and at least one other medical doctor with a PhD in public health.

Private capitated scheme

There was a high degree of technical and managerial capacity internal to the service provider with the company employing lawyers and marketing experts to design the contract that it used. As described above there was also an extensive system of hierarchical control - internal, hierarchical monitoring relied on computer systems which were directly linked to head office and area managers visiting clinics regularly.

HUMAN FACTORS, ORGANISATIONAL CONTEXT & MOTIVATION OF PROVIDERS

Lesotho

In interviews, the motivation of both the engineering contractor who held the overall contract and the sub-contractor, medical services were expressed purely in terms of profit. The engineering contractor's comments expressed a lack of interest in the whole health contracting process. A representative was emphatic that the obligation to run the health services had not been an undertaking made by choice:

"We are contracted to construct this tunnel....now over and above the construction contract is a contract to provide the medical services.....the provision of those (medical) services was included in that contract, so it wasn't any choice or decision by us...that was LHDA's decision"
Engineering contractor, LHWP

From the perspective of the subcontractor, a doctor described how the engineering contractor:

" regards the clinic as such an unimportant part of the contract...we become not only second best but totally insignificant" Medical officer, medical sub-contractor

The sub-contractor, medical services also clearly framed their motivation in profit-seeking terms:

"It's like hotel management. We know how to do it"/"this company is profit seeking"
Manager, medical sub-contractor

Motivation for service delivery was described at clinic level in terms of maintaining the firm's reputation and professional standards:

"We believe that [the provider] *is an international company and that* [it] *has standards to maintain and we like to maintain those standards"* Project manager, medical sub-contractor

In contrast to the PDS system, no one at any level in the company mentioned a feeling of duty to the community. This is largely explained by the distance between personnel working for the contractor, even at clinic level, and the community. All employees had moved to the site from elsewhere and were living there only for the duration of the contract. The remoteness of the setting seemed to take its toll on the morale and motivation of staff, which appeared to be lower at the more remote of the two clinics. Comments revealed a lack of concern about whether the services being provided were comprehensive or were covering all those in need in the local community population. A lack of regard for the welfare of the community was demonstrated by the comments of an administrator, which contrasts some of the views expressed in the PDS case study:

"At first the local community wasn't going to pay anything but then we negotiated because we said that we would have the locals here every single day for all kinds of things. We said to them NO." Administrator, medical sub-contractor

One doctor claimed:

"there is no point in us duplicating what the MOH is doing. They do the antenatal care, immunisations and we do the curative" Medical officer, private capitated scheme

However, it was clearly known that the MOH clinic in that area was closed, meaning that there would be no preventive care provided by any facility. Another doctor, when asked *"who is immunising babies in this area?"* replied *"nobody"*, but did not appear to feel any responsibility for this.

Private Capitated Scheme

The motivation of the company offering the private capitated scheme was again expressed purely in commercial, profit-seeking terms. The company had perceived a gap in the market for good quality, low cost primary care services and based their method of delivery and especially the capitated payment approach on the idea of what they termed the "health care triangle". This emphasised easy access to quality services without a user fee at the 'bottom' of the triangle, so that health problems would be treated at an early stage and the number of patients likely to need expensive referrals would be minimised. This underlying commercial motivation contributed to a wish to provide services which were both effective and perceived to be of good quality by the community.

CONTRACT DESIGN, AWARD AND NEGOTIATION PROCESS

LESOTHO CONTRACT DESIGN

The Lesotho contract was subject to a long and formal award process. A prequalification phase started in September 1996 and service delivery under the health care contract only commenced in April/May 1999. The process of bid evaluation was also more formal. Nevertheless, the key feature of the contract award process, as with the PDS contract, remained a lack of competition. Whilst competition for the overall construction contract was keen, there was very little effective competition for the medical services contract. The eight engineering consortia competing for the overall project offered only two properly qualified medical sub-contractors between them. There were no bids from Lesotho based groups, NGOs or missions.

In contrast with the nature of the PDS contract, the general preamble to the Lesotho contract emphasised that the nature of the interaction was to be specified entirely within the written document:

"this sub–contract embodies the entire agreement between the Contractor and the Sub-Contractor. The parties shall not be bound by or be liable for any statement, representation, promise, inducement or understanding of any kind or nature not set forth herein. No changes, amendments or modifications of any of the terms and conditions hereof shall be valid unless reduced to writing and signed by both parties. This clause itself is not subject to variation without the written and signed agreement of both parties"

The form of the contract was that of a typical construction contract, laying down basic principles governing the way that the services were to be delivered and only specifying actual facilities and services to be operated in an addendum to the contract and a bill of quantities. The duration of the contract was fixed at five years.

Duties specified

Also unlike the PDS contract, the Lesotho contract was focussed on input requirements. These included the staffing, equipping (including with medical supplies) and operation of 4 clinics and first aid posts for five construction sites. Nevertheless, as with the PDS contract, actual services to be delivered were specified broadly, as *"general and medical conditions – non job related", "midwifery and paediatric services", "serious medical diagnosis, initial treatment", "minor ailments"* and *"domestic accidents"*.

On the subject of the quality of the services to be delivered the main contract said that the *"sub-contractor shall implement and maintain to the satisfaction of the contractor appropriate and adequate quality assurance and quality control programmes in accordance with formally established procedures"* but no further detail was given.

Method of payment

The Bill of Quantities specifying all inputs that would be supplied by the contractor identified those to be paid according to a "fixed charge" and others as a "time-related charge". Fixed charges were paid for capital items and as a one-off payment per member of staff, and included a 5% mark-up on the cost of any equipment to cover handling expenses for the sub-contractor. Payment of salary and other recurrent expenditures was covered by the time related charge. Every month whilst a member of staff was on site, a charge equivalent to their salary was paid. Maintenance of the clinic buildings was also paid for as a time related charge.

The contractor could claim for drugs that were dispensed at the rates that would be used by GPs with a privately insured patient, which was a 50% mark up on cost. This is the only variable payment in the design of this contract; all other charges were laid out and calculated in the Bill of Quantities and therefore at the bid stage.

Reporting, sanctions and penalties

Various detailed provisions were made in the sub-contract for reporting mechanisms between the sub-contractor and the contractor and access for the contractor to the sub-contractor's site of work and work plans. Levels of written communication were closely specified but do not always appear entirely appropriate. For instance the sub-contractor must provide the contractor with periodic plans of work and then report progress against them, a task not easily achieved for service delivery in response to the unpredictable demand for health care.

Sanctions and penalties were also laid out in greater detail than in the case of the PDS. If the main contract was delayed due to delays in provision of health services, the sub-contractor was liable for any fines on behalf of the contractor. If the sub-contractor failed to execute the sub-contract works so as to:

"materially affect the proper execution of the sub-contract works, the contractor may give notice requiring him to either make good such failure or neglect or provide details in writing of the measures that will be taken to remedy the situation."

This may be followed by seven days notice and then termination of the sub-contract. Failing to provide the documentation required by the main contractor (e.g. purchase orders or work plans) also constituted a breach of contract. In this case, payments could be delayed or withheld.

For any other disputes between the contractor and the sub-contract the contract specified that an arbitrator between the parties would be appointed. There was no mention of sanctions which the sub-contractor may exercise against the principal contractor.

Purchaser and Provider opinions of the contract

Despite the different style of the Lesotho contract, many of the comments by those involved with it echoed the same themes as the PDS case study. The difficulty of specifying the requirements of providing a primary care service in a contract and the potential gap between what the contract stipulated and what services were delivered was again raised. The engineers saw this as a problem inherent in any contract:

"it's very clear what the employer wants from the contractor. Of course you always find out later we should have added this or that, but that goes with technical specifications too. So, it's not particular that it's a new thing with health care specifications." Engineering contractor, LHWP

Whilst the sub-contractor said of the manner of contract specification:

"(the) contract looks well specified but it is in fact a list of equipment"
Medical officer, medical sub-contractor

Members of LHDA also expressed frustration with the process of trying to specify health care activities in a contract and the degree to which the contract was open to interpretation:

"you see it doesn't actually spell out what they should do. It says that they have to do health promotion activities and prevention. And they could say that that doesn't mean that they have to do vaccinations, that they have to do whatever... they could say that people come here and we teach them about health promotion and preventive stuff, we give them condoms, so we are doing it. But unfortunately most of the people are of the clinical mindset" Purchaser, LHDA

The inability of contract specification to act as a substitute for motivation was also commented on:

"they aren't really doing PHC, it is there in the contract but they are still not doing it. This is the problem, you can tell someone else to do something and they will still say yes they are doing it, but they need to believe in it very enthusiastically and to understand what has to be done. There is no reason why they shouldn't do vaccinations there, under 5s. And they don't do it. There is no reason why they can't do Family Planning..." Purchaser, LHDA

PRIVATE CAPITATED SCHEME CONTRACT DESIGN

The contract was a tripartite agreement with a medical scheme, the subscriber (industrial company) and the service provider (private capitated scheme). A standard contract was offered to multiple purchasers simultaneously. Entry into and exit from the contract was determined by the purchaser and could take place on a rolling basis e.g. there was no fixed duration to the contract. Within each company subscribing to a contract with the provider, individuals could start and stop coverage with that scheme by means of whether they made a monthly payment. Both the company and individual subscribers under the scheme could exit the contract at any time by giving notice or simply stopping the monthly subscription payments.

The contract was brief, in the form of a memorandum of understanding between the three parties with an appendix detailing the package of benefits on offer. The marketing manager commented about the single comprehensive package of services on offer that it was a way of minimising complications with different entitlements for different patients:

"it's like all Mercedes come with air-conditioning. You get it whether you want it or not. If you don't want it you don't use it, but you still pay for it." Marketing manager, private capitated scheme

Access to all clinic services was unlimited and the services available were specified in one long list: consultations, acute medication, chronic medication, pathology, radiology, ECG tests, pregnancy tests and family planning, immunisation, injury on duty, antenatal care and sonar, minor trauma, conservative dentistry (fillings, cleanings, extractions, preventative treatment, fluoride treatment) optometry, and then hospital in-patient and outpatient care (but these were to be provided by a different provider).

Two limitations were imposed on subscribers' entitlements 1) out of hospital specialist visits were limited to three per year and 2) out of network visits[33] were limited to two per year. The contract did not outline any requirements in terms of the reporting obligations of the service provider, monitoring

or changes to the contract. The only breach of contract outlined was non-payment by a subscriber, in which case their rights to receive treatment was simply terminated.

The head office of the service provider received payments from each subscribing company according to the number of workers to be covered at the beginning of the month. When a patient with capitated cover visited a clinic, the head office reimbursed the clinic for the cost of drugs dispensed to the capitated patients, but their visit represented no additional income for the clinic. For referrals, each individual covered or their family group was limited to three specialist referrals per annum and these were financed by the company's head office. Basic pathology was done at each clinic and more specialised testing services also paid for by head office.

To further strengthen incentives to minimise visits whilst keeping patients healthy at primary care level, in some cases of this contract there was a form of risk-sharing specified between the private capitated scheme provider and the medical scheme. This specified target outcomes in terms of maximum hospitalisation rates or expense for patients falling under their responsibility for primary care services. If hospitalisation rates exceeded this level, they would be required to pay a share of the resulting expense to the medical scheme:

" we are saying 'you can trust us. We will not allow this to happen' ". Manager, private capitated scheme

(It is interesting to note how the phrase trust is used here – they do not actually ask for trust, they are using financial mechanisms to signal that trustworthy behaviour will be assured).

[33] visits to GPs in areas where there is no clinic owned by the company

THE CONTRACTUAL OUTCOME - OPERATION OF THE CONTRACTS

CONTRACT INCENTIVES

Lesotho

Managers of the sub- contractor, medical services described the incentives contained in the contract:

"there is no fat in it, I can tell you right now. The contract, the value of what we get out, is fixed"

"We really gain nothing from the consultations point of view because we don't get the money, whether we charge the guy or not. It's the drugs."

"it's only that we only have drugs to make our main profit, and the little bit that we get on the staff"

The financial incentives in the contract were to ensure that all goods specified in the Bill of Quantities were in place to gain the administration fee on each one and in addition, the mark up on each drug prescribed of 50% gave an incentive to supply a high volume of expensive drugs. As the contract was not fee for service, there was no incentive to see high volumes of patients as in the PDS contract. The sub-contractor was required to pass the user fee on to LHDA and so even this did not act as an incentive to see local community patients. There was also a limited supply of potential patients, as the neighbouring communities were not large and the likelihood of people travelling great distances to access the service was limited by Lesotho's rough terrain, poor transport and the relatively high user fee (R15 vs R5 to R10 in Lesotho Government clinics).

Private capitated scheme

"great thing about [this] system is that there are no perverse incentives. Health care providers don't even see drug representatives. There is a formulary. They have no room to prescribe what they like. They have no incentive to refer....". Chairman, private capitated scheme

Head office had strong incentives to control costs created by the capitated payment system. Strong hierarchical management was used to align incentives at clinic level to keep patients healthy at the minimum cost level possible, in particular minimising the use of expensive referrals, tests or drugs. This was done by a system of strict monitoring of clinical practice and drug use. In addition, the risk sharing between primary and secondary level care providers in some versions of the contract strengthened incentives for head office to minimise referrals. However, there were also incentives

acting to prevent under-treatment of patients. First, patients had to believe that they were receiving adequate care to continue subscribing to this scheme. Second, if there was consistent under-treatment of sick patients, this would worsen their condition, resulting in eventual expensive referral. This further encouraged greater interest in preventive care and cautious referral, as summed up by one manager:

"the watchword is appropriate referrals. That is what we are trying to do, appropriate referrals". Manager, private capitated scheme

SERVICE DELIVERY

As with the PDS contract, Table 8.1 suggests that in Lesotho the services being delivered were overwhelmingly curative, reflecting the problems of specifying the boundaries of the service to be delivered in relation to the public sector services available, and the contractor's preference to deliver curative consultations rather than preventive. Reasons for this preference probably included that they may take less time and generate more profits on drugs. For instance, antenatal care was actively discouraged by the Lesotho clinics as they did not wish to be involved in deliveries and so encouraged pregnant women to seek antenatal care in the public sector. As mentioned above, immunisations were also not offered.

Volume cost and structural quality of services[34]

Table 8.1: Type of services delivered (% of total patients)

Service category	Lesotho	Private capitated scheme
Acute	84.0%	74.7%
Chronic	14.0%	12.5%
ANC/PNC/FP	2.0%	12.8%
Total	100.0%	100.0%

In the case of the private capitated scheme, a higher proportion of antenatal/postnatal and family planning services shows that a more comprehensive service was being delivered, and may also reflect

[34] The data presented in tables 8.1 to 8.6 are drawn from the results of the broader research project 'New purchaser/provider relationships in health care: the desirability of contracts with primary care providers'

a greater tendency to give attention to 'preventive'[35] aspects of primary care services due to the capitated, risk sharing contract design described above.

Table 8.2 shows one measure of the volume of patients being seen in the clinics. The average patients seen per full time equivalent (FTE) professional were the lowest in the Lesotho clinics, demonstrating that staffing levels were kept high relative to patient volumes. This combination was also reflected in long consultation times as shown in table 8.3.

Table 8.2: Patients seen per full time equivalent (FTE) consulting professional

Type of provider	Patients per FTE per annum
Lesotho range (2 clinics)	803-1076
Private capitated scheme range (2 clinics)	10166-13089

The private capitated scheme clinics had the longest average consultation time of all the models. This is likely to reflect the more demanding nature of private clients, and their higher expectations of the quality of care that they should receive, as well as perhaps the higher proportion of time given to preventive health care in line with the contract's incentives. The consultation time in the Lesotho clinics was also high relative to those reviewed in the PDS model and the public sector in chapter 7.

Table 8.3: Average consultation time (minutes)

Type of provider	Average consultation time
Lesotho	8
Private capitated scheme	9

The average cost of the services delivered is shown in Table 8.4 below.

[35] In South Africa, services such as antenatal care and family planning, TB treatment and some treatment of chronic cases are all classified under the term "preventive"

Table 8.4: Average cost per visit (Rand)

Cost category	Lesotho	%	Private capitated scheme	%
External admin and management	0.50	0.3%	2.66	7.5%
Internal admin and management	34.80	21.9%	3.03	8.6%
Building operating costs	11.46	7.2%	3.42	9.6%
Clinical staff	47.80	30.1%	9.17	25.7%
Medical and surgical supplies	31.10	19.6%	9.06	25.4%
Transport/vehicle running costs	8.21	5.2%		
Total recurrent cost	**133.86**	**84.3%**	**27.33**	**76.8%**
Building costs	4.91	3.1%	2.23	6.2%
Medical equipment	8.43	5.3%	3.12	8.8%
Furniture and equipment	1.26	0.8%	2.92	8.2%
Vehicle costs	10.24	6.5%		
Total capital costs	**24.84**	**15.7%**	**8.27**	**23.3%**
Total cost	**158.70**	**100.0%**	**35.6**	**100.0%**

Overall the private capitated scheme ran at a lower cost than the Lesotho clinics and both the PDS cases and the public sector comparisons shown in the previous chapter. These clinics had very low recurrent costs, particularly for medical and surgical supplies and clinical personnel. Relatively generous capital spending may reflect the need to attract patients by having well maintained and equipped premises although the private capitated scheme's rather mixed structural scores reported below (Table 8.5) demonstrate that high capital spending was concentrated more on items that signal quality than items essential for technical quality. The costs of the Lesotho contract were extremely high, reflecting the incentives of a contract which reimbursed all costs with an additional mark-up, encouraging the contractor to maximise spending.

Table 8.5: Structural quality of care indicators

Structural indicator	Lesotho contract clinics	Private capitated scheme
General state of repair of facilities	Excellent	Good
Adequate toilets	100%	75%
Functioning refrigerator	100%	100%
Adequate emergency kit	100%	25%
Items of essential equipment	100%	75%
Lockable drug storage facility	100%	75%
Waiting area: large enough and under cover	100%	100%
Adequate patient records kept	100%	75%

For Lesotho, where the contract stipulated clearly the inputs required and gave an incentive to procure them by paying an administration fee of 5% for each item purchased, the input design of the contract clearly achieved good structural quality. However, the cost consequences of this, particularly in terms of medical equipment, were substantial, as shown in Table 8.4.

Drug use indicators also suggest that the Lesotho contract encouraged generous prescribing patterns. Of all the clinic models evaluated, the Lesotho clinics prescribed the highest number of drugs per script and the highest percentage of antibiotics to their patients. The private capitated scheme's incentive to minimise expenditure per patient visit was again reflected in it having the lowest number of drugs per script and a high use of generic drugs in their formulary. The competing needs of keeping costs down whilst maintaining an acceptable level of perceived quality for patients is reflected in their use of antibiotics still being in line with the PDS and public sector providers evaluated (Table 7.5) whilst drugs per script were lower and the proportion of generic drugs used the highest.

Table 8.6: Drug use indicators

	Number of drugs per script	% antibiotics	% generic name used
Lesotho clinics	2.9	50.8%	49.2%
Private capitated scheme	1.8	32.6%	41.2%

From this performance data it seems that contracted providers behaviour was comparable with the financial incentives in their contract, with quite different patterns of service delivery in the two contracts. However, as with the PDS, it is difficult to state to what degree the patterns reflected by the data presented above are a result of contract design and what else might be influencing service delivery.

Perceptions from FGDs

Focus Group Discussions with communities using both models of clinic examined by these case studies revealed that patients felt that both services were of a high standard.

