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

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

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

Macneil asserts that, in practice, the contract has moved from a classic rigid, nonflexible instrument to a slightly flexible neoclassical approach, and to a relational contract where specific content in the contract becomes subordinate to the need to harmonize conflicts, preserve the relation and build up trust.[4] This is confirmed by the United Kingdom's National Health Service contracts to primary care general practitioners, which were often vague about risks and responsibilities and ignored sanctions for failure to perform.

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

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

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

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