In Lesotho, comments were made about the much better levels of resources available than in the public sector clinics, the cleanliness and the sophisticated equipment *"there are enough nurses so the services are quicker"/ "we feel like we are going to town when we go there"/ "the clinic is very clean..the staff is clean" / "one even feels ashamed to walk on the clean floor and make it dirty"*.

Views on the treatment at the private capitated scheme's clinics were overwhelmingly positive. Commonly identified elements of positive experience were a good reception (*"their reception is very good. When you get inside they ask you so nicely, "mama, what is the problem?" They make you feel important*); limited waiting time *("you don't have to wait in long queues, you walk in and they help you"*); cleanliness *("you ask yourself why do places which cater for both black and white be clean whilst those that cater for blacks are dirty"*); good attitudes of staff *("they really treat you like a patient"/ "their attitude is excellent"*) and thorough attention and technical competence (*"they check you thoroughly"*).

MONITORING

Lesotho

Monitoring was done principally via reports to the consulting engineer with few visits to the clinics. The consulting engineer employed a health and safety officer who visited construction sites and occasionally the clinics *("on the odd occasion")* but it was acknowledged that what he did was:

"not specialist monitoring, it's monitoring "is it open?" "are they treating people?" "...he wouldn't monitor to a decent level the PHC facilities". Purchaser, LHDA

As with the PDS, concerns were expressed about the feasibility of technical monitoring for those given the responsibility:

"we are a construction company so we do not have any people employed who have any knowledge of medical service provision or of the running of clinics, that's not our business"
Consulting engineer, LHWP

Even administrative monitoring was acknowledged to be haphazard:

"if they give us a timesheet that is not correct, unless we catch them by my popping in there one day and checking if that person is there...we wouldn't know" Engineering contractor, LHWP

In spite of the considerable capacity available to LHDA and their consulting engineer, the monitoring function of the Lesotho contract therefore appeared to be subject to similar weaknesses as the PDS contract. The difficulty of monitoring the technical quality of services delivered, number of patients seen and number of drugs dispensed were raised in a very similar manner to the PDS case. The logistical difficulties of monitoring services delivered in remote settings were also echoed. However, unlike the PDS contract, greater confidence was expressed in the feasibility of monitoring inputs such as staffing levels, mainly as a reflection that both purchaser and provider were in the same small town:

"our staff complement is laid down by our contract. We have to supply them with a list. We have a list of who we can employ and we have to supply names that have filled these posts. In such a small community they would know if these persons weren't employed."
Administrator, medical sub-contractor

This was echoed by a member of the consulting engineer firm:

"you come to realise very quickly because we are in a small community, it's two villages and you know very soon if there are problems with the delivery of the service." Engineering contractor, LHDA

The strength of the community as a back up to the purchaser's monitoring also seemed more of a realistic option in this contract:

"We have meetings with the local community on a regular basis and any problems would certainly come up very quickly if there was a serious problem." Consulting engineer, LHDA

Whilst this is again similar to the PDS situation, in this case no doubts were expressed about the likelihood of the community to complain. This is due to the construction to which these clinics was attached having been a controversial development project and therefore accompanied by a multitude of community empowerment efforts and social research. Due to these unusual circumstances there appeared little doubt that this community knew the channels to make complaints and had the confidence to do so:

"we report through committees, Then Principal chief. We go to meetings with LHDA. Here problems are reported and then taken to the right people" FGD participant

There were therefore some reasons which made monitoring more likely to succeed in the Lesotho context than that of the PDS case reviewed earlier, but these were highly context specific, related to the small community and the existence of better established channels for complaint.

Last, the incentive to exaggerate the number of patients seen was weaker:

"we really gain nothing from the consultation point of view, because we don't get the money". Medical officer/ administrator, medical sub-contractor

Nevertheless, again similar to some PDS, the medical sub-contractor commented of the monitoring arrangements that there was very little chance for either LHDA or the engineering contractor to know what services the contract was delivering and to what standard. Whilst they seemed *"up on the ball"* on issues regarding the treatment of the workforce :

"as for the local population we present monthly figures of numbers seen. But we could quite easily touch up the figures if we wanted to." Manager, medical sub-contractor

The claim for drugs dispensed was also submitted simply as a total per patient and for all patients without any detailed breakdown of what drugs were dispensed and how much they cost. The administrator at one clinic said that although she had once been asked to submit a stock report showing opening and closing month balances, she had never done so.

The feasibility of little used monitoring mechanisms such as spot checks, as with the PDS, were acknowledged and seen as a threat despite their lack of use:

*" if they feel like it they can come and audit the books, they can look at a guy on the list and say "well here's Mr Smith"and could we please have a look at his file to make sure that he came on that day?". **"Have they ever come and tried to do that?"** "No"* Medical officer/administrator, medical sub-contractor

One key difference between the Lesotho contract and the PDS was a greater number of administrative personnel and tasks attached to the operation of the Lesotho contract, generating greater transaction costs. In the view of the provider this had made decisions slow and cumbersome

"MTC has to agree to everything that we buy and it takes them so long to agree to anything" Medical officer, medical sub-contractor

Whilst the consulting engineer also expressed doubts about how reasonable some of the administrative demands of the contract were:

*"the employer has got a list called 'list of affected persons'. It's a list very thick. I can't see the contractor or [*the sub-contractor*] trawling through that list"* Engineering contractor, LHDA

There was a need for large quantities of paperwork to be carried out at the beginning of the contract to a degree that was found to be quite onerous by the provider, who supplied much of the requested documentation late. In addition, the description of the billing requirements to be sent in monthly by the provider was:

"it takes hours and hours, days, to do a month end run. We have a lady working here who sits every morning of every day to do that" Project manager, medical sub-contractor

In terms of staffing, there were personnel at the purchaser, the consulting engineer and the engineering consortium all involved in overseeing the payment arrangements and contractual negotiations related to this contract. The transactions costs of monitoring in the Lesotho case therefore appear high. These high costs reflect the more tightly specified contract as well as the greater number of "layers" involved in its operation (purchaser→consulting engineer→engineering contractor→provider). However, it is not clear from the comments reported above that incurring these greater costs was effective in improving the level of monitoring possible.

Private capitated scheme

The contract operated without formal monitoring by any purchaser, on the basis of simple monthly pre-payments. However, the company had its own quite extensive systems of monitoring the services delivered in each clinic both via use of clinical protocols and via financial monitoring. The computer system used in the clinics could also be accessed directly from head office, which considerably reduced asymmetries of information between clinic and head office.

In the context of a competitive market, each individual patient signed up under a company's contract had the opportunity to move to a different provider or stop having medical cover if they felt that the quality of services was inadequate or low for the price that they were paying and this was an additional monitoring mechanism. The main issue around monitoring in this case was therefore first whether patients were happy with the service and secondly whether they were in a position to monitor the technical quality of the services that they received. A public purchaser is generally not willing to leave this function to purchasers, fearing that they would not be able to adequately monitor the services themselves, and concerned not to waste funds on poor service provision. In this case, because the purchaser is in effect the user of the service[36] and there is no public funding involved, it appeared more acceptable to allow them to take responsibility for deciding on the acceptability of the service that they received.

PAYMENT

Lesotho

There had been no problems with payments in the Lesotho contract. Payments were considered to be generally accurate and on time.

Private capitated scheme

If payment was not made on time by subscribers to the scheme, their right to access services was simply terminated. This was laid out clearly in the contract:

"non paying members or groups will be suspended where no payment is received by the end of the month, and will not be eligible for services".

[36] Payment systems vary but subscriptions would either be deducted 100% from an individual's income by their employer and paid to a medical scheme or would be paid jointly by employer and employee.

CHANGES TO THE CONTRACT

Lesotho

Changes to the contract were another source of transaction costs in the Lesotho contract. Initially, for all parties to the contract, time was taken up dealing with shortcomings in the original contract and the facilities provided. One engineer described:

"lots of wrangling over documentation and needing changes to the contract e.g. extension, parking bays, whether the providers were to deal with all road accidents in the area" Engineering contractor, LHDA

There were *"endless discussions"* between the contractor, the consulting engineer and LHDA as each issue that came up which was not dealt with in the original specification had to be renegotiated.

However, unlike the monitoring function, the manner in which changes to the contract were approached in the Lesotho case study did not resemble the PDS situation. All alterations to the terms of the contract were subject to negotiation and made within the terms of the written contract. There were no examples of the type of abrupt unilateral changes to the terms of the agreement common in the PDS case. Nevertheless the need for contract variation due to the impossibility of accurately specifying a contract for the service was acknowledged by the consulting engineer:

" it is obvious in a contract like this that nobody can think of every contingency. So you can raise variation orders and negotiate them with the clients through the engineer etc where extra money is required. You may have forgotten something or underestimated the complexity of something". Consulting engineer, LHDA

So far disputes about how to interpret the terms of the contract had all been resolved without the need for arbitration. The manner in which contractual disputes were approached was to seek informal agreement between individuals and then formalise this within a variation to the contract:

"We talk around them and negotiate things. It very often starts out as an informal thing, picking up the phone etc and once you have negotiated around and sort of agreed then you send a formal letter in so that there can't be any disputes..." Engineering contractor, LHDA

"every now and then someone will come along and read the contract and say that that isn't the way that we should be doing it. ....it never really comes to a dispute. It just comes to an interpretation of how we should be doing it" Project manager, medical sub-contractor

However, changes to the contract which may have been desirable from the point of view of the sub-contractor, were not always achieved. A manager of the service provider complained:

"there is never any chance to renegotiate the terms of the contract" Manager, medical sub-contractor

This often resulted in the medical contractor having to bear risk where the terms of the contract had originally specified something which was inappropriate, due to the difficulty of changing the contract terms. Thus the same power of the purchaser to determine changes to the contract as described under the PDS case study is shown here as the purchaser's power to block changes to the contract. This was illustrated in the following cases. First was a need for greater staffing levels than were specified in the original Bill of Quantities to run a 24 hour service. The sub-contractor raised this issue at the time of contract negotiation but was told by the principal contractor not to seek to change the Bill of Quantities but to just use the staff hours specified for the total contract at a faster rate. A manager for the sub-contractor commented:

"we are sort of taking an advance on the man months and hoping that at the end of the day it will square off....we are just hoping and praying that things will work out" Manager, medical sub-contractor

Similar problems with the rigidities of the contract design occurred due to the lapse of one year between bidding and starting work on the contract. Prices for fixed items had been set at the contract award stage and in some cases had increased by up to three times by the time that the items came to be purchased. These differences in prices had to be borne by the sub-contractor as the contract made no allowance for cost inflation and no change could be negotiated. However, there were other examples where LHDA bore the risk of a change to the contract. Where problems had arisen from a mismatch between the tender specification calling for services to be delivered for which there was no provision made in the clinic design, LHDA had agreed to build such extra facilities.

Private capitated scheme

Changes to the contract were not made other than rare changes to the package of benefits offered by the scheme to bring this in line with what the clinics were offering. When this took place a new addendum to the contract was simply circulated to all subscribers.

SUBSTITUTES FOR A COMPLETE CONTRACT

Lesotho

Similarities to the PDS included the monitoring function which still appeared weak, and evidence that financial incentives were strongly influencing the manner in which services were delivered. In contrast, the payment and variation functions of the Lesotho contract were carried out more formally than in the case of the PDS contract, with considerable formal negotiation surrounding the terms of the contract, and where these were changed this was done with mutual agreement.

Given the greater formality of this contract's functioning, there was potentially a lesser role played by the "residual" or external factors highlighted under the PDS case as shaping the contractual relationship. Interviewees did have less to say on this subject. However, although with less vigour, the same issues were raised as for the PDS contract, such as recognition of a degree of dependence on the part of the purchaser, and a tendency to bypass the formal contractual routes and rely on personal relationships to underpin the functioning of the contract.

Echoing the PDS contract was a sense of dependence, for instance over-riding the formal stipulations of the contract regarding breach of contract:

"We were given no time, from 1 May they wanted us to render a service and we couldn't do it. ....It was stressful, there were lots of threats you know that they were going to close the site down.... So you get to the point where you just say "if you want to close it, close it" because you cannot close a contract like this in one day" Manager, medical sub-contractor

Even at such a point of conflict the sanctions contained in the contract were not exercised. Again as with the PDS, there was use of the concept of competence trust and the importance of interpersonal

relations to express what governs the relationship when there is little control left for the purchaser over what the provider does:

"well we trust them, yes certainly from the basis of a layman as far as medical services are concerned" Engineering contractor, LHDA

"One can't go without the other...there is good co-operation between us you know. It's a friendly situation, we have our arguments and differences of opinion but at the end the work gets done." Manager, medical sub-contractor

Despite the clear stipulations of the contract that all agreements must be contained within it, and that there was to be no contact between the purchaser of the overall contract and the medical sub-contractor, the bulk of the contact appears to have been between the consulting engineer and LHDA and the medical sub-contractor. The engineering consortia's personnel commented that they found it easier to "*step out of the way*" whilst the consulting engineer said:

*"I used to tend to deal with X [*project director of medical sub-contractor] *direct on a lot of issues. Going through the contractor as intermediary didn't add, it took some time"*

This was also commented on by the engineering consortium's manager:

"The project manager and consulting engineers are good friends, that makes co-operation so much easier you know" Engineering contractor, LHDA

Lastly however, the greater weight attached to the contract in the Lesotho case study was summed up by one of the sub-contractors:

"You have to live according to the contract. As we all try to do it you know, but we don't always succeed. You cannot ignore the contract. Breach of contract is terrible" Manager, medical sub-contractor

Since both this and the following case study were contracts with companies as opposed to individuals, the role of internal management in determining the nature of services delivered, as opposed to the decision process of an independent GP, is also relevant. In this case the chairman of the company still emphasised the role of personnel in determining what took place within the clinics:

"...There is financial monitoring to make sure that it is running on what we predicted. But I can tell you that all of these contracts depend on your personnel. Bits of paper and computer systems in the end mean absolutely nothing" Chairman, medical sub-contractor

Private capitated scheme

Given the anonymous nature of the purchasers, their multitude and the competitive nature of the market, the nature of this contractual relationship appears fundamentally different from either of those examined previously. Because there was no single institutional purchaser, purchasers were not interviewed for this case study. Service providers, when asked for their impression of how the contract operated or asked to describe the nature of the contractual relationship, looked bemused. It appeared that the brief contract and list of benefits seemed to require no further explanation, effectively describing and framing service delivery with no further reliance on interpersonal relationships to help determine how the contract should operate. In fact this private capitated scheme contract is a good example of a contractual relationship where there were no specific, consistent interpersonal relationships.

Several factors explain why this final contract operated so differently from the previous two case studies. First, the service provider operated on very closely managed protocols and guidelines set by internal, hierarchical systems of management, which made it easier to define what services were to be offered under the contract and how. This provider was an example of a company with functioning, strong systems of internal management and these were the primary force in determining the nature of service delivery. Second it was possible to define the population to be treated and hence to use capitation payment in the contract design which created an effective, desirable package of incentives for providers to deliver cost-effective care that gave due attention to preventive services. Third, a competitive market acted as a back up to ensuring the quality of service delivery by providing an exit option for subscribers. All of these factors appear to lessen the need to "check up" found in the other two contracts, with monitoring one of the most problematic features of the other contracts reviewed. However, the method of operation of this contract, leaving monitoring and judgement of the quality of service essentially up to the user, is of questionable effectiveness in ensuring the technical quality of the services. As was discussed in chapter 2, whilst patients may be able to judge the interpersonal quality of the consultation, their waiting times and whether the environment in the clinic is

satisfactory, they may be less able to judge whether the quality of care that they are receiving is technically adequate.

CONCLUSION

This chapter has shown the varying nature of contract design and external factors in the case of two further case studies of contracting for primary care services in South Africa and Lesotho. Both cases demonstrated quite different approaches to contract design and payment for broadly similar types of service. They also demonstrated the impact of variations in external factors such as the level of capacity, degree of market competition and nature of provider on the nature of how a contract operates. The Lesotho case demonstrates an attempt to use considerable capacity to specify a contract for primary care services in a more complete way, against a similar backdrop to that of the PDS case study of a lack of competition for the contract, and the difficulty of separating out services to be provided by the contractor from those provided by public sector clinics. The result is a more detailed contract document, but one which is still not possible to monitor adequately and to some extent is still reliant on interpersonal relationships and recognition of some forms of dependence and trust for its operation, whilst also having higher transaction costs. In contrast, the urban setting of the private capitated scheme demonstrated the impact of an increase in the number of both purchasers and providers on the nature of a contract for primary care services, as well as the role that internal systems of hierarchical management can potentially play in replacing the rather 'ad hoc' manner in which service delivery was defined and monitored in the previous two case studies. Overall the functioning of the contract was quite dramatically different.

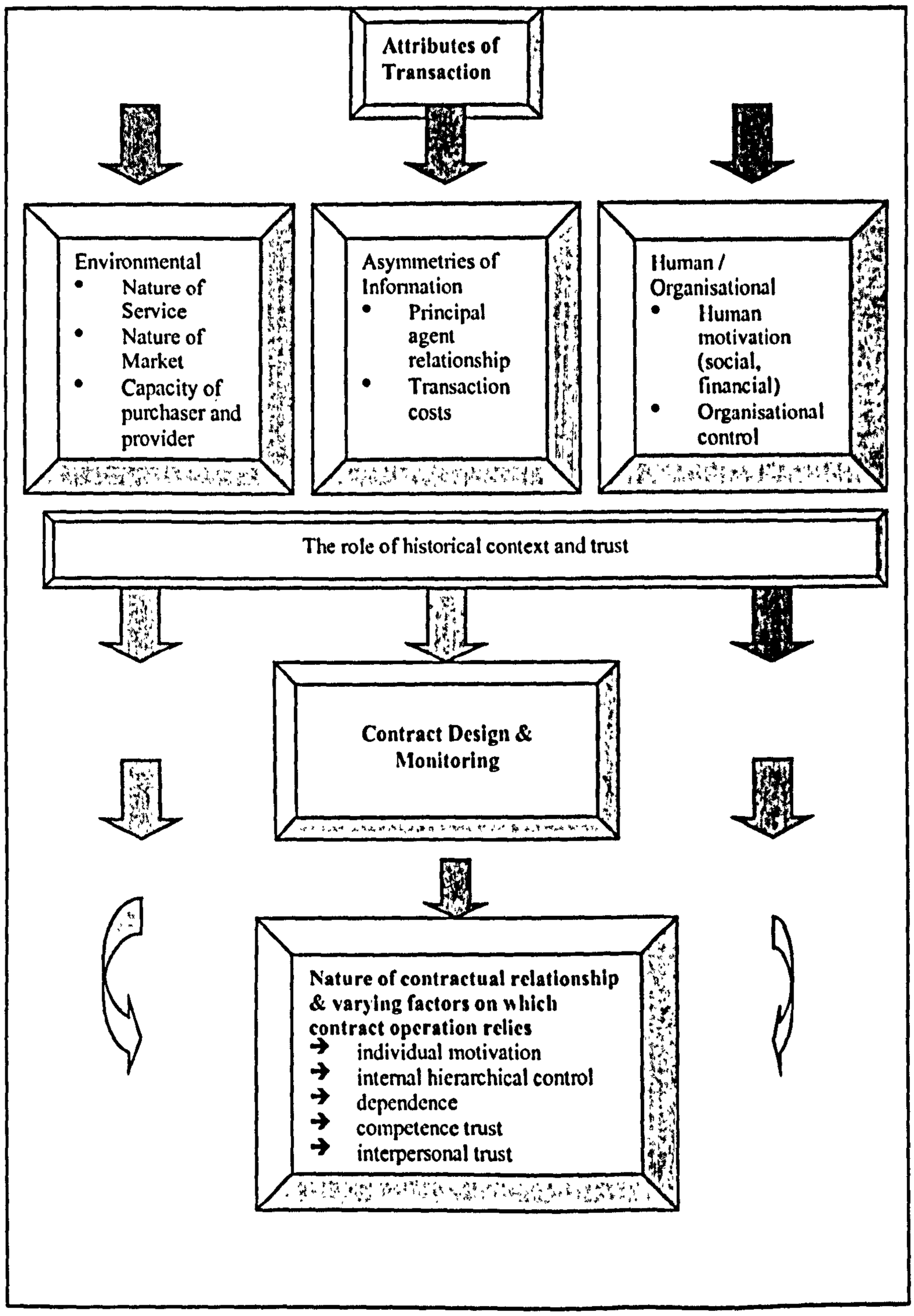
CHAPTER 9 : DISCUSSION OF FINDINGS

This thesis set out to explore the nature of contractual relationships for primary care services in an LMIC, and factors controlling and influencing this. Previous chapters have presented data on the external factors, contract design and resulting contractual relationship from three case studies of contracts for primary care services. A broad literature review in chapter 2 gave rise to a framework which synthesised many potential factors in influencing the nature of contracts and was used to examine these case studies. The framework is presented again below as figure 9.1, with some additions showing controlling mechanisms which the case studies suggested were important elements in explaining the contracts' functioning.

In line with some of the more recent literature on public service contracting in the UK reviewed in chapter 2, the nature of these case studies emphasised that factors and circumstances surrounding each contract were at least as important as the contract document itself. The nature of each contractual relationship was made up of a combination of all of the factors shown in figure 9.1, and an understanding of it had to include the 'contractual substitutes' or operating mechanisms shown in the bottom section, as well as the environment in which it was operating, to truly explain its functioning. The three case studies highlighted different combinations of these factors making it possible to consider what the influence of each was in greater detail than if only one case (combination of factors) had been studied.

This chapter considers some of the strengths and weaknesses of the methodology of the study used and then discusses each case study and its findings in turn. Findings highlighted by a comparison between the case studies are then discussed. In this discussion the term "contract" is often used to describe the broader contractual relationship rather than a single document.

Figure 9.1: Components of a contractual relationship



METHODOLOGICAL AND DATA ISSUES

Research into contracts faces a number of difficulties. First, despite the urgency for more information about the nature of contracts in LMICs, there is a dearth of suitable research methods for addressing this. This is because there are relatively few functioning examples of contracts, making large scale quantitative studies rarely feasible, and because the nature of the research questions being asked also often requires a qualitative approach to allow for the complexity of the factors that need to

be included. Second, it is difficult to disentangle factors which are relevant indicators of contractual performance from the very 'noisy' world and multitude of other influences amongst which health care contracts operate. This study was therefore faced with a limited methodology to address a complex topic. The largely qualitative case study approach adopted had both strengths and weaknesses. Strengths were its ability to accommodate the variety of factors that needed to be considered. Case studies were able to examine contracts as multi-faceted phenomena, using documentary sources, performance data and interviews to access both facts and perceptions about the contracts. They were thus able to deal both with more concrete factors such as the level of competition (which can be objectively compared), and other more subjective concepts such as the role of obligation, trust and dependence.

Whilst case studies appear to have been the most appropriate approach, several problems were still encountered due to the complex nature of the study subject. For instance, some concepts used to explain the dynamics of these contracts are not easily 'measured' or accessed in a consistent manner and whilst interviews seem to be the most effective way of doing so, they still give only partial and highly subjective access. The problems of drawing conclusions to anything broader than the case level with data which are a highly situated account of a social phenomenon must also be acknowledged. For this study, a mechanism for doing this via use of a theoretical framework is described in greater detail in the concluding chapter. A related problem, making even comparison between the three cases difficult, was the differing nature of the information which the case studies yielded. The nature of the results of each case study were themselves a reflection of the nature of each contract, showing the difficulties in such interview based case studies of separating out results from the research process itself. For instance, interviews about the PDS contract, arguably the most dependent on external contractual substitutes, also provided the richest interview data as interviewees spoke at length about the nature of their interaction within the contractual relationship rather than just the nuts and bolts of contract design. In contrast, interviewees asked about the private capitated scheme contract were able to describe its functioning but had little to say on the more abstract issues

which appeared to be so important to understanding the PDS case. This was in itself a form of finding. Therefore it was sometimes difficult to separate out the form in which results presented themselves from the findings themselves.

The heavy reliance on interview data in this study also raises the question of the influence of the interviewer's own role in the research process and how this is likely to have affected the study's findings. Interviewees were apparently willing to speak very openly about the contractual relationships in question due to the distance of the interviewer from the issue e.g. a foreign researcher coming from an overseas university. They appeared to speak frankly about their opinions of the other party in the contractual relationship and were happy to do so. Some providers, in particular the PDS, may have been less frank about the nature of service delivery which took place under the contract than they would have been with a medically trained person or a South African. There may have been a tendency to hope that a foreign researcher would be less sensitive to the history of the PDS system and the sometimes still discriminatory way in which services were delivered. Given that the nature of service delivery under the contract was not the main focus of the study, this is unlikely to have been a major drawback.

In some cases it was possible to triangulate findings methodologically by drawing on data on service delivery or cross-checking perceptions with facts, and where this was so it has been carried out. For instance, checks could be made of willingness to resort to legal sanctions (stated in interviews) versus whether lawyers had ever been employed, or the volume of patients seen versus what was said about the incentives contained in the contract, but there are many examples where such triangulation was not possible e.g. in response to questions about more subjective issues such as trust and motivation. Because there was not an opportunity to observe the day to day interaction between purchaser and provider over a long time period, an account of the nature of the relationship had to a large extent to rely on what was said about it by those involved.

Triangulation of analysis and member validation were not carried out and both of these could have potentially strengthened the findings of the study. As mentioned in chapter 3, member validation was felt to be inappropriate due to the sensitive nature of some of the information (particularly in the PDS case) and the lack of time of most of those interviewed to read and respond to this type of analysis. Triangulation of analysis could have lessened its extreme reliance on one person's interpretation of the data, but the feasibility of such triangulation seemed doubtful. This was partly logistical (the analysis was a long-winded task that few appropriately qualified researchers would have been willing to undertake for someone else's PhD thesis) and partly due to questions about the usefulness of triangulation in this type of study. The way in which the interview data were analysed and written up must be acknowledged to be a single unique commentary on the phenomenon under investigation and the analysis of a second researcher was likely to produce a second unique commentary. How these two competing narratives would then be reconciled may have been problematic. Seale (1999 p. 57) cites Ciccourel's critique of triangulation in qualitative research which may become 'indefinite' - different versions of commentaries on a single set of data may continue to be produced for as long as you increase the number of individuals doing the analysis. He summarises Ciccourel's point as *"that we are all, including social researchers, engaged in story telling at all times"*.

In conclusion, this study's heavy reliance on interviews reflects the strengths of this type of qualitative inquiry and also the dearth of other methods available to triangulate findings on the complex set of factors identified in this study. The strengths and weaknesses of the study's methodology are in fact the same - that some parts are a largely subjective account of the experiences of individuals involved in operating contracts for primary care services. By reporting their accounts, the study is vulnerable to manipulation by those interviewed. However, equally its strength is that it is able to reflect some of the richness and inter-connectedness of the influences upon how contracts operate. It is safe to conclude that what is said and revealed by each of the interviewees in the study may not be a complete factual account, but is in its turn highly revealing about the nature of the contracting relationship, which was the ultimate subject of the study.

DISCUSSION OF EACH CASE STUDY

The PDS case

The bulk of this thesis has been taken up with data from the case study of the PDS contract. This section briefly reviews the contract's strengths as a case study and its likely relevance to other contracts in LMICs. The nature of the contractual relationship that was revealed by the case study is then reviewed in terms of the nature of external factors present, the degree of control exercised by contract design and monitoring and the role of other factors as controlling mechanisms in the contractual relationship.

The PDS contract is a rare example of a well-established and widely functioning contract for primary care services in an LMIC. Because it is a standard contract with a series of self-employed individuals, it offers a chance to examine the degree to which the same contract may operate in different settings. In one sense the model represented by the PDS contract is quite widespread – other Southern African countries such as Zimbabwe or Namibia have or have had a similar system as did Britain in the 19th Century, and it is an obvious solution to the problem of weak public services in sparsely populated areas where there are private sector resources that can be drawn upon. However it is also important to acknowledge the uniqueness of this contract's setting. It is a system surviving from the "old" South Africa into the "new". The political and historical context of the contract mean that it is surrounded by uncertainty and confusion and this may have influenced the findings of the case study. It also makes it a case study in which the history and context of the contract are a profound influence and this has implications for the relevance of its findings to other, newer contractual forms.

The literature review in chapter 2, in particular the work of MacNeil (1974; 1978) highlighted that contracts can come in a variety of shapes and forms. In the case of the PDS case study, the contract document was incomplete and even out of date; for instance it still referred to a system of referral of

patients from a magistrate that had ceased to exist in 1996. Overall, the contract's operation resembled MacNeil's concept of the relational contract, with an emphasis on the continuance of the contractual relationship over time and the social context and situation between the contracting parties being at least as important determinants as the written contract. In that sense the "contract" studied was far more than a document and to a large extent was a construct of the people involved in the contractual relationship. Many of the PDS interviewed either could not find their contracts or had not been given one. In such cases the service was being operated according to what the PDS *thought* the contract would say, if they had one.

A review of the environment in which the PDS contract operated revealed the context and history of the contract as an important force which encompassed many influences such as the nature of the service being contracted (confusion over the curative/preventive split) the supply of doctors, capacity of the government to manage contracts adequately, the attitude and motivation of providers, and to some extent the mutual dependence of purchaser and provider. In particular, South Africa's apartheid past left not only organisational problems (with the government facing huge problems of organisational capacity, a tight budgetary situation and the upheaval of re-organisation) but also flavoured the relationship between purchasers and providers - two sets of people who had historically belonged to opposing 'sides' of South African society. Both organisational and interpersonal issues had a clear impact on the way in which the PDS contract was managed. Poor government capacity to define policy, write and monitor contracts and manage financial systems were all largely historically determined, but were key influences on the current functioning of the PDS contract. Differences in capacity between the Western and Eastern Cape were also historically determined, and again a clear determinant of the nature of the contractual relationship. Weaker Eastern Cape provincial management was reflected by a contractual relationship characterised by less trust, weaker monitoring and a higher degree of suspicion and antagonism between the two parties. Roots of this were partly historical, partly due to present weak capacity but ultimately all of this was historically determined.

A second major external influence on the nature of the contractual relationship was the situation of bilateral monopoly in most PDS towns. In all of the towns visited there was little effective competition or even contestability of the market. There was one purchasing authority, the province, and only a third of towns visited had any potential competition in the form of more than one private practice which could potentially take on the PDS work. In addition, it was not clear that any of these practices would actually have been interested in the work. Williamson's fundamental transformation was relevant (Williamson 1985) – once one practice had secured the PDS contract it was likely to stay with them until they chose to terminate it; few other practices would remain within the market as few towns could support private practices that would both survive without the PDS contract and then wish to compete for it when it became available. In addition, geographic barriers to entry and exit of the market tended to be high, making the market very segmented. Exacerbating this lack of competition was the unpleasant nature of some PDS work, the 24 hour commitment required and the perception that being the PDS could damage private practice, in towns where there was a choice of practices for private patients. There was also a degree of human asset specificity involved in who knew how to do the work. All these factors decreased potential competition for the contract. The difficulty of finding substitutes to deliver such a broad service were extensive, and suggested that the sense of mutual dependence which characterised this case study was likely to be a permanent feature.

Classic mechanisms of contractual control are via specification and monitoring. In the case of the PDS, neither of these appeared likely to exercise much influence on their individual behaviour. The contract design offered a framework to the relationship by setting some parameters, but was not able to define its day to day functioning in any detail. The exact specification of duties was vague and open to future revision. Risk allocation was broadly clear but the nature of the commitment on both sides quite open-ended - the service provider could be called upon to deliver a range of unspecified duties in the future, whilst the purchaser faced an open-ended financial commitment. The contract was not specified in terms of either inputs or outputs, but more in terms of process and obligation on

the part of the service provider. The difficulties of distinguishing this from a general clause contract of employment, the legal problem which was at the heart of the court case in the Free State (described in chapter 4) was summarised by the presiding judge's summing up of that case:

"to define the word 'employee' in such a way that it is easy to make the distinction between an employee and an independent contractor, or to put it differently, to make a distinction between a contract of service and a contract of work is one of the most difficult question which the courts have grappled with for decades" (Basson et al 1998)

Comments by PDS that their contract was out-dated, irrelevant, and '*more of a job description than a contract*' echo this.

The result of this vague specification was a contract that was open to interpretation by all parties. PDS did this as a group and individually. They helped to interpret the contract by passing on to colleagues and successors their interpretation of what was expected. Many mentioned that they did what they thought was "right" and that they were confident that most PDS delivered roughly the same type of service. They emphasised the role of professional discretion and competence in determining the nature of service delivery under the contract. For individual practices, there was an overall sense of contract definition as "do it yourself". For example, different interpretations made of the contract document included, in the Eastern Cape, one practice using nurses to screen their patients, another by-passing the requirement that patients be referred by the clinic, whilst other PDS continued to see only referred patients. PDS tended to describe their contract with the emphasis on "their"- emphasising that it was a relationship framed by whatever deals they had struck with the province and using the original written document more as a starting point.

Another external influence making the contract open to interpretation was the fragmented nature of service provision, making the definition of services to be delivered context-specific in the extreme and varying from town to town. Here, the role of history and weak capacity meant that the contract was not only open to interpretation, but virtually required it. Whilst this situation was very context specific, it may highlight what could be perennial problems in specifying contracts for primary health

care on any basis other than a block grant - for primary care services, what services need to be delivered, in what quantity or to whom, are all problematic to specify in any detail. Contracting out one specific service also highlights the difficulties of separating out areas of responsibility between public and private sectors. PDS still rely on the public health infrastructure for their referral networks, public sector drugs and other services such as ambulances. They cannot operate independently of these services and their ability to deliver an adequate PDS service is dependent on other parts of the public sector. This is likely to be a relevant problem for many examples of selective contracting out of primary care services by the public sector.

The second obvious method of contractual control, monitoring, was also beset with difficulties and highlighted the influence of many of the factors shown in figure 9.1. The nature of the service, lack of choice of provider and the weak capacity of the purchaser all combined to make monitoring difficult and its value questionable. Monitoring in both provinces was restricted to a very basic form. In the Western Cape, greater financial and administrative capacity was demonstrated by a more comprehensive monitoring system via a computer programme, but neither province made any attempt to monitor the quality or appropriateness of care delivered and even basic financial monitoring was acknowledged to be patchy, particularly in the Eastern Cape. Again, many of these problems are likely to be of relevance elsewhere, although to what degree the weak monitoring of PDS was attributable to poor capacity combined with the problematic nature of the service, and to what degree to the province simply perceiving it as not a high priority, is not possible to say. Whatever the cause, PDS did not seem to perceive monitoring as a control on their behaviour, beyond perhaps the distant threat of being investigated for fraud. Monitoring was not acting as any form of realistic control on the actions of the PDS.

Explanations offered for why monitoring was so weak also reflect on the broader nature of the contractual relationship. In the Eastern Cape, PDS complained that the lack of monitoring was a problem of the province not bothering to do their job and in some cases preferring to believe that the

PDS were not honest than bother to check up on what they were actually doing. This negative view of the province was particular to the Eastern Cape, and accompanied by a feeling that they were out of touch and unconcerned with what was happening in the areas where PDS were working. In the Western Cape PDS had a more positive relationship with the provincial purchaser and although they also saw the province as relatively unconcerned to monitor them, they put this down to the province feeling confident to leave these issues up to their professional discretion.

The inadequate control of PDS service delivery exercised by contract design and monitoring leads to the question of what other mechanisms were controlling the interaction between purchaser and provider in this contract, as well as the behaviour of PDS in their practices. Three sets of explanations of more informal controlling mechanisms arose in the case study; dependence, individual motivation and trust. Each of these is briefly discussed in turn.

After examining external factors and contract design and monitoring, an explanation is still necessary for why PDS continued to co-operate in a system by which they often felt mistreated, and equally why the province did not terminate a system that many of them appeared openly to resent. For most practices, the question of whether to compete for the PDS contract was either an answer of "must have/ must do" or "don't want". A sense on the part of both purchaser and provider that "we don't have options" served to lessen the importance of factors such as the completeness of the contract or the monitoring function in recognition that the contract must continue in all eventualities. Reasons for this were financial dependence on the part of the PDS and a lack of options to get the service delivered for the province. The instances of late payment, non-payment and abrupt, unilateral changes to the contract are examples of a form of tolerance or dependence on the side of PDS. The question of why PDS continue to render services when they are not paid can be explained by either their feeling of obligation to the community or a feeling of fear of confrontation with the province which may result in them terminating a contract on which the PDS financially depends. The combination of these factors differs from practice to practice and from individual to individual, linked to both their

financial situation and their individual approach to their role as PDS. A reluctance to get involved in legal action even with a valid reason, which has been observed in other studies of contracting (Williamson 1985; MacNeil 1974) was also borne out by this case study. PDS did not relish the prospect of any confrontation with the province and the explanation for this was a combination of needing the income from the PDS work, and recognising that it was work that they would anyway have to do. For many PDS, even if the province terminated their contracts, their role as community doctor would have to continue in some form or other. On the side of the province the lack of detailed specification of breach of contract and the penalties which would be incurred also suggests a recognition of the inevitably long term nature of the contractual relationship.

This is also reflected in descriptions of the contract award process – in most cases there was no negotiation of the terms of the contract, and it was usually passed on within a practice or offered verbally to another doctor in the town. There was very little sense of a competitive process. For the provider there was less at stake if the service they delivered was poor quality because they knew that they were the only ones available to supply it and so were unlikely to lose their contract. The purchaser equally became resigned to the status quo in recognition of few alternatives to getting the service provided. Any value in even the limited degree of monitoring possible may have been lessened by the lack of realistic penalties available to the purchaser in the absence of an alternative provider. In some cases it appeared that the work was taken on reluctantly by the PDS, with the sense of not being able to say no. Rather than a competitively awarded contract, the process sometimes more resembled the fulfilling of an obligation or duty.

This link between feelings of obligation and the taking on of the PDS contract introduces the important role of the motivation of providers. This is shown as an environmental or external factor in figure 9.1, and also as a factor on which contract operation relies. Both external factors and the influence of contract design and the incentives which that creates upon motivation must also be acknowledged. The data on PDS service delivery presented suggest that PDS responded to the

financial incentives created by their contract However, it was also clear from the case study that a degree of externally determined motivation for each provider strongly influenced how they worked under the conditions of the PDS contract. PDS spoke about their feelings of duty and sense of obligation as a doctor to treat all members of their local community and also about their concern to maintain a decent professional reputation in all of the work that they did. This also meant that they were happy to work under a poorly specified contract because they did not view it as the job of the provincial purchaser to tell them how to practice medicine. It is feasible that the sense of obligation or inability to refuse treatment to community members of some doctors was exploited by the provincial purchaser - some PDS were seeing patients beyond what they were allowed to charge the province for, others viewed the contract as minor compensation for a job that they would have to do anyway - another dimension increasing the PDS' resignation to the contractual relationship, no matter what form it takes.

From practice to practice the manner in which PDS approached their role and their patients differed quite dramatically, some seeing themselves as fulfilling an important community and social role whereas others showed less concern for their role beyond that of delivering a service for which they would be paid. Such differences in motivation are probably beyond the control of a purchaser to influence via a contract, but remain a key influence on how the PDS contract operated. It was clear from comparing the transcripts of FGDs across sites and also from visiting all the practices that some PDS simply did a better job than others. Some of the explanation for this lies with them as individuals and how they perceive their role as PDS, factors which are socially and individually influenced. Potentially this is the most profound effect on the quality of the services delivered under the contract. It is also extremely difficult to assess in any meaningful way, especially prior to someone taking on the role of the PDS. Further, the likely outcome of interaction of an individual PDS' existing personal motivation for his work with the incentives created by a specific contract is very difficult to judge.

In some cases, trust also acted as a substitute for the more formal contractual mechanisms of design and monitoring between the contracting parties. However it did not appear that trust was universal and a discussion of its role must acknowledge that, for this contract, the whole atmosphere between purchaser and provider was permeated with uncertainty regarding the future and the acceptance that many instances of fraud had taken place. Where there was trust between PDS and provider, interpersonal trust and competence trust were the most relevant categories to describe it. Trust between purchaser and provider appeared stronger in the Western Cape, suggesting that it benefited from situations where there was greater identification between parties to the contract and where monitoring could act as a complement to trust. In the Eastern Cape there was an assumption on the part of some provincial officials that all PDS were almost by definition cheats, and this could not be altered due to their inability to do even basic financial monitoring adequately. Trust and capacity to monitor therefore appear to have been positively correlated.

Competence trust, or trust in the professional standards of PDS, appeared to underlie the operation of the PDS contract in all cases. Whilst the province may have had doubts about the financial probity of some of their PDS , few doubts were expressed about the technical quality of the services that they provided, although one manager did raise the issue of racism, suggesting that other aspects of care may be poor. In contrast, interpersonal trust was not always present between purchaser and provider and was most notably absent again in the Eastern Cape.

Mishra's definition of trust (1996) is useful as one approach to analysing the nature of trust in the PDS contract:

"one party's willingness to be vulnerable to another party based on the belief that the latter party is a)competent b) open c) concerned and d)reliable. Last, trust is voluntary...".

To use these categories to classify the situation between purchaser and PDS is quite illuminating. Both provinces appeared to rely on their PDS to be competent and reliable, but views on their degree of openness (taken here as honestness) and concern were formed about each individual and were not

always favourable. What the PDS felt about the province was even more negative, in particular in the Eastern Cape, where there was little evidence that they felt that the province fulfilled any of the above categories. Last, the criteria of voluntariness of trust was not always met as is very obvious from comments like *"we have to trust them, we have no choice"*. Puffit's (1998) continuum of trust to distrust, via hope and indifference, may be more useful to capture the essence of the PDS contractual relationship- whilst instances of unmitigated trust and distrust were present, what was more common was a mixture of hope and indifference in the dealings between PDS and province.

Overall the findings from this case study did not confirm that trust automatically underlies complex contracting for public services. The weakness of many of the other determining factors for the relationship resulted in a situation that was often too antagonistic and uncertain for trust to perform any important function, with the exception of competence trust, which even in the "low trust" environment presented in this case, appeared to underlie the PDS contract. It was the need for shared beliefs and values to underlie much interpersonal trust, and the role played by history and context in providing these, that appeared to be where the PDS contract often failed. The prevailing climate of suspicion and uncertainty created by some PDS' fraudulent behaviour, recent changes in the government and the current government's less sympathetic attitude both to the private sector in general and to the PDS system in particular prevented trust from playing any major role in explaining how the PDS contract operated. Whilst this does not disprove the potential value of trust in contracting, it does show that to call upon trust as an explanation for all incomplete contracts is not accurate.

Dependence and the individual motivations of PDS therefore emerge as strong residual explanatory factors for this case study. The concept of relational contracting is partially based in a recognition of the many situations in which dependence between purchaser and provider is important, but the example of this case is perhaps quite extreme. Once the incomplete contract, the poor monitoring , the partial trust, and the generally poor state of the contractual relationship is considered, there

remained a sense of HAVING to continue with this relationship and make it work because there was little choice. There was also a recognition that this dependence extended beyond just the PDS contract even if this terminated – the situation of bilateral monopoly/dependence between private and public sector in many rural towns would remain. Combined with a sense of having little control over the contractual relationship, dependence led to a reliance on the motivation of each PDS to do a reasonable job. These two factors interact - dependence can only develop in a system which does function in some form, and this is often a reflection of the individual motivation of the PDS.

In conclusion, despite the incomplete nature of the written PDS contract and the unsatisfactory nature of the monitoring, a consideration of the nature of other controlling factors in the contractual relationship makes its functioning more understandable. These less formal but nonetheless important controlling factors need to be understood as defined by the particular circumstances and context of the contract.

The Lesotho case

The second case study contrasts with the PDS situation in a number of ways but most importantly it gives an example of what may be the effect of access to greater capacity on the nature of contracting for primary care services. The Lesotho contract was still in a remote rural setting but did not face the same shortage of management capacity as in the PDS case. Other differences with the PDS case are that instead of being with a series of individual self-employed providers, this contract was with a single commercial company, so the individuals delivering care were subject to a system of hierarchical management and less immediately exposed to the incentives of the contract. Second, it was a contract with much less history or context to it. Third, the delivery of services under the contract was not a key activity or source of vital income for purchaser or provider companies, so the nature of dependence was less, or different. As with the PDS, this case study is again in a rather unique set of circumstances; although it is much less influenced by previous history, context still plays a large part. However, despite these differences, although proceedings were generally more

formal and paid more attention to the written contract, some findings were remarkably reminiscent of those from the PDS.

There were some similarities in environmental factors with the PDS study, such as the problems of defining the nature of service delivery within the parameters of a public sector system and the lack of competition in the market. It was interesting that despite there being no historical ground to it, as there was in South Africa, the same tendency to separate curative and preventive services between the contracted and public sector clinics was noticeable. The second similar factor, lack of competition for the contract, was due to both the remote setting in which service delivery was taking place and the quite technical nature of the services contained within the whole contract (e.g. 24 hour doctor cover and emergency evacuation facilities).

In contrast, the capacity situation for the Lesotho contract was quite different from the problems described in the South African public sector. With the well-resourced LHDA acting as purchaser, and backed up by a firm of consulting engineers, there was plenty of expertise in writing contracts. The motivation of the provider was also different in that it was expressed purely in terms of profit seeking, and there was little connection or feeling of obligation between any of the contractors and the community that they were required to serve.

The outcomes of this set of factors can be considered in turn. First the form of the contract was quite dramatically different from the PDS, and it is interesting to note how one of its clauses specifically emphasised that it was meant to encompass all relevant aspects of the contractual relationship and that resort to any other agreement outside of the contract was incorrect. Following this explicit attempt to be complete, the contract design focused heavily on inputs and specified these in great detail. Attempts were also made to specify the form of monitoring and possible breaches to the contract and ensuing penalties in complete detail, but some of these parts of the contract began to reflect the problems associated with trying to specify such issues in complete contractual terms. For

instance, monitoring via reports was specified in great detail but not in particularly practical or relevant terms, and there was still no attempt to tackle the issue of monitoring quality of care or the nature of service delivery by visiting the facility or by other potentially more effective means.

Furthermore, despite the greater detail of the contract design, it still remained incomplete. Comments about this resembled the PDS case. Frustration was expressed by the purchaser about the problems of getting the provider to do what they wanted, such as deliver comprehensive primary care services, despite the fact that they felt it was clearly specified in the contract. Building on the PDS case which suggested the difficulty of specifying contracts for primary care generally, this suggests that any attempt at such specification, no matter how detailed, was still open to interpretation by those who deliver services. The same issue of poor control of providers and having to some extent to rely on their own motivation and determination of the meaning of the contract was raised as with the PDS contract. The central problem of the principal-agent relationship and its link to motivation was expressed by one Lesotho purchaser:

"you can tell someone else to do something and they will still say yes they are doing it, but they need to believe in it very enthusiastically and to understand what has to be done".

Monitoring the Lesotho contract was also problematic. Again, given the relatively greater capacity available compared to the PDS case, this suggests that the logistical and information problems inherent in monitoring primary care delivery in scattered or remote areas are not purely due to lack of capacity. Again in this case the purchaser resorted to reliance on the surrounding community to report any major problems with service delivery, although here because of the stronger nature of the community groups in this area and established channels for complaint, this was likely to be more effective. Overall, the greater level of capacity within this contract was only noticeable in minor ways, such as there having been no difficulties related to late or inaccurate payment of the contract. The level of transaction costs was also likely to have been raised by these additional "layers" of management expertise.

The incentives in the Lesotho contract were to supply all the inputs specified and maximise the value of drugs prescribed. The data on service delivery suggest that the provider was responding to these incentives, although again it is difficult to separate this out from the other potential influences, such as the higher standard of service delivery that the provider was accustomed to due to their largely private sector work.

Overall this second contractual relationship had made a greater effort to lay out and abide by formal contractual mechanisms of specification and monitoring and there was a general sense of needing to pay attention to the written contract ("*we must live within the contract, breach of contract is terrible*"). Nevertheless, the reality of the contract's functioning as described in the interviews still suggested a reliance on interpersonal relations and a recognition that both monitoring and specification of the contract were unsatisfactory. For instance, whilst changes to the contract were approached in a more formal, negotiated manner it was acknowledged that it was often a by-passing of the formal routes and a conversation between two individuals who knew each other socially that would clinch an agreement or smooth a dispute. One interviewee spoke of the tendency to lift the phone and then formalise the agreement contractually later, and also of the tendency not to follow the strict hierarchy of communication between the different parties to the contract as they were laid out[35].

In conclusion, in this still incompletely specified and monitored contract, the role of other factors in controlling the behaviour of the contracting parties remained important and the role of trust and dependence in particular were acknowledged by both purchaser and provider. Here the nature of the relationship between purchaser and provider was less antagonistic and perhaps this made the potential role of trust correspondingly greater. The individual motivation of providers was lessened as a mechanism for determining their behaviour because the provider was a company and therefore hierarchical mechanisms also came into play to determine how service providers behaved (although

[35] that the sub-contractor, medical services should only communicate with the engineering contractor who would then communicate on their behalf with the consulting engineer and LHDA.

these mechanisms were stressed by the managing director of the contractor to rely on "personnel" rather than "systems").

The private capitated scheme

The third case study was of contracting for primary care services entirely within the private sector. This is a weakness of the case, but overriden by the interesting addition of examining what the private sector can do to bring a different perspective to the study. Other strengths of the case were that it was not related to such a unique set of historical or geographical circumstances as either of the previous two case studies and that it was highly repeatable in many urban contexts (although whether this is true within the public sector is discussed further below). It was also highly relevant to the current dynamic of the health sector in South Africa which is seeing an increasing move towards low cost, privately provided primary care services, delivered by providers with whom the public sector could potentially contract in the future.

In design, this case study differed slightly from the preceding two in that it lacked the same detailed interviews with individual purchasers and providers under the contract. This was because due to the more segmented nature of the market in which this contract was functioning and the greater number of institutional purchasers, there was not an equivalent single, large scale purchaser to be interviewed or provider facilities functioning under one single contract. Also, both purchasers and providers had less to say about the dynamics of the contractual relationship. In the case of providers this was because they did not differentiate between patients that they saw covered by this contract and those who were paying cash or who had other forms of health insurance. Less of the case study therefore came from interview data and more from document review and objective assessment of some external factors, reflecting the different, more self contained nature of the contractual relationship.

In terms of the environmental factors described for the other case studies, this case had several considerable differences. First, with regard to the nature of the service, because of the way that the

provider was organised and managed, there was a very standardised service on offer, overseen by close internal management and monitoring, which made it very straightforward to specify in the contract. Also, because this contract was not involved in delivering services to public sector patients, there was no issue of how it would interact with existing public sector services. It was also possible to exactly define the population that were to be covered by the contract, which had implications for the payment mechanisms that could be used. The nature of the market for this contract was also profoundly different from the prior case studies, and resembled much more closely the market of neo-classical theory. First there were multiple purchasing organisations and even within these, each individual made their own decision whether to continue to subscribe to this package of health cover or not. Second there were a number of competing providers who could remain in the market because each contract was far smaller, making Williamson's (1985) fundamental transformation less relevant than for the previous two case studies. Basically the structure of competition and the market in this case study illuminate how far removed from a real market the other two case studies were. In this case there was a genuine choice of whether to remain in or exit from the contractual relationship. The option of changing provider was realistic, and the provider would not lose his livelihood if this took place. This situation of low dependence was further increased by the low asset specificity of the contractor clinics, largely because they were located in urban areas where there were multiple alternative uses for both their human and capital assets.

Overall, the picture that then arises from this final case study is of a completely different nature of contractual relationship. Whilst this private capitated scheme's written contract was perhaps the simplest in its form and the shortest, it appeared to become the most comprehensive by virtue of the external factors described above. In particular the following factors created the correct environment for a contract less reliant on other controlling mechanisms - a well defined, comprehensive service, a defined population, and a payment mechanism which did not create any perverse incentives. The use of a capitation payment mechanism relied on having a defined population and being within a competitive market so that the risk of under-servicing was balanced out by the ability of patients to

exit from the contract and go elsewhere, as well as the risk to the provider of having to pay for specialist referrals.

The second formal control mechanism, monitoring, also took a different form. First, the chain of clinics had in place strong, standardised internal systems of quality assurance and monitoring which constituted one type of control on service delivery. Second, the opportunity for each individual to opt in or out of subscribing to the private capitated scheme meant that the role of the individual in monitoring the acceptability of the service was greatly strengthened.

The result was a contract that, unlike the previous two case studies, was free of reliance on interpersonal relations or interpretation for its functioning. Minimising the need for interpretation was reliance on a contract design that first, eliminated the incentive to over-service patients and guarded against under servicing by means of sharing risk with providers at higher levels of care and second, that was linked to a clearly specified, comprehensive package of services. Monitoring of the quality of service provision was carried out by internal control procedures of the provider and underpinned by the greater power of each individual consumer in judging whether the quality of the service was acceptable.

The main question raised by this final case study is to what extent any of these observed characteristics could be replicated in other settings. In particular, the replicability of these conditions with a public sector purchaser is debatable; defining the population to be covered, achieving realistic competition within a market with a public sector purchaser, and relying on consumers to monitor services may all be problematic. A further difference is that if the state purchases on behalf of state patients, principal agent problems become relevant (with patient as principal and the state the agent) and patients no longer have the power to use the exit option at their discretion, taking their funding with them, which weakens many of the incentives in this contract design.

KEY OVERALL FINDINGS FROM THE CASE STUDIES

The three case studies presented all demonstrate that contracts for primary care services were unlikely to be written in a complete way and that formal monitoring of such services was also likely to be incomplete. As suggested by some of the literature reviewed in chapter 2, operation of primary care contracts is better understood by looking at the circumstances and external factors which surround them and the more informal contractual controls that these circumstances gave rise to. For instance, in the PDS case, limited competition (arising from the external nature of the market) gave rise to dependence, and for the private capitated scheme, a favourable external context (competitive market, defined population, good internal management) allowed a simple contract to operate with few external controls.

The Lesotho contract appears to sit somewhere between the two, with an attempt at a completely specified contract which falls short of success and relies to some extent on relational factors. Despite this range of contractual outcomes, a comparison of the case studies illuminates several features likely to have relevance for primary care contracts elsewhere. Some of these features are presented in figure 9.1. Below, the role of the formal contractual control mechanisms of design and monitoring are reviewed followed by a discussion of the importance of external factors and less formal contractual controls. Such contractual substitutes or controlling mechanisms act to complete contracts that are incompletely specified and monitored and arise from the external conditions of the market and the nature of the provider. These two factors combine to determine the type of influences shown in the last two columns of table 9.1.

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Table 9.1: Features of the different case studies presented

Contract	Market Setting	Purchaser & capacity	Type of contract design and service delivery	Monitoring	Service provider	Nature of possible influence upon service provider	What is controlling behaviour of service provider and purchaser?
PDS	Rural towns - very little competition	Public sector – provincial authority. Limited capacity.	Fee for service. No limit to financial and service commitment by either party. High volume, mainly curative services delivered.	Formal monitoring by purchaser but not perceived as highly effective. Informal monitoring by peers and users of service but unclear whether dissatisfaction is reported by community.	Private sector -individual GPs who are also engaged in private practice.	INDIVIDUAL: Professional Social Financial	Financial incentives Some degree of trust Dependence Individual Motivation
Lesotho	Remote rural - very little competition	Public sector -parastatal via contract with construction consortium. Relatively high capacity to write and manage contracts.	Fee for service. Limited financial commitment by purchaser except for drug payment. Inputs required from provider specified completely. High cost and quality, low volume, mainly curative services delivered.	Formal monitoring by purchaser but not perceived as highly effective. Informal monitoring by peers and users of service. Hierarchical monitoring within company.	Private sector – commercial company whose main income is not provided by this contract.	INDIVIDUAL: Professional Social Financial COMPANY: Some hierarchical control	Financial incentives Hierarchical control Trust Dependence
Private capitated scheme	Urban - competition	Private sector companies - via medical scheme. High capacity to write and manage contracts plus strong internal management capacity.	Capitation. Financial commitment by purchaser limited to capitation payment. Services to be delivered specified completely in type but not volume. Low cost combination of curative and preventive services delivered.	Mainly hierarchical. Strong internal systems of monitoring and control of service delivery. No monitoring by purchasing institution. Informal monitoring of service by users.	Private sector – commercial company running a chain of clinics which are its main business.	INDIVIDUAL: Professional Social Financial COMPANY: Strong hierarchical control and internal procedures	Financial incentives Hierarchical control User's power to exit the contract

With regard to contract design, contracts tended to be incompletely written and specified. Whilst Allen (1995) recommended that a contract should deal with inputs, outputs, throughputs, outcomes and quality, the contracts examined in this study all tended to focus on a list of services to be delivered, or inputs to be provided, alongside a payment mechanism. Observations in the literature regarding the difficulties of writing comprehensive contracts were clearly demonstrated by both the PDS and Lesotho cases, but perhaps most definitely by the Lesotho contract's unsuccessful attempt at completeness, given the ample contract writing capacity in LHDA. This contract attempted to specify in some detail issues of breach of contract, dispute resolution, and detailed monitoring requirements but whilst these were clearly laid out, they appeared of questionable relevance for a health service, especially the detailed monitoring requirements. None of the contracts tackled the issue of defining or monitoring the quality of services delivered. One aspect of the contract that was however clearly influential in all of the case studies was the package of financial incentives which it created. To a large extent, the very different nature of service delivery in the three types of facility visited was a result of the financial incentives in the contract.

The case studies also demonstrated how the status of the written contract within the contractual relationship could vary. The PDS study gave an example of a contractual relationship that operated with some parties not even being in possession of a written contract. In Lesotho, there was greater respect for and recourse to the written document but it was still acknowledged that agreements were usually made 'around' it rather than 'through' it. Last, the private capitated scheme was an example of a short, succinct contract which managed to offer a very fixed set of services in a very specific way with success, largely due to the support of a favourable set of external factors. Each can be argued to work within their respective settings, demonstrating the importance of considering each of the factors identified in this study when designing a contractual system in an LMIC setting.

The second type of formal contractual control is monitoring. Again in all cases this was found to be problematic largely due to the nature of the service, but weak capacity and service delivery in remote areas also served to worsen these problems. The question of purchaser's motivation to put adequate monitoring systems in place was also raised. This may be due to their recognition of the impossibility of monitoring primary care services, but some comments by providers in the PDS case study and also Lesotho suggested that their belief was that purchasers simply did not make the effort to put adequate monitoring systems in place. This may be a reflection that in both the PDS and Lesotho cases purchasers were involved in the contract due to a lack of choice and perhaps this lessened their enthusiasm for the task of monitoring. Either way the case studies confirmed that either through lack of capacity, lack of will or lack of ability, formal monitoring by the purchaser of services delivered did not appear to be a feasible control mechanism. Monitoring by users and by peers was consistently raised as a more attractive alternative, although the effectiveness of this must also be considered closely.

The case studies therefore demonstrate the limitations of the formal contractual functions of design and monitoring in controlling what takes place under a contract. This was largely due to the settings and circumstances in which contracting was taking place. Each setting also defined the type of controlling mechanisms that arose to substitute for complete contracts and extensive monitoring.

Informal controls on contracts took a variety of forms. The PDS case demonstrated that the historical context of a contract can be very influential, but this is clearly something that will differ from case to case in its importance. In contrast, capacity was of great relevance in all the case studies. Adequate capacity appeared to be a necessary but not sufficient condition for the successful operation of contracts, but the precise nature of its role was difficult to assess. On one hand it is tempting to blame a lack of capacity for every gap within a

contracting relationship that falls short of the classical contracting model. But much in the case studies suggested that this may be an oversimplification. In Lesotho there was considerable expertise and financial capacity and yet there were still problems in the specifying and monitoring of the contract, suggesting some more fundamental problems in the asymmetries of information inherent in a service like primary care. On the other hand it was interesting that the private capitated scheme functioned with very little need for capacity to specify or monitor contracts so it is also possible for some contractual relationships to be self enforcing, or reliant on other systems of control such as a competitive market, a well-defined, influential beneficiary population and strong systems of internal management. These too can be included in the broadest definition of capacity (Bennett and Mills 1998).

Another key aspect arising from a contract's setting was the degree of market competition. This appeared to be influenced by geographical setting – e.g. rural areas lacked competitive markets, and by the nature of the purchaser- e.g. a publicly purchased service reduces the competitiveness of any market. A comparison between the nature of the market in the private capitated scheme case study and the other two studies demonstrated this second point. By their nature, publicly purchased services will tend to be purchased in large blocks and by one purchaser. Because they are purchased in large blocks this will tend to also concentrate the provider market, as those who are not successful in winning the contract will have spare capacity (that which they would have used to provide the large block of services) and so have to either scale down or leave the market. This implies an inherent tendency to bilateral monopoly. The nature of the market that arises when there are many potential purchasers and providers is quite different. This has clear implications for public sector organisations wishing to contract out services in rural settings.

The last set of important external factors is related to the nature of the provider with whom the contract is made, with the key difference being whether it is an individual or a company,

and then in turn the controls upon the behaviour of each of these. From these case studies it appeared that the motivation of individual providers was both an important determinant of contractual behaviour and quite variable. Case studies gave a sense of the different controls on the behaviour of individual GPs and for profit companies. One common factor was their response to financial incentives, suggested by the service delivery data in chapters 7 and 8. Beyond this, the divergent nature of an individual GP's motivation from that of a health care provider working within a for-profit company highlights some interesting differences in the way in which either can be controlled by a contractual mechanism. In addition to the social, financial and professional factors which go to determine an individual GP's professional behaviour, a service provider working in a company may face a second set of internal, hierarchical controls on his practice. This adds a further potential layer of control, and simultaneously lessens the importance of motivating factors more specific to the individual.

A basic degree of trust underlay all the contracts studied, as it probably does all transactions. Beyond this, quite different degrees and types of trust characterised each set of purchaser/provider relationships reviewed in the case studies. Purchasers most commonly had competence trust in the providers, whilst certainly in the PDS case the providers did not necessarily have the same confidence in the abilities of the purchaser. In many cases of the PDS contract and within the Lesotho contract there was also evidence of interpersonal trust. But other potential components of trust were often missing; for instance in the PDS contract, trust that each party would be open and honest. Some type of competence trust even seemed able to co-exist with considerable suspicion on both sides. The fact that there were greater expressions of trust in situations where there was more contact between contracting parties suggests that contract, trust and monitoring act not as alternatives but complements. The nature of trust in the private capitated scheme was highly impersonal and did not appear to be an important mechanism between the contracting parties.

CONCLUSION

This chapter has discussed the findings from the three case studies examined by this research, as well as some of the shortcomings of the data available. Each contract was found to be very different in its setting, form and operation but looking at a combination of all of the case studies it is possible to shed light on some factors which are likely to be key for any contractual relationship in an LMIC. First, contract design and monitoring are both likely to be only partial controls on the operation of the contract. This means that in many cases penalties and sanctions may be ineffective in influencing providers' behaviour. Incentives may have better results, but only in situations where they are also not reliant on any formal monitoring for their operation. It also means that informal contractual controls such as trust, dependence and the motivation of individuals will be important, as will any hierarchical control within an organisation if the provider is a company rather than an individual. From the examples of these case studies, capacity, the competitiveness of the market (setting and nature of purchaser) and the nature of the provider are all highlighted as factors which will define the nature of such informal controls.

CHAPTER 10: CONCLUSIONS AND RECOMMENDATIONS

This study has sought to describe the nature of three contractual relationships in Southern Africa in order to shed light on what different forms contracts for primary care services can take according to the various contexts in which they are set. It has also considered different controls on the behaviour of purchasers and providers under these different contractual forms. It aimed to start to redress the dearth of empirical data on the nature of contracts for primary care services and how they are operating in LMICs. This chapter will summarise conclusions both about the nature of each individual contract and what can potentially be generalised from these findings to policy on contracting in LMICs more broadly. For the latter, it is necessary to consider how findings useful to policy-makers can be generated from the case study approach adopted in the study. Via the framework of factors employed throughout the study, a series of conclusions and policy recommendations are made and the contribution that this study has made to knowledge about contracts for primary care in LMICs summarised. This addresses the final objective of the study by making recommendations on how policy-makers in South Africa and elsewhere could best approach a policy of contracting with the private sector, and what is likely to be appropriate for different types of service and different types of provider. Finally, suggestions are made for future research in this area.

SUMMARY OF RESULTS CHAPTERS AND KEY FINDINGS

The three contracts described in this study suggest that contracts for essentially similar primary level services do not conform to a pattern either in their design or in the manner of their operation. In particular the three contracts examined had very little in common in their contract design. To understand each contract it was necessary to examine a range of factors including their environmental context, the individuals involved (and whether the provider was an individual or a commercial company), the history of the contract and the nature of the service being contracted. In line with the objectives of study, the results chapters of this thesis have reported on a range of these factors for the three contracts.

In **chapter 4**, historical and policy context for each of the contracts was described. The PDS contract was heavily influenced by the history and current reform of the South African health sector. The other contracts carried less of a historical legacy.

Chapters 5-7 then presented the PDS case study. **Chapter 5** explored the environmental and human factors potentially influencing the operation of the PDS contract. The market for PDS services resembled a bilateral monopoly with very little effective competition. Interaction between the PDS and existing public sector services made the nature of the service to be delivered highly context specific and therefore difficult to specify in a generally used contract. PDS described their motivations for being involved in contracting to the public sector as both financial and through a feeling of obligation to the community in which they lived. Both **chapters 4 and 5** demonstrated the weakness of current provincial government capacity in South Africa to write and manage contracts. **Chapter 6** described the PDS contract design and award process. The contract was not specified in detail, and was in many respects incomplete, simply distributing financial risk to the purchaser in return for an open-ended service delivery commitment by the provider. The contract award process showed few signs of any competition in the range of cases studied. **Chapter 7** sought to describe the manner in which this incomplete contract operated and what mechanisms were used to complete it. PDS respond in a way consistent with the financial incentives in the contract whilst on the side of the purchaser monitoring was problematic and payment often incomplete or late. It was concluded that the contract's operation was dependent to a limited degree on trust between purchaser and provider and relied heavily on a situation of mutual dependence and the individual motivation or obligation of the PDS to ensure its continued functioning.

Chapter 8 presented two briefer case studies of a contract in Lesotho and a private capitated scheme. The Lesotho contract, whilst being specified in greater detail and drawing on a higher level of capacity, appeared to resemble the PDS contract in the manner in which it still relied upon relational

factors to determine its operation. The private capitated scheme contract demonstrated a more impersonal contractual process, benefiting from a competitive market, a defined beneficiary population and a more comprehensive service to be delivered.

CONCLUSIONS

Conclusion that can be drawn from this study fall into two groups. First, substantive conclusions can be made about each of the three contracts which were the subject of the case studies. For each case, the nature of the contractual relationship and what the influences upon this were likely to have been can be described in definite terms. Second, theoretical conclusions can be drawn about what the three case studies reveal about the nature of contracts for primary care services more generally. This second set of conclusions are of greater interest to a wider audience of policy-makers, but their nature is more tentative. They focus on the possible nature and role of a range of factors identified to be influential in contractual relationships, rather than on general conclusions about contractual relationships *per se*.

SUBSTANTIVE CONCLUSIONS ON THE THREE CASE STUDY CONTRACTS

Conclusions on the PDS contract

The nature of the PDS contract reflects the uncompetitive nature of the market in which it is delivered and the subsequent high degree of dependency between purchaser and provider. It conformed closely to MacNeil's model of a relational contract and demonstrated a marginal role played by the written contract in determining the conduct of the overall contractual relationship. The nature of the contract's operation appeared more determined by environmental factors in each town such as its health care delivery requirements and the nature of the individual PDS. Demand for the services of a PDS is difficult to predict and specify contractually and purchaser capacity to do this was weak in both provinces, but dramatically so in the Eastern Cape. Reflecting this weak capacity, the contract itself was incomplete and out of date, and many PDS were operating either without a copy of it, or not knowing where their copy was.

In both provinces monitoring was acknowledged as an inadequate check on the activities of PDS; this was blamed partly on lack of capacity but also on the inherent difficulties of monitoring scattered PHC service delivery. To a large extent PDS were left to determine individually the manner in which they would deliver services under the contract - and this decision was both socially and financially influenced. Aside from financial motivation, influences included what other colleagues did, professional standards, a feeling of obligation to the community to provide basic care to all and the wish to preserve a reputation as a good doctor in "their" town. Greater capacity to monitor and maintain regular communication acted as a positive reinforcement to the contractual relationship in the Western Cape but overall the contractual relationship was strained and distrustful - appearing to continue as a result of mutual recognition of dependence.

Conclusions on the Lesotho contract

The Lesotho contract exhibited both similarities and differences with the PDS case. Despite a greater attempt at detailed contract specification, the operation of the contract was again largely relational, influenced by a remote, uncompetitive market and the close proximity of purchaser and provider. The same problems of specifying the service adequately and how it integrated with public sector supplied services were encountered as with the PDS contract. High levels of capacity to manage and write contracts were available, but did not appear to solve the problems of monitoring and defining the contract exhibited in the PDS case study.

The design of the contract concentrated on a comprehensive specification of inputs, but despite this, in the opinion of the purchasers, it failed to obtain the type of comprehensive service delivery desired. Monitoring was still problematic and the nature of service delivery again largely defined by what the provider was willing to do. Responding to the incentives of the contract design, service delivery was both high quality and high cost. As the contract was with a commercial company rather than a series of individuals, the role of each individual in interpreting the contract was lessened, with

clearer resort to hierarchical mechanisms in governing service delivery. Both purchaser and provider acknowledged the role of dependence and trust in determining the nature of the contractual relationship.

Conclusions on the private capitated scheme contract

The environmental context of the private capitated scheme was a dramatic contrast from the other two case studies. By being within the private sector and in an urban setting, the nature of the market was highly competitive. The nature of the service on offer under contract was also more easily specified as there was no necessary overlap with public sector services and contracts could be specified as covering all services on offer at any clinic which was part of the company. The nature of services delivered was therefore more resembling a comprehensive primary care service than in the case of the other two contracts. The more voluntary nature of each individual's entry into the contract also had some interesting consequences. First it was possible to define the population to be covered, which allowed for the use of a capitation payment mechanism. In conjunction with capitation, the contract design made the provider partially bear the risk of expensive referrals. This is likely to have increased attention to the preventive aspects of care. Second, incentives were stronger to ensure that the quality of care was acceptable to consumers, as they were effectively purchasers as well. Third, the opinion of users was the principal external monitoring mechanism used by this contract, reducing the problems of trying to monitor delivery of such a complex service by other means. The provider's strong hierarchical management controls acted as a second key mechanism of control.

The private capitated scheme contract therefore represented a departure from the more relational contracts of the PDS and Lesotho models. Key differences which contributed to this are a competitive market (providing a feasible exit option), a defined population (allowing the use of capitation payment) and the use of alternative monitoring mechanisms rather then the purchaser attempting to monitor service delivery itself.

How can conclusions from the case studies be generalised?

As well as conclusions specific to their own operation, the three case studies can offer findings more broadly generalisable to contracting in an LMIC environment. However, given the debate about the use of case-studies to generate generalisable findings, it is desirable to describe the mechanism by which they are suggested in this study. This analysis draws on the type of approach suggested by authors such as Mitchell (1983) and Yin (1994) of a line of generalisation from specific findings back to some theoretical framework. Some of the factors which have been used as an analytical tool throughout this study are the level to which generalisation is sought. Rather than trying to predict the nature of any type of contractual relationship, conclusions drawn below relate to the possible characteristics of each factor influencing the nature of a contract's operation. This can provide a framework by which the essential characteristics of any contractual relationship, potential or real, can be analysed. The factors about which conclusions are drawn are shown in table 10.1. The aim of the conclusions drawn by this study is to suggest possibilities relevant to a range of contractual situations rather than dictate any particular set of findings or action.

Table 10.1 : Factors for which generalisable conclusions may be drawn

Category	Factor (example)
Environmental context	Nature of market; Nature of service; Capacity
Human and organisational context	(Individual motivation; Hierarchical control)
Formal contract controlling mechanisms	Contract design; Monitoring
Informal contract controlling mechanisms	Contractual substitutes/relational mechanisms (e.g. trust, dependence, individual motivation, and hierarchical control).

A second issue of generalisability is to what extent the conditions and context in which contracts in this study were operating can be argued to shed useful light on what may be the case in other LMICs. Whilst classified as an LMIC, South Africa is relatively affluent in comparison to most LMICs, certainly in Africa. The setting of this study is probably most directly comparable to middle income countries in Asia and Latin America. Whilst it is not possible to predict what the nature of each factor will be in different settings, the resources employed in the South African health sector are

generous, implying that in other low income settings problems of low capacity will be exacerbated and in some areas markets of providers may be even less competitive or non-existent due to a lack of human resources. It should also be recognised that in other countries, the dynamic between public and private sectors may be quite different, altering what was recognised as an important contextual factor in the South African setting.

CONCLUSIONS PER FACTOR

Factors which have emerged as important determinants of the nature of the contractual relationships studied here are reviewed below, and some conclusions about their broader relevance to LMIC contract settings drawn.

ENVIRONMENTAL CONTEXT

I. Nature of market

The case studies all demonstrated that the nature of the market in which contracting took place was a key determinant of the nature of the contractual relationship. The competitiveness of the market is made up of the number of potential purchasers of a service and the number of potential suppliers. In the case of both the Lesotho and PDS cases there was a bilateral monopoly, or a single purchaser and usually a single potential supplier. This created a situation of dependence which had a clear impact on the working of the contractual relationship. The private capitated scheme contrasted with the other two case studies by demonstrating the impact of a competitive market on the way in which a contract can function. Here both purchaser and provider were not reliant on one another and consequently the nature of the contractual relationship was no longer dependent or particularly relational. Other problems in the functioning of contractual relationships were potentially lessened by the 'exit' option which this competitive market represented.

Generalisable conclusions about the nature of the market:

1) The market in which a contract is let and its degree of competitiveness are key in determining the nature of contract that will arise.
2) Principal determinants of whether a market was competitive that were highlighted by these case studies was whether the setting was rural or urban, and the nature of the purchaser.
3) Rural settings were more likely to have uncompetitive markets due to the smaller size of the market which could not support many suppliers.
4) Public purchasers offering large contracts encouraged market concentration and reduced competition.

II. Nature of service

Considerable asymmetries of information will exist in any contractual relationship governing the delivery of clinical primary care services. This is due to their broad nature and the way in which they inter-relate with other parts of the health system, which does not make them easy to specify separately in a contract or to monitor.

In terms of service specification, both the Lesotho and the PDS case study demonstrated similar problems. These arose in defining the separation of contracted from public sector services (echoing the findings of Broomberg (1997) regarding contracting out hospitals) and in encouraging service providers to deliver preventive services. If some form of public sector service exists alongside the service that is being contracted out, it is likely to be difficult to specify comprehensively the nature of services to be contracted out. This situation is worsened if the contract is to cover a number of different clinics and the precise nature of the public/private mix in each clinic area is different. Here either very detailed contracts would have to be written for each case or a more general clause contract, which in some respects is incomplete, will tend to be used.

Because primary care services are the first point of contact between a patient and the health service, service delivery is always via multiple, scattered sites. The nature of primary care is also that it is made up of a broad variety of activities, demand for which is unpredictable. Monitoring of a service that is delivered in unpredictable quantities, at unpredictable times in a series of scattered locations has considerable inherent difficulties.

Generalisable conclusions about the nature of the service:

1) Primary care services are difficult to specify comprehensively in a contract due to the unpredictable nature and volume of the services to be delivered
2) In particular, specifying one part of a primary care package which is to be delivered in tandem with other (often public sector) service providers is problematic
3) Contracts for primary care services will therefore tend to be incomplete
4) Monitoring of a service of such unpredictable volume and nature which is delivered in many scattered locations will also tend to be incomplete.

III. Capacity

Capacity on the part of the purchaser to write and monitor contracts adequately is an important support for a contract to function adequately. However, given the inherent difficulties in writing contracts and monitoring for primary care services described above, the role of adequate capacity should not be overestimated. The Lesotho case study gave an example of a situation in which despite high levels of capacity, contract specification and monitoring were both still incomplete, due to these asymmetries of information inherent in primary care service delivery. On the other hand, the contrast between the Western and Eastern Cape PDS case studies suggests the positive effects of stronger capacity in the greater success of the Western Cape PDS relationship.

Generalisable conclusions about capacity:

1) Capacity is an important support to the functioning of contractual relationships, but its existence does not solve all problems inherent to their functioning
2) A minimal level of capacity for the administration and payment of contracts must be in place to assure their adequate management
3) Beyond this minimal level, a further role for capacity appears to be two fold:

- Rather than being able to enforce the contract in any way, to execute some monitoring functions competently enough that they act as a marginal deterrent
- To enable the devotion of time and resources to maintaining adequate degrees of communication between purchaser and provider. This helps to ensure the continuance of a cordial relationship and some mutual understanding of the perspective of each contracting party.

HUMAN AND ORGANISATIONAL CONTEXT

The case studies revealed the role of the individual as another extremely important factor, especially in the operation of incomplete contracts with individual service providers. Incompletely specified contracts with individuals are likely to rely heavily on each individual's personal decisions about how to deliver care. The PDS case was a good example of this. In the case of contracts with commercial companies it is necessary to consider their internal management structure and to what extent these control the behaviour of frontline providers. In such a setting, individual motivation will still be important but may be less directly affected by the contract and be more affected by the nature of the employment contract and hierarchical supervision. The private capitated scheme is a good example of a company which had sufficiently strong internal monitoring mechanisms for these to act as a control on the behaviour of providers.

Generalisable conclusions about the human/organisational context of contracts:

1) Behaviour of health care providers is controlled by multiple influences, of which the design of the contract is only one

2) Whether health care providers are employed by a company, and therefore subject to hierarchical control, or self-employed is a further important factor in controlling their behaviour
3) It is also important to make allowance for the social and historical influences upon individuals which will to some extent determine the nature of a contractual relationship
4) In addition, for individual service providers, motivating factors will include the following –
    - Personal psychology and beliefs e.g. feelings of duty, obligation, attitude to the community that they are serving
    - Professional ethics, and the wish to preserve a good reputation
    - Financial incentives
5) For service providers working in a company setting, the hierarchical control mechanisms and incentive structures of that company will also be important and will include the following –
    - Method of payment
    - Processes by which quality of service delivery is monitored and controlled internally

FORMAL CONTRACT CONTROLLING MECHANISMS

I. Contract design

Due to the difficulties of designing comprehensive contracts for primary care, the contract document itself will always tend to be incomplete. Its operation will be completed by external factors such as those highlighted in the case studies, e.g. either by reliance on individual interpretation and negotiation as in the case of the PDS or Lesotho case studies, or by a favourable set of external factors which allow the contract to operate in a relatively self contained manner, such as for the private capitated scheme. In the absence of these favourable factors, even extensive attempts to completely specify a contract may backfire and simply result in greater levels of transaction costs.

However incomplete, each contract will nevertheless still contain important information and create incentives. The payment mechanism in particular will create a set of financial incentives to which providers are likely to respond. Where sanctions are specified, it is less clear to what extent they will

influence behaviour, as they may not be perceived to be enforceable or realistic. However, they may still act as an important deterrent in some cases.

Generalisable conclusions about contract design:

1) Written contracts for primary care services in LMICs are unlikely to provide strong control over the behaviour of service providers. Because they will tend to be incomplete, they will also be heavily influenced by a range of external factors determining the nature of their operation.
2) In some circumstances contracts will tend towards what was identified in the literature review as a relational contract, but this is determined by the circumstance in which they operate and may not automatically be the case. As dependence of the purchaser on one provider increases, the operation of the contract is likely to become more relational. This may be more common in situations where the purchaser is in the public sector, because of the nature of the market likely to develop and their obligation to deliver services under all eventualities.
3) In circumstances where external factors do not favour a classical type of contract, trying to specify a complete contract and monitor it by means of formal reporting mechanisms is unlikely to be effective and may simply increase transaction costs.
4) Given the questionable enforcability of sanctions in many settings, contract design that focuses on incentives rather than sanctions may be more effective in controlling the behaviour of providers. However, it should be recognised that incentives and sanctions are conceptually very similar, a sanction simply being a negative incentive, and it is therefore not incentives *per se* that are desirable, but the move toward a system of incentives that can be relatively 'self enforcing' in comparison to sanctions.

In each case the type of incentives which are appropriate and requirements for them to operate effectively need to be considered. Financial incentives such as payment for the achievement of targets (such as immunisation rates) require monitoring and administrative capacity similar to sanctions. These may not be appropriate in a setting where monitoring and capacity are acknowledged to be weak. In contrast, the combination of capitation payment and bearing of

some risk for the cost of referrals described in the private capitated scheme case is an example of a more 'self enforcing' package of incentives. Without formal monitoring the contractual mechanism offers its own constant incentives, neither to overtreat patients (as this would increase costs), nor to undertreat, as patients may chose to leave the system or the cost of referrals may increase. Such a set of incentives is successful without recourse to monitoring by an external purchaser. Furthermore, non financial incentives may also increase the quality of services offered by appealing to other aspects of providers' motivation, and these would also be of a more 'self enforcing' nature. What form these might take is discussed further under recommendations for future research.

5) Providers of primary care under many types of contract may neglect preventive services, both because of the nature of demand for them and because it is difficult to design a payment mechanism which encourages providers to give them due attention. Capitation payment offers one route to encourage providers to give due attention to preventive as well as curative care, but can only be used in circumstances where the population to be covered can be registered and subsequently kept track of.

II. Monitoring

Monitoring of contracts for primary care is problematic due to the nature of the service, capacity problems and the likelihood that contracts will be incompletely specified. All the case study contracts in this study were operating with incomplete monitoring. In the PDS and Lesotho cases, provision was made for monitoring by the purchaser, largely by reports submitted by the service provider but also with the threat of check-ups at the service delivery site. However, in both cases the ineffectiveness of this approach was acknowledged. Monitoring by the community, or users, was consistently suggested as the most effective form of monitoring likely, although there were also varying opinions about the adequacy of this approach. In the case of the PDS and Lesotho contracts, such an approach to monitoring was problematic as communication between users and the purchaser was not particularly well established and it was doubtful whether consumers were sufficiently

empowered to exercise their feelings of dissatisfaction. In all cases, the adequacy of this approach in ensuring the delivery of technically good quality care, as opposed to procedurally good quality care, must be questioned.

The varying degrees of capacity in the different case studies appeared to have little impact on solving the problem of monitoring, suggesting that sufficient resources may not solve the problem, or that the level of resources that would be required is not cost-effective. The cost of monitoring a primary care service adequately in terms of personnel, systems and contract enforcement may be too high and of too questionable value for any purchaser in a resource poor LMIC setting to be willing to undertake.

Generalisable conclusions about monitoring:

1) Formal monitoring of primary care service delivery in an LMIC setting is likely to be beset with difficulties, even in situations with adequate capacity, and should not be relied upon as a foundation for determining how a contract will operate
2) Monitoring of rural service delivery is most problematic. Here, patients and community members may be in the best position to fulfil an important monitoring function if issues around their empowerment and the manner in which they judge services could be addressed
3) Where the service provider is a company, internal systems of control and quality monitoring may provide an important back up to the purchaser's own monitoring efforts.

INFORMAL CONTRACT CONTROLLING MECHANISMS

The section above concluded that contracts for primary care services in LMICs are likely to be incompletely controlled by the formal mechanisms of contract design and monitoring. They will therefore to some extent rely on other mechanisms (other than contract design and monitoring) to determine the manner in which they operate. The case studies reported in this thesis suggest several key informal controls on incomplete contracts.

First, trust was a possible substitute for contract specification and monitoring and to some extent must underlie all contractual relationships. From comments in this study, trust appears to be built by a shared sense of identity, motivations and beliefs, a positive history and good communication. In contrast, feelings of alienation from the other party's identity and beliefs and a lack of communication appear to undermine the development of trust. The study found that trust did not automatically underlie the operation of all contracts except in a very minimal form; to explain the operation of some of the PDS contracts studied by reference to trust would have been blatantly incorrect. Competence trust of the purchaser in the provider was common but often the only form of trust discernible. Terms such as hope and indifference (Puffitt 1998) may be just as relevant in describing what underlies some contractual relationships in LMICs.

Potentially more relevant in many LMICs, dependence was highlighted as the factor often explaining contractual relationships that were not operating to the satisfaction of either party. It arose from a combination of poor market competition and the necessity of having certain services provided/purchased under an existing arrangement. Dependence could shape the entire nature of the contract relationship by reducing the importance of short term events and increasing the importance of the continuation of the relationship, exactly what MacNeil described as a 'relational' contract. In LMICs especially in rural areas, this is likely to guarantee the continuation of a contract and knowledge of this dependence influences all aspects of the behaviour of both contracting parties. Demonstrating its strong link to the nature of the market, the likelihood of dependence between

purchaser and provider is strongest where there is a single purchaser, such as in the case of the public sector contracting out to private providers, and in rural areas where there are few providers.

Last, controlling mechanisms on the behaviour of providers will also act as informal controls on what happens in an incomplete contractual relationship. The lessor the role of the contract, the greater the role of an individual's decisions about how to deliver services. Therefore the factors reviewed under the human/organisational context heading above are also highly relevant as informal controlling mechanisms of contracts.

Generalisable conclusions about informal contract controlling mechanisms:

1) Incomplete contracts may rely on informal controls to determine their operation, such as trust and dependence between the contracting parties as well as influences on the motivation of individual service providers
2) Trust is not fundamental to the operation of incomplete contracts, and may only be present in minimal form in some cases
3) Dependence, closely related to the nature of the market into which contracts are let, can act as the key control on behaviour under a contractual relationship
4) As the role of formal mechanisms of control such as contract design is lessened in determining behaviour under a contract, the influence of individual motivation and internal hierarchical controls of the provider are increased.

SUMMARY OF CONCLUSIONS

This research therefore can conclude the following:

1. The manner in which contracts for primary care operate in LMICs is both complex and highly varied. In many cases contracts are likely to be incomplete and relational, with their operation largely determined by factors outside of the contract design. Such factors are partly socially

determined, partly historical and partly environmental. In order to appreciate the dynamic of contracting, such contextual factors must be taken into consideration.

2. A useful framework of factors for examining the potential influences on an existing or potential contractual relationship includes the environmental context (nature of the service to be contracted, nature of the market, capacity of the purchaser), the human/organisational context (motivation and perceptions of individuals involved in the contract, hierarchical controls upon them) formal contractual controls (contract design and monitoring) and informal contractual controls (trust, dependence, provider's motivations).

3. Use of a case study approach such as described in this thesis can generate conclusions about the potential nature of this framework of factors in different circumstances. It is not able to draw direct conclusions about the nature of any contract beyond the three described in the case studies. Care must be taken not to attempt to generalise the specific of these case studies directly to other contracts.

About such factors, this research can conclude the following:

Formal contractual controls

4. Contract design for primary care services can adopt different approaches, for instance focusing on services to be delivered or inputs to be provided. This may reflect what is known about the type of service that is to be delivered or the capacity or training of those specifying the contract. Equally a range of payment mechanisms may be adopted. Despite this range of approaches, contracts are likely to have two common factors. The first is that primary care contract specification is likely to be incomplete. This is due to the nature of services required being too broad and unpredictable to make it worthwhile specifying every eventuality in detail. The second is that providers will respond to the financial incentives created, whether these be incentives to

deliver good quality comprehensive care or less desirable incentives such as those which a fee for service system may create.

5. Monitoring of service delivery by the purchaser is extremely problematic due to difficult access to the site of delivery, shortages of capacity and the asymmetries of information inherent in primary care delivery which make even on-site monitoring, were it possible, of questionable accuracy. This is especially true in rural, remote settings as may be common in some LMICs. The only group in a position to carry out a monitoring function consistently may be the users of the service, and consumer monitoring of this type has several potential weaknesses. First consumers may not be able to judge the technical quality of the service. Second monitoring by users is only effective if they either report problems or are able to leave the provider in the case of poor quality. Neither of these actions may be feasible in some cases. A further alternative to formal monitoring is trust, but this cannot be relied upon to exist in all eventualities or to be created without considerable time and resources devoted to its generation.

External factors and informal contractual controls

6. Adequate capacity is a necessary condition for any policy of contracting to function adequately as it acts as a vital support to all the purchaser's roles. It underlies the performance of all functions related to purchasing services by contract (contract specification, negotiation, monitoring and payment). In most situations in LMICs, capacity is likely to be scarce and this will undermine the efficient functioning of contracts. However, capacity should not be seen as the answer to all contractual problems. Its existence does not guarantee that all of the functions mentioned above can be carried out comprehensively. Asymmetries of information inherent in health care and contracts for health care will still make monitoring or specifying primary care service contracts problematic.

7. The nature of the market into which contracts are introduced is a key determinant of the likely nature of the contractual relationship that will result. Both the demand and supply side of the market are important. In cases where there is a single purchaser and few potential providers a situation of mutual dependence may arise. Such dependence in turn has consequences for the way in which all the functions of a contract will operate (see point 9). In cases where the purchaser is the public sector, it is common that there will be one purchaser offering large contracts to service a relatively high volume of patients. Even if there are several potential providers, in areas of LMICs where the demand for private services is limited there is likely to be a concentration in the market as unsuccessful bidders leave after the first bidding process. Therefore, unless contracts are structured differently, there is an inherent tendency towards uncompetitive markets in many areas of public sector contracting in LMICs. This is again likely to be particularly true in rural areas.

8. In markets where it is possible to have multiple purchasers and providers and to define the population to be covered by the contract, it is possible to create a system of incentives for the provider which are more self enforcing. Capitated payment encourages adequate attention to preventive care, as does sharing the cost of referrals to higher levels of care. A choice of provider for the consumer goes some way to ensuring that the quality of care delivered is acceptable in at least some ways. In combination with some form of hierarchical control of technical quality of care this type of system may represent one that is less reliant on close monitoring and specification by the purchaser.

9. The 'dependent' form of contracting likely to arise in uncompetitive market settings also has profound implications for the manner in which contracts operate. Whilst providers still respond to the financial incentives of the contract, penalties, sanctions and monitoring will all take on a lesser role in recognition of there being no effective exit from the contractual relationship. Formal control over the contract is correspondingly lessened and the role of the informal control

of dependence is likely to become dominant. Trust may be present, but it is equally possible that the contract simply exists due to lack of alternatives to get the service provided.

10. Once it is recognised that contracts are likely to be incompletely specified and monitored the question of what else is controlling the behaviour of service providers becomes relevant. Not all service providers are motivated or controlled in the same way. The identity of the service provider with whom a contract is made is therefore a further key determinant of the nature of the contract. This study reviewed three different examples - one of individuals operating as independent, self-employed professionals, one of a commercial company with on-site management and one of a commercial company with extremely strong hierarchical and on-site management by both personnel and computer system. If contracts are made with self employed individuals, controls on their behaviour are weaker and the purchaser is more reliant on their individual motivations to define the quality of services that they will deliver. If contracts are made with hierarchical companies, there may exist considerable internal controls on the quality of services provided as an additional check on the behaviour of each individual provider.

CONTRIBUTION TO THEORY

What do the above conclusions represent in terms of contribution to the theory outlined in chapter 2? First, this study offers a rich set of data about the nature of 'real life' contracts for primary care in an LMIC, something which so far has been lacking from the debate about their desirability and the form that they are likely to take. The data in this thesis do not shed light on the desirability of contracting for primary care services in general, but do contribute an insight into the way in which contracts may operate in different types of LMIC setting. Factors that are likely to be influential in determining the nature of contracts and how they interact with one another have been highlighted. Many are similar to those arising from the developed country literature, but their relative importance and consequences for contracting may be greater. In particular, as well as being subject to the same problems of asymmetries of information and principal-agent relationships as any contract, reservations about

applying some assumptions from microeconomic theory to markets for health care in LMICs (e.g. such as expressed by Clague 1997; Schick 1998) are found to be highly appropriate.

Literature reviewed in chapter 2 outlined neo-classical and institutional approaches to explaining how contracts operate. Findings of these case studies confirm the value of the institutional approach which stresses the role of external factors in determining how contracts operate. MacNeil's (1974) classification of different types of contracts according to the attributes of the transaction, and his assertion that in many settings relational contracts may be the most appropriate approach, provided a useful framework for interpreting the results of the case studies. In line with MacNeil's work, this study highlighted the variety of forms that contracts can take and confirmed the need to look to context and external factors to explain this. Given the highly varied, hybrid situations in which contracts may arise in an LMIC setting, this is perhaps even more important than in a developed country setting. A variety of contractual relationships may arise, for instance in urban areas the potential for competitive contracting exists, as was demonstrated by the private capitated scheme case study. The most appropriate approach to contracting in an LMIC setting is therefore highly context specific and may range across the whole spectrum from classical to relational contracts.

An examination of the conditions of these contracts highlighted where publicly purchased contracts in particular were likely to depart from the classical model, mainly due to issues around the competitiveness of the market and capacity of the purchaser, echoing the same reservations about public sector contracting as were raised in some UK literature (Walsh et al 1997; Le Grand and Bartlett 1993; Roberts 1993) and much of the existing literature on contracting in developing countries, which questions the likelihood of adequate capacity being available (Mills 1998). Whilst capacity to gather and process information was acknowledged as a drawback to effective contracting, this study also highlighted that some problems inherent to contracting primary care services (e.g. those raised by nature of the service and in some settings, nature of the market) are more fundamental than those caused by a shortage of capacity. Second, the assumption of competitive markets was also

found to be extremely questionable in many LMIC settings, and Walsh et al's (1997) observation that the public authority purchaser has a tendency to monopoly was echoed.

Such findings clearly call into question much of the justification offered for introducing contracts into LMICs by multilateral and bilateral donors (WHO 1999; World Bank 1997a; World Bank 1997b) which often stress the benefits of competition between providers and how transparency of public expenditure may be increased by the use of contracts. Arguments for contracting which underlie this approach were outlined by Broomberg (1994) early in chapter 2, and findings of this study directly contradict many of them, suggesting:

a) that in many settings there will be little competition on the provider side

b) that a single public purchaser is likely to further concentrate providers in LMIC markets

c) that government capacity to enter into and manage contractual relationships with the public sector is likely to be weak.

In addition, the asymmetries of information inherent to the nature of primary care delivery were found to be high.

More influential attributes of the transaction were found to be those leading to a form of bilateral dependence between the contracting parties. This has been stressed in the existing literature by authors such as Williamson (1975; 1985) and Axelrod (1984), highlighting that the likelihood of continued future interaction radically affects the nature of any transaction. In recognition of the quite extreme form that this may take in some LMICs, a key contribution to theory arising from this study's consideration of the external factors impacting on the nature of contracts in LMICs is to highlight the potential importance of dependence. In many settings this may be a key concept for explaining much of the dynamic of public sector contracts with private providers and this in turn has implications for the body of theory which suggests that governments face a "make or buy" decision when deciding whether to contract out a service. In at least one of the cases reported here, there was no such decision for the government purchaser, and the pursuit of a contract with the private sector was more

an attempt to buy in specific expertise, which cannot be drawn into the public sector, than to try to contract out a service which could have been delivered by the public sector. This findings echoes results from other studies of the motivation for entering into contracts in LMICs reported in Bennett, McPake and Mills (1997).

As Allen (1995) observed, payment appeared to be the most effective contractual incentive in determining service delivery. Beyond this, the study echoed the findings of Hart (1995), Allen (1995) and Mills (1998) on the deficiencies of written contracts as mechanisms to adequately control service delivery or form the basis for monitoring of service delivery. Its findings were also in line with Allen (1995), Williamson (1985) and MacNeil (1974) in finding a minimal role for court ordering in the enforcement of contracts. In addition, it highlighted the tendency of for-profit providers to concentrate on delivering curative services under a fee for service system, and the difficulty, when specifying contracts, of separating primary care services from other elements of the public sector health care delivery system on which they rely.

The study also highlighted a range of external influences in determining these incomplete contracts, of a different nature from the institutional frameworks stressed in the existing developed country literature (such as by Deakin and Wilkinson 1995). Whilst such formal institutional frameworks were found to be of little relevance, this increased the influence of the social context in which individuals operated in determining their behaviour. Such social influences are in line with those stressed by Hodgson (1988), and highlight the importance of Williamson's (1975) acknowledgement of the role played by 'human factors'. The data presented in this study suggest that influences on an individual's performance as a health service provider include social, personal and financial factors and can be very varied. Whilst issues such as opportunism need to be considered, the role of professional ethics and personal obligations may be at least as relevant in understanding an individual's motivation. In line with Williamson's description of the firm as a governance structure (1985), the study also demonstrated how, in contrast to the varied influences upon the behaviour of

an individual, hierarchical control can act as a controlling mechanism when the provider under contract is a firm.

The study suggested that the role of trust in contracting in LMICs may be less fundamental than suggested for developed countries. Trying to apply an overall concept of "trust" to the situations of these case studies was problematic and more nuanced interpretations such as those offered by Sako (in Goddard and Mannion 1998) were found to be more useful in operationalising the concept for this study. It was concluded that trust exists as a very basic underpinning of contracts but its role beyond that in some LMICs settings can be quite marginal. This does not discount from the potential value of trust as a controlling mechanism in contracts, but recognises that context and history may undermine its development and that factors such as dependence may override its importance. Findings from this study therefore recognise the potential value of trust but echo the cautious approach expressed by authors such as Puffitt (1998) and Newman (1998) in the developed country literature.

Following the literature review, options such as trust, detailed monitoring or detailed contract specification were suggested as alternative approaches to managing contracts, but the findings of this study has question the feasibility of any of these approaches in some LMIC settings. The study's principal contribution to theory has been to highlight both the importance of external factors and informal controlling mechanisms to incomplete contracts in LMICs, and to provide some information on what these factors/mechanisms are in different settings.

POLICY IMPLICATIONS

Recommendations are made for LMICs considering a policy of using contracts with the private sector, followed by some more specific to the case study contracts examined in this study.

Policy implications for LMICs

1. The findings of this study have stressed that contracts in different settings will take a variety of shapes and operate in different ways. It is not argued that any form of contract is found to be better or more effective than another, but that each unique set of circumstances will require a different approach.

   As the phrase 'contracting' covers this wide variety of systems and outcomes, policy-makers need to consider 1) whether contracts are likely to be a good idea in that setting (evaluate the options of 'make or buy') and 2) what type of contract is likely to arise in that circumstance and on what controlling mechanisms it is likely to rely. The implications for service provision under that type of contract then need to be considered.

   For instance, if it is recognised that in a specific setting the purchaser's control will be weak, consideration needs to be given to the motivation of the provider with whom the contract is being made and the nature of the institutional environment in which the contract will operate which will determine many of the informal controls upon it (history, professional controls etc.).

2. The market into which a contract will be introduced must be recognised as a key determinant of its likely nature. In rural areas, markets are unlikely to be functioning in a competitive manner and this implies that the type of contractual relationship that will develop will be relational/dependent. Government may attempt to lower barriers to entry to rural practice by lowering the asset investment required e.g. by building facilities and contracting out their operation. In some settings, other ways in which the market could be segmented include decentralising the purchasing

function, making each contract smaller so that there is less tendency toward a bilateral monopoly. The use of vouchers may be possible in urban areas where there is a choice of providers, so that service users can each make their own purchasing decision. This is discussed further under suggestions for further research.

3. Capacity to write and manage contracts is a necessary condition for any contracting policy to function well. Governments must acknowledge this and take measures to build such capacity if they chose to enter into contracts with the private sector. Contracting should not be seen as a way of by-passing a lack of public sector capacity, and basic capacity for the administration and payment of contracts must be in place.

4. Consideration should be given to the nature of the provider that contracts can be made with, and the nature of their motivation, and controls upon that. The likely choice ranges from self-employed individuals, through NGOs to commercial companies. Each type of provider will have a different set of controlling mechanisms upon their behaviour, both individual and in the case of NGOs/companies, hierarchical. In some settings it will be possible to rely on strong hierarchical controls within the provider company, in others (such as the PDS) it will be necessary to consider the nature of influences upon each individually operating provider. In some cases, strongly controlled commercial companies delivering primary care services (such as that examined under the private capitated scheme) may be increasingly interesting as providers of primary care services on the state's behalf.

5. Difficulties in adequately specifying primary care services to be contracted out, in particular how these fit in with existing public sector services, suggest that care should be given to defining the service that is being contracted out. Governments should try to contract out primary care services in the broadest, most comprehensive blocks possible. This will minimise the scope for private providers to say that certain services are not their responsibility.

Although the desirability of contracting out services to the private sector *per se* was not the subject of this study, this issue of service specification highlights a key problem of contracting out primary care services generally, which is how to divide up responsibility between the public and private sectors and still maintain a comprehensive service delivery system. Private sector providers supplying care on the state's behalf remain reliant on a functioning public sector for many support and referral services. The feasibility for the public sector of carving out a portion of their responsibility for service delivery to be handed to the private sector, whilst having to maintain overall responsibility for all the related support services, is questionable and highlights a dilemma at the heart of the desirability of contracting out clinical primary care services.

6. The likelihood that formal monitoring will be ineffective as a control on service delivery should be recognised. New, more effective approaches to monitoring service delivery by private providers need to be developed. In some settings, government may chose to explore using peer groups and consumers as means to monitor service delivery. In others, providers may have systems of internal control established which could be drawn on as additional monitoring mechanisms.

7. Contract design should reflect the nature of the contract being entered into:

- For instance, in cases where it is recognised that the contract will be of a relational/dependent type with individual service providers, contracts can be designed in a way that recognises that service delivery is largely at their discretion, focusing on building trust between purchaser and provider and emphasising the important role of professional discretion. In such a situation, care should be taken not to undermine mutual respect between the contracting parties by an overly legalistic approach to the contract, and to keep communication and emphasis on co-operation high between government and these private contractors.

- In alternative cases, for instance where there are greater opportunities for monitoring, stronger hierarchical controls or a more competitive market, a more comprehensive, detailed contract design may be feasible and appropriate.
- In all types of contract, care must be given to consider the type of payment mechanism and any targets set in the contract and the incentives that these create.

8. Given that the role of informal controls on contractual behaviour may often be as important as the written contract, purchasing authorities should consider how to strengthen alternative routes of control such as trust and informal incentives on providers to provide a good service.

Specific recommendations and policy implications for the case study contracts

1. In the case of the PDS contract, the findings of this study suggest the following steps would lessen current uncertainty and improve its operation:

- Recognition of the dependence between purchaser and provider in many towns would emphasise the importance of building trust and establishing a package of financial and non-financial incentives which would aim to be self-enforcing to motivate each PDS to deliver good quality services.
- Re-design of the contract could include a change in the payment mechanism to make allowance for reimbursement of capital spending and put more explicit emphasis on reimbursing the delivery of preventive services (although this requires the desired role of the PDS *vis a vis* public sector clinics to be clarified).
- Outside of the contract, measures could be taken to improve communication between the PDS and provincial authorities, and to emphasise PDS' importance in public sector health care delivery. The removal of suspicion and uncertainty regarding the future of the contract would be a first step in improving relations and building a more co-operative approach.

- The potentially valuable role of communities in monitoring the acceptability of the services delivered by PDS should be recognised and steps taken to increase the channels of communication between them and the provincial purchaser.
- The Eastern Cape province should acknowledge the need to invest in basic capacity to manage the administration of the contract, although such a recommendation against the backdrop of an acute shortage of resources for the health sector as a whole may be rather meaningless.

2. In the case of contracts similar to the Lesotho model, the findings of this study suggest that here too the degree of dependence between purchaser and provider needs to be recognised. Where such dependence is high the role of formal contractual controls is lessened, although the specification of services to be delivered and the payment mechanism remain important. A contract such as the Lesotho example would benefit from:

- Clearer definition of the service provider's role *vis a vis* existing public sector services.
- Some upper limits on expenditure on the inputs specified in the contract to aid in controlling its costs.
- Experimentation with a capitated payment system in remote areas such as this contract's setting, where it may be feasible to register the eligible population.
- Reducing written reporting requirements which were not considered an effective check on service delivery, and may simply have increased transaction costs.
- Encouragement of greater involvement of the local community and any nearby public sector facilities as monitors of the acceptability of the services delivered.

3. For the private capitated scheme the main issue of relevance is their potential to deliver care on behalf of the public sector. Their existing internal capacity for management and control of service delivery suggests that in urban settings such providers may represent an attractive option

for purchasers, as a service that would be relatively easy to monitor and control and that is currently delivered at low cost. However, the following hurdles need to be acknowledged:

- Whether the purchasing authority would be able to define the population to be covered, thereby duplicating the benefits of a capitated payment system recorded in this study, or whether fee for service would have to be introduced. In this latter case, the impact of this on the nature of service delivery may be dramatic.
- To what extent such clinics should complement or substitute existing public sector services.

RECOMMENDATIONS FOR FUTURE RESEARCH

1. Various recommendations can be made for the development of research methodology in this field. Studies recording the interaction between purchasers and providers over a longer time period, both by observation of interaction and collection of documents passing between the contracting parties, would decrease the current heavy reliance on interviews as the only way to access the nature of interaction between contracting parties. Second, given that the motivation and beliefs of each individual appear to play such an important role in the determining of a contractual relationship the development of methods to better assess these factors would also be advantageous.

2. Given the emphasis in the study's findings on the potential role of individual patients as monitors of service delivery, research into the role of service users as prospective purchasers and monitors should consider:

- The necessary conditions for a decentralised system of patients purchasing their own primary care services. In particular the use of vouchers could be examined in terms of their administrative requirements, the requirements of the market setting, their acceptability for patients, and the desirability of their impact on service delivery.
- An examination of the type of monitoring mechanism that patients can fulfil, including a) On what criteria do they judge services? Are these appropriate? How can these be used or changed? b)

How can service users be empowered to act as better informed and more effective monitors of service delivery?

3. Given the emphasis in the study's findings on the importance of individual motivation as a determinant of the nature of service delivery, research into some of the informal controls on individuals working under contract would increase understanding of the range of motivations that individual health care providers have and how incentives can be built into contract design or other contractual process which appeal to these and may be more 'self enforcing'. Potentially this is a large and varied research agenda, which could include:

- consideration of the institutional and environmental conditions that are conducive to the development of trust between contracting parties
- what other positive influences on non-financial motivation exist and how these can be better incorporated into contracts
- the role of professional bodies as a control on the behaviour of providers
- lessons from private sector practices (not necessarily in the health sector) for motivating and controlling professionals.

4. In addition, research into the controls on health care providers working in a more hierarchical setting would shed light on the desirability of relying on the internal control mechanisms of private provider companies as an option to increase control over private service providers.

5. More research defining the necessary conditions for the public sector to use capitation payment in primary care contracts with the private sector would be helpful in defining the range of options open to governments considering a policy of contracting in different settings.

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LIST OF APPENDICES

DESCRIPTION OF PUBLIC SECTOR SITES

Data from the four following public sector sites were used to provide a comparison with the PDS data in chapter 7. Some characteristics of each of these sites are briefly described below:

Public sector site no. 1

Large community health centre attached to the outpatient department of a provincial hospital in a large rural town in the Western Cape. This facility only offered curative primary care services. Patients here were seen first by a primary health care nurse and then if necessary referred to private doctors who attended the clinic twice a day. These doctors had previously been the PDS in that town, but the system had recently been 'converted' to a purely public sector delivery system.

Public sector site no. 2

Large community health centre delivering comprehensive primary care services in a rural town in the Western Cape. Arranged along similar lines as site no. 1 with nurses screening patients and if necessary referring to private doctors who visited the clinic twice a day to see referrals. As above this system was the result of a 'conversion' of the previous PDS system.

Public sector site no. 3

Large community health centre in a rural town in the Eastern Cape, offering comprehensive primary care services. This facility was staffed by primary health care nurses and visited daily by a Community Service Doctor. The PDS system in this town had been terminated the previous year due to fraud.

Public sector site no. 4

Small rural facility in the Eastern Cape offering comprehensive primary care services. This clinic was staffed by two primary care nurses and had no access to a doctor. The PDS had left the town the previous year and it had not been possible to attract another doctor to the town.

INTERVIEW SCHEDULES

1. Interview with provider

[Background (relevant only if the contractor has more than one contract)]

Describe the contracts for primary care that your organization has with both the public and private sectors

How important is primary care contracting for your organization? What proportion of your turnover does it represent? What about contracts with the public sector?

Explain the history of primary care contracting in your organization (overall and with the public sector)

Describe the different categories/types of primary care contract, including nature of services provided, who the purchaser is, and what services are provided

How do decisions to contract with the public sector arise? Do communities have any role in the decisions? What other stakeholders have influenced contracting decisions?

Note: from here on, all questions are about contracts with the public sector

Staff

What staff are involved in managing your primary care contract(s)? (list by job and grade)

What are their responsibilities both in general and in relation to contracting?

What proportion of their time do they spend on contracting in general? On the contract of interest?

Who are they responsible to?

Describe their education level and experience

Is staff turnover a problem? Does your relationship with the contractor depend especially on any individuals in particular, either in this organisation and in the contractor organisation?

Do you think you have the right staff skills and experience to manage contracting? Is ability to contract increasing (likely to increase) with experience? Would you like some additional skills - if so, what? Would you want these in your organization or to be able to draw on them from a higher level?

The current contract

Before the contract started, what sort of relationships did you have with the purchaser?

Who initiated discussions over a possible contract: you, the purchaser, or other body?

What were your reasons for wanting this contract? What analyses did you do before deciding to accept the contract (eg cost estimation)?

Why do you think the purchaser wanted this contract? What are/were his motivations? Do you trust him?

When was the contract awarded?

Was this a first or subsequent contract? If the latter, what was the duration of the initial contract? On what basis was the initial contract awarded - competitive tender, direct negotiation, or some other mechanism? Would you say that the nature of the contract is changing over time, if so, how?

On what basis was current contract awarded - competitive tender, direct negotiation, or some other mechanism? ((Were there changes between the previous and the current contract?))

If competitive - do you know who were your main competitors, how many competitors there were, why you won the contract? Do you think that the process of competition was valid (e.g. not a costly waste of time?)

If direct negotiation, could you describe the process? Who were involved/consulted (including communities; other stakeholders)

Any explanations for why this form of contracting was used? Do you think this mechanism has any advantages over any of the other possible approaches to awarding contracts?

How would you describe your current relationship with the purchaser?

Has your relationship with the purchaser changed over the period of the contract(s)? If so, in what way?

Do you think the purchaser has any alternatives now to the current contract to get the service provided?

Scope and nature of contract, review mechanisms and contract duration

What are the contractor's responsibilities in terms of provision of services? Are those the ones you would ideally want?

What specific *inputs*/outputs are specified in the contract; in what level of detail are these specified? Are any standards of quality or other standards defined in the contract? *Is there any attempt to allow for variations in casemix/severity of conditions treated?*

What are the contractor's responsibilities, as defined in the contract or as agreed implicitly, with respect to:

Capital items

Was investment in land, buildings, equipment etc. required? If so, what was the scale of this investment? If not, who owns the capital stock at present? Who is responsible for maintenance of buildings and equipment; what happens at termination of contract? Do you think that service

development is constrained in the absence of longer-term contracts? For instance , are there any investments in specific assets that you would make if there was greater security/duration in your contract(s)?

Staff

Who employs the various categories of staff? If contractor - does purchaser have any influence over staffing decisions; if purchaser, does contractor exert any influence?

Supplies

Does the contract place any constraints on the contractor in terms of costs, the use of particular inputs (e.g. staff, supplies, drugs etc.) etc?

Overall, do you think you have the appropriate resources (staff, buildings, equipment) to deliver an adequate service (eg as compared to public sector facilities)

Do you feel that your company/organisation is exposed to any risks that are not spelled out in the contract?

Contract review mechanisms

Are any performance monitoring or review mechanisms built in to the contract? What are these and how frequently is your performance supposed to be reviewed? How time consuming do you find this review process?

Are any penalties for breach of contract specified? What are these penalties? Are they enforceable? Have there been contract related disputes or breaches of contract in the past, in this or other contracts? Were penalties applied in these or other cases?

Are problems on the whole resolved amicably, or is there an atmosphere of distrust between you and the purchaser?

What is the duration of the current contract? What is planned to happen at the end of the contract term? [If relevant: Do you think the contract will be put out to competitive tender, or will another mechanism be used? What would you prefer?]

Reimbursement mechanisms

What is the payment mechanism/s specified in the contract?

Are there any minimum or maximum payment levels specified?

How do these payment mechanisms affect the riskiness of the contract from your perspective?

Do you think these payment mechanisms influence the way in which you provide services? Do you think for-profit/ not-for-profit providers would behave similarly? (ask about which ever the contractor is not)

How was the price of the contract decided?

Do you think the current price of the contract is a fair price?

How do you handle price increases?

Apart from the direct costs of providing the services, what other costs are associated with each contract? (e.g. staff time, accounting and legal fees, consultancy fees, travel costs). Which is the most significant of these?

Do they tend to be incurred during the negotiation or the implementation and monitoring phase of a contract?

In addition, were there any transitional costs e.g. setting up new information systems?

Attitudes to risk, and responses to contractual incentives

What do you see as the existing or potential risks in the present contractual situation as well as specifically in the current contract?

Do you see the existing distribution of risk as 'fair'?

Is this contract generally regarded as posing high, medium or low risk to you? Could you give reasons for this?

Management systems

Describe the management systems in place for managing the contracting process

What mechanisms do you use to ensure high staff productivity?

Have you had any problems with billing?

Are you happy with your cost control systems? What are they? What routine cost analyses can you produce?

Do you have a system for quality assurance? If so, what is it?

What information do you give the purchaser about what you are doing? In what form? How frequently? Is this information which you have to collect especially, or is it also useful for management purposes?

Do you think the purchaser uses this information to monitor your performance? Are there other ways in which he monitors performance? How frequently? What happens if he detects problems? What action can he take?

Have you had any (other) problems in managing the contract? (e.g. getting paid on time). If problems arose, how were these resolved?

Do you get support from higher/lower management levels in negotiating and managing the contract? Is there any confusion over who does what?

Are communications good with higher/lower levels?

Do you have any mechanisms for involving or consulting communities and/or users about the contracted service?

What is the financial status of the whole company?

Performance of the contract

What do you think are the main benefits and disadvantages to your organisation of contracting services?

What do you think are the effects of these contracting arrangements on the costs of services, and on the quality of care?

Do the current contracting arrangements encourage you to provide services efficiently? If so, which aspects of the contract are most important for this?

Could elements of the contract be improved to enhance efficiency; to improve quality?

Do you think your performance is better or worse than the performance of similar public services in terms of cost, quality, range of services, responsiveness to users? Why? Do you organise services differently?

Has the decision to contract had any effect on equity: e.g. in terms of access of disadvantaged groups? if so, has access increased or decreased?

How well do you think you are meeting the needs of disadvantaged groups? Does you do better/worse/the same as a similar public service?

What would an ideal contract look like from your perspective?

Attitude to increased use of contracts to deliver PHC

[If relevant: Would your organisation be interested in more PHC contracts with public purchasers? If so, why?]

Do you think there are many private sector organisations and providers interested in contracts with the public sector? Would it be possible to attract in suppliers not currently working in this field (e.g. commercial companies)

How competitive do you think you are relative to your competitors in this market?

Do you think current laws and regulations are adequate or need changing - especially if more use is made of contracting?

3. Interview with Purchaser

Background

Describe what contracts for primary care services exist in your province/district

Can you estimate what proportion of primary care visits are provided by contractors? And/or what proportion of primary care expenditure goes to contractors?

Explain the history of primary care contracting in your province/district

Describe the different categories/types of primary care contract, including nature of services provided, who the contractor is, and what services are provided *(if there are different payment mechanisms, explain why they are used)*

How do decisions to contract arise? Do communities have any role in the decisions? What other stakeholders have influenced contracting decisions?

Are you happy with current regulations affecting the practice of private primary care providers? Do they need changing? If so, how?

Do the contracts affect your ability to plan PHC services for the whole province/district?

Staff

What staff are involved in managing primary care contracts?

What are their responsibilities both in general and in relation to contracting?

What proportion of their time do they spend on contracting in general? On the contract of interest?

Who are they responsible to?

Describe their education level and experience

Is staff turnover a problem? Does your relationship with the contractor depend especially on any individuals in particular, either in this organisation and in the contractor organisation?

Do you think you have the right staff skills and experience to manage contracting? Is ability to contract increasing (likely to increase) with experience? Would you like some additional skills - if so, what? Would you want these in your organization or to be able to draw on them from a higher level?

Which do you think is more demanding for your staff: to manage contracting or to manage direct provision? Why?

The current contract

[If relevant:
Before the contract started, what sort of relationships did you have with the contractor?]

Who initiated discussions over a possible contract: purchaser, provider, or other body?

What were your reasons for agreeing this contract? Did you do any analyses before deciding to contract (e.g. cost estimation)?

Why do you think the contractor wanted this contract? What are/were his motivations? Do you trust him?

How would you describe your current relationship with the contractor?

Were there any other alternatives open to you to get this service provided? If so, why did you reject them?

When was the contract awarded?

Was this a first or subsequent contract? If the latter, what was the duration of the initial contract? On what basis was the initial contract awarded - competitive tender, direct negotiation, or some other mechanism?

On what basis was current contract awarded - competitive tender, direct negotiation, or some other mechanism? Were there changes between the previous and the current contract?

If competitive - open or closed tender; how many competitors, who were the competitors, what factors entered into the decision to award the contract? How was the decision made?

If direct negotiation, could you describe the process? Who were involved/consulted (including communities; other stakeholders)

Any explanations for why this form of contracting was used? Does this mechanism have any advantages over any of the other possible approaches to awarding contracts?

Has your relationship with the contractor changed over the period of the contract(s)? If so, in what way?

Are there any alternatives now to the current contractor?

Scope and nature of contract, review mechanisms and contract duration

What are the contractor's responsibilities in terms of provision of services? Are those the ones you would ideally want? Do they correspond with the goals of publicly provided services?

What specific inputs/outputs are specified in the contract; in what level of detail are these specified? Are any standards of quality or other standards defined in the contract?

What are the contractor's responsibilities, as defined in the contract or as agreed implicitly, with respect to:

Capital items

Was investment in land, buildings, equipment etc. required? If so, what was the scale of this investment? If not, who owns the capital stock at present? Who is responsible for maintenance of buildings and equipment; what happens at termination of contract?

Staff

Who employs the various categories of staff? If contractor - does purchaser have any influence over staffing decisions; if purchaser, does contractor exert any influence?

Supplies

Does the contract place any constraints on the contractor in terms of costs, the use of particular inputs (e.g. staff, supplies, drugs etc.), etc.?

Overall, do you think the contractor has the appropriate resources (staff, buildings, equipment) to deliver an adequate service (e.g. as compared to public sector facilities)

Contract review mechanisms

Are any performance monitoring or review mechanisms built in to the contract? What are these and how frequently is contractor performance supposed to be reviewed? How time consuming is this monitoring activity?

Are any penalties for breach of contract specified? What are these penalties? Are they enforceable? Have there been contract related disputes or breaches of contract in the past, in this or other contracts? Were penalties applied in these or other cases?

Are problems on the whole resolved amicably, or is there an atmosphere of distrust between you and the contractor?

What is the duration of the current contract? What is planned to happen at the end of the contract term? Will the contract be put out to competitive tender, or will another mechanism be used? What would you prefer? What information/conditions would you want to see before you were willing to enter into longer term contracts?

Reimbursement mechanisms

What is the payment mechanism/s specified in the contract?

Are there any minimum or maximum payment levels specified?

How do these payment mechanisms affect the riskiness of the contract from the department's perspective?

Do you think these payment mechanisms influence the way in which the contractor provides services? Do you think this would differ between for-profit and not-for-profit providers?

How was the price of the contract decided?

Do you think the current price of the contract is a fair price?

How would you respond if the contractor said the price should increase?

Has finding the money for the contract been a problem?

Apart from the price of the contract, what other costs are associated with each contract? (e.g. staff time, accounting and legal fees, consultancy fees, travel costs). Which is the most significant of these?

Do they tend to be incurred during the negotiation or the implementation and monitoring phase of a contract?

In addition were there any transitional costs e.g. setting up new information systems?

Attitudes to risk, and responses to contractual incentives

What do you see as the existing or potential risks in the present contractual situation as well as specifically in the current contract?

Do you think that contracting with a non-profit organisation is/would be less "risky" than with a for-profit organisation? Why?

Do you see the existing distribution of risk as 'fair'?

Is this contract generally regarded as posing high, medium or low risk to you? Could you give reasons for this?

Management systems

Describe the management systems in place for managing the contracting process

What information do you get from the contractor about what he is doing? In what form? How frequently?

What is the main method which you use to measure service delivery? How effective do you think it is?

Do you use this information to monitor the performance of the contractor? Are there other ways in which you monitor performance? How frequently do you monitor? What happens if you detect problems? What action do you/can you take?

Have you had any (other) problems in managing the contract? (e.g. paying on time, controlling the total cost, getting information on performance, getting contractors to improve their performance). If problems arose, how were these resolved?

Are you able to compare the contractor's performance with the performance of similar services that are publicly provided? (is there the information to do so?)

How do you think the costs to you of the contracting process compare with those of providing services directly?

Do you get enough support from higher/lower management levels in negotiating and managing the contract? Is there any confusion over who does what?

Are communications good with higher/lower levels?

Do you have any mechanisms for involving or consulting communities and/or users about the contracted service?

Performance of the contract

What do you think are the main benefits and disadvantages to your organisation of contracting services? Do you see other potential benefits which haven't been realised yet?

What do you think are the effects of these contracting arrangements on the costs of services, and on the quality of care?

Do the current contracting arrangements encourage the contractor to provide services efficiently? If so, which aspects of the contract are most important for this?

What elements of the contract could be improved to enhance efficiency; to improve quality?

Do you think contractor performance is better or worse than the performance of similar public services in terms of cost, quality, range of services, responsiveness to users? Why? Does the contractor organise services differently?

Has the decision to contract had any effect on equity: eg in terms of access of disadvantaged groups? if so, has access increased or decreased?

How well is the contractor meeting the needs of disadvantaged groups? Does he do better/worse/the same as a similar public service?

What would an ideal contract look like from your perspective?

Attitude to increased use of contracts to deliver PHC

Would you like to see contracts used more frequently for primary care services? If so, why?

Who would be your preferred contractors?

Do you think there are many providers of this type interested in contracts? Would it be possible to attract in suppliers not currently working in your area (eg commercial companies)?

Do you think the current framework of laws and regulations are adequate or need changing - especially if more use is made of contracting?

3. Interviews with key informants, national policy-makers and prospective purchasers and providers

a) national policy-makers

Please describe how you see the government's policy towards interaction with the private sector since 1994, particulary with regard to contracting out primary care services: what have been the main influences on it? (ideology/analysis/capacity/particular people). Is it an adequate response? what do you see as the pros/cons of using the private sector at PHC level?

What is the role of the provinces in making/implementing this policy? Do you think they agree/disagree?

Please describe any existing interaction with private PHC providers: what is driving it? (policy/lack of choice/history), what are its advantages and disadvantages? Are there any types of services or situations that you feel are more suited to contracting to primary care providers?

What would you say could be possible benefits of collaboration with private sector? What problems?
What are the constraints on the government side?

Who would be potential private sector contractors? How would you describe their motivations?

What are your perceptions of the following in the private sector if they had contracts to deliver primary care: quality of service, effiiciency, monitoring possible, degree of trust, likelihood of fraud?

Would overall quality, efficiency and accessibility of primary care services in SA be helped or hindered by increased involvement of private sector? If so, under what conditions? If not, why?

b) prospective purchasers

Do you think you have the right staff skills and experience to manage contracting?

Which do you think will be more demanding for your staff: to manage contracting or to manage direct provision? Why?

Would you like to see contracts used more frequently in primary care? If so, why?

Who would be your preferred contractors?

c) key informants outside of public sector (professional associations, prospective private sector providers)

Please describe organisation/ role

How do you see the government's policy (for South Africa, since1994) towards contracts for primary care with the private sector? ....what do you think is driving this?

What have been the moves of the private sector? What are the motivations driving this?

What would you see as particular successes/failures in government/private sector interaction at present, what is causing these?

What would you say are particular strengths in the private sector which the government could draw upon?

Which issues are particularly problematic in idea of government contracting out services *(prompt if appropriate – Contracts? Specification? Monitoring ? Motivations of private sector?)*

If interviewee is from an organisation that is a prospective contractor...

Would you/your organisation wish to contract with government? If so, why? If not, why not?

What do you perceive as the likelihood of this happening? Obstacles?

Why do you think the government would be interested in contracting with the private sector?

Why DON't you think the government would be interested in contracting with the private sector?

Appendix III

SCORES FOR ASSESSING STRUCTURAL QUALITY

Please score all the following categories as shown

Category 1: Infrastructure

1. Electricity

	Score
(a)None	0.1
(b)Power fails more than 6 times/year and no backup system	2
(c)Power fails up to 6 times/year and no backup system	4
(d)Power failures occur- there is a working backup system	8
(e)Reliable power supply or automatic backup system	10

2. Toilet

	Score
(a)No Toilets	0.1
(b)Less than 3 toilets per 100 patients per day	2
(c)Adequate toilets (3 + per 100 patients) but no wheelchair access toilet	8
(d)Adequate toilets including one wheelchair access	10

3. Refrigerator

	Score
(a) No refrigerator, not functioning or functioning at incorrect temperature	0.1
(b) Functioning refrigerator, alternative fuel supply but no spare cylinder	1
(c) Functioning refrigerator, alternative fuel supply and spare cylinder	9
(d) Electric refrigerator	10

4. Emergency Kit

	Score
(a) No emergency kit available	0.1
(b) Emergency kit on site but incomplete or inaccessible	3
(c) Complete emergency kit available and accessible	10

5. Drug Storage

	Score
(a)No drug cabinet or room	5
(b)"Lockable" cabinet/room	10

6. Storage of waste (sharps)

	Score
(a) Unsafe (storage or removal)	4
(b) Safe (storage and removal)	10

7. Cleanliness

	Score
(a) More than one area of the facility is dirty	2
(b) One area of the facility is dirty	7
(c) All areas in the facility are clean	10

Category 2: Access

1. Access by disabled patients

	Score
(a) Disabled cannot enter or move within the facility independently	3
(b) Disabled cannot enter facility alone but once in can move freely OR disabled can enter alone but cannot move freely within facility	5
(c) Disabled have free access to entry and movement within facility	10

2. Emergency instruction after-hours

	Score
(a) No after-hours instructions/contact/phone	8
(b) Instructions clearly visible	10

3. Facility opening times

	Score
(a) Facility opens less than 40 hours over fewer than 5 days	3
(b) Facility opens less than forty hours but over 5 days	6
(c) Facility opens at least forty hours over 5 days or more	8
(d) Facility opens more than forty hours over 6 days and/or includes some evenings	10

4. Range of routine services	**Score**
(a)Facility offers less than 75% of the "core" core package	0.1
(b) Facility offers between 75% and 100% of the "core" core package	7
(c) Facility offers 100% of the "core" core package	10

(see essential packages for different facilities in table at end)

Category 3: Management and staffing

1. Continuing education (seminars, conferences, courses etc)

	Score
(a) No formal continuing education programme available	3
(b) Informal, infrequent (every two months or longer), continuing education programme, or only for certain staff categories	7
(c) Formal, structured continuing education programme available to all categories of staff	10

2. Patient load per FTE *consulting* staff (doctor, PHCN)

	Score
(a) Over 45 or under 15 patients are seen per day per FTE consulting staff	1
(b) Between 40-45 or 15-28 patients are seen per day per FTE consulting staff	7
(c) Between 28 and 40 patients are seen per day per FTE consulting staff	10

3. Patient load per FTE *professional* staff (doctors, PHCNs, professional nurses, enrolled nurses)

	Score
(a) Over 45 or under 15 patients are seen per day per FTE professional staff	1
(b) Between 40-45 or 15-28 patients are seen per day per FTE professional staff	7
(c) Between 28 and 40 patients are seen per day per FTE professional staff	10

4. Record Systems

	Score
(a) Not possible to link a patient to his/her records	1
(b) Possible to link a patient to his/her records	10

Category 4: Patient environment

1. Waiting Time

	Score
(a) Over 60 minutes	3
(b) 45-60 minutes	5
(c) 30-45 minutes	8
(d) Under 30 minutes	10

2. Waiting Area

	Score
(a) Some patients have to wait outside with no shelter from sun/rain, no seating	3
(b) Some patients wait outside but with shelter AND seating	7
(c) Patients are all accommodated inside but some have to stand/sit on floor	8
(d) Patients are seated inside on most days	10

3. Patient Privacy (e.g. for reproductive health and curative services)

	Score
(a) No audial or visual privacy	1
(b) Visual privacy but little/no audial privacy	6
(c) Complete audial and visual privacy	10

4. Health Education Materials

	Score
(a) None on display or available	3
(b) Inappropriate materials available	4
(c) Appropriate materials on display only	8
(d) Appropriate materials on display and available to take home	10

Category 6: Drugs, supplies, equipment and laboratory services

1. Essential Drugs List

	Score
(a) No copy of the Essential Drugs List is available	2
(b) A copy of the Essential Drugs List is available	10

2. Essential equipment

	Score
(a) One or more of the essential equipment (list below) is not available	0.1
(b) Essential equipment is all available	10

3. Supplies

	Score
(a) One or more of the essential supplies are not available	0.1
(b) All essential supplies are available	10

4. Drugs

	Score
(a) One or more of the essential drugs shown below, or its equivalent, is not available	0.1
(b) All drugs appropriate for the services offered at the clinic are available	10

Category 7: Tracer Drugs

I. STDs	**Score**
(a) Basic STD drugs are not available	0.1
(b) All drugs listed are available	10

II. TB	
(where providing chronic treatment)	**Score**
(a) Basic TB drugs are not available	0.1
(b) All appropriate drugs at the clinic are available	10

III. Diabetes	
(a) Basic diabetes drugs are not available	0.1
(b) All appropriate drugs at the clinic are available	10

IV. Hypertension	
(a) Basic hypertension drugs are not available	0.1
(b) All appropriate drugs at the clinic are available	10

V. Asthma	
(a) Basic asthma drugs are not available	0.1
(b) All appropriate drugs at the clinic are available	10

Category 8: Diagnostic Testing and Laboratory services

1. Syphilis Screening

	Score
(a) Syphilis screening is not available	0.1
(b) Syphilis screening is available for ANC but not on-site	7
(c) On site syphilis screening is available	10

2. Diagnostic testing

	Score
(a) TB, Haemaglobin or BGL testing is not available	0.1
(b) TB, Haemaglobin and Blood glucose tests are all available but not all of the tests shown on the list below	7
(c) All of the tests shown below are available	10

- Haemaglobin testing
- Blood Glucose testing
- Urine Microscopy
- TB Microscopy
- TB Culture
- Other microscopy and culture

Proposed Essential Package of PHC services

Community Services	• mass immunisation campaigns • organise DOT for TB, follow-up chronic diseases • home based care • occupational health services • school health services • environmental health services
Outreach	• curative care • geriatric and chronic care • ante-natal and post-natal care • immunisations/child health and growth monitoring • family planning • psychiatry • other (please specify)
Clinics and mobile services	• child preventive and curative services • reproductive health i. ante/post natal ii. family planning iii. medical TOP iv. sexual abuse v. cervical cancer screening • STD care • HIV/AIDS care • chronic disease: TB, mental ill-health, diabetes, hypertension and others • acute curative
Community health centre	• all of the above • specialised services: eye care, dental, dermatology • services for disabled people • 24 hour emergency care/casualty • short-stay facility • maternity • x-ray and laboratory

Appendix IV

STANDARD COSTING METHODOLOGY

The aim of the costing analysis was to generate comparable costs between different study facilities.

Costs of providing primary care services in each facility were analysed. Recurrent and capital costs were calculated separately and summed to give the total cost at each facility. Total costs were divided by utilisation figures to give an average cost per visit. Total costs were also apportioned to different service categories (e.g. STD visit, chronic visit) to give a total cost per type of visit.

Costs were determined for the 1997/98 financial year. Recurrent and capital costs were calculated separately and summed to give the total cost at each facility. In terms of recurrent costs, both internal and external costs were included (e.g. costs of medical supplies where the government supplies these free of charge and diagnostic tests where an outside laboratory service is used). The main sources of recurrent cost data were financial records, accounts, patient records and stock books at each facility.

Capital costs were estimated by completing a checklist of all equipment and furniture used in each facility, as well as measuring the size of all buildings and assessing what portion of each was used to render primary care services to state patients. Current market prices for the equipment and furniture were obtained from the local suppliers. Capital costs were annualised using a discount rate of 8% and the assumption that the expected years of life was 30 years for buildings, and 5 years for medical equipment, furniture and vehicles.

Transport and vehicle running costs were calculated using AA rates (R0.68 per km). These rates are assumed to cover recurrent costs like fuel, oil and maintenance.

In the case of the PDS and Lesotho facilities, costs which were applicable to the delivery of primary care services to public patients had to be separated out for each facility. This entailed estimating the proportion of each cost that should be attributed to the public side of the practice. Senior clinical staff in were asked to make such estimates for each cost category and where possible this estimate was verified by checking the ratio between public and private patient visits.

Apportioning capital costs was less problematic as waiting rooms and consultation rooms tended to be separate for public and private patients. The only areas which were shared tended to be the administrative office(s) and sometimes the area used for drug storage. In these cases both estimates and observation were used to determine what the split should be.

Costing the services of self-employed doctors such as the PDS was problematic. As they were self-employed, their salary had to be estimated. As a preliminary estimate, the total payment (consultation fees, dispensing fee and travel allowance) that they received from the state for seeing primary care patients was taken, and expenses which they incurred in running their public practice subtracted. These included salaries, other staff related expenses, administrative and building operating costs, transport costs and capital costs.

COSTS PER VISIT AT INDIVIDUAL PDS FACILITIES (RAND)

	WCPDS			ECPDS					
	A	B	C	D	E	F	G	H	J
Internal admin and management	1.78	0.56	0.99	1.20	0.97	2.35	1.44	0.50	1.10
Building operating costs	0.96	1.25	1.22	3.53	0.84	5.10	1.87	1.47	5.70
Diagnostic tests	0.59	1.32	0.58	1.27	0.49	0.83	0.38	0.29	0.98
Transport/vehicle running costs	0.41	0.08	0.06	0.12	0.08	0.32	0.15	0.27	0.32
Recurrent cost excluding staff and drugs	3.73	3.21	2.84	6.12	2.38	8.61	3.84	2.54	8.10
Clinical staff	24.69	12.01	16.67	15.75	27.05	9.22	26.20	26.52	13.22
Medical and surgical supplies	15.57	18.45	12.36	15.95	14.41	5.38	8.59	8.19	14.16
Total recurrent cost	43.99	33.67	31.86	37.81	43.84	23.21	38.62	37.24	35.47
Building costs	0.48	0.60	0.48	0.77	0.75	4.54	0.77	0.81	5.85
Medical equipment	0.02	0.08	0.07	0.25	0.04	0.18	0.02	0.05	0.20
Furniture and equipment	0.05	0.02	0.03	0.02	0.07	0.16	0.03	0.06	0.25
Vehicle costs	1.52	5.10	4.32	3.26	2.96	5.04	2.31	2.69	3.46
Total capital cost	2.07	5.80	4.90	4.29	3.82	9.92	3.14	3.61	9.76
Total cost	46.06	39.47	36.77	42.10	47.66	33.13	41.76	40.86	45.24