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ABSTRACT

Background: The Malawi government in 2002 embarked on an innovative health care financing mechanism called Service Level Agreement (SLA) with Christian Health Association of Malawi (CHAM) institutions that are located in areas where people with low incomes reside. The rationale of SLA was to increase access, equity and quality of health care services as well as to reduce the financial burden of health expenditure faced by poor and rural communities. This thesis evaluates the implications of SLA contracting out mechanism on access, utilization and financial risk protection, and determines factors that might have affected the performance of SLAs in relation to their objectives.

Methods: The study adopted a triangulation approach using qualitative and quantitative methods and case studies to investigate the implications of contracting out in Malawi. Data sources included documentary review, in-depth, semi-structured interviews and questionnaire survey. The principal agent model guided the conceptual framework of the study.

Results: We find positive impact on overall access to health care services, qualitative evidence of perverse incentives for both parties to the contracting out programme and that some intended beneficiaries are still exposed to financial risk.

Conclusion: An important conclusion of this study is that contracting out has succeeded in improving access to maternal and child health care as well as provided financial risk protection associated with out of pocket expenditure. However, despite this improvement in access and reduction in financial risk, we observe little evidence of meaningful improvement in quality and efficiency, perhaps because SLA focused on demand side factors, and paid little attention to supply factors: resources, materials and infrastructure continued to be inadequate.

Introduction

The Malawi government in 2002 embarked on an innovative health care financing mechanism called Service Level Agreement (SLA) with Christian Health Association of Malawi (CHAM) institutions that are located in areas where people with low incomes reside. The rationale of SLA was to increase access, equity and quality of health care services as well as to reduce the financial burden of health expenditure faced by poor and rural communities (MNHA, 2005).

Using the SLA mechanism, CHAM facilities are contracted by the Ministry of Health (MoH) to provide health care services to people within their catchment area free of charge. The government pay the facilities for the materials used in treating the people based on agreed price list. The main objectives of the SLA between government and CHAM institutions is to improve access, equity, quality and reduce the financial burden of out of pocket expenditure on health care (Meis and Eldridge, 2007;MOH,2008; EHP; SWAp; GTZ,2009; GIZ, 2011).

While contracting out of health care provision is relatively new in Malawi, empirical evidence and experience from countries including Pakistan, India and Denmark (De Costa and Diwan, 2007; Nishtar, 2006; Asante and Zwi, 2007; Vrangbaeck, 2008) suggests that contracting out of health care provision to private health care providers has the potential to mobilize additional resources for the national health system. Nishtar (2004) has stated that a public private mix is fostered when government or its agencies contract with the not for profit private health sector to increase health care coverage, or the for profit private health sector for technical expertise among other things. On the practical side Nishtar (2006) has shown that the involvement of the private health sector has increased the capacity of primary health care and health outreach programmes in Pakistan. Similarly, it has been argued that, allowing the public and private health sectors to work together under a formal and properly regulated contract in the provision of health care has the potential to foster the capacity of the health system, through sharing skilled human resources, financing of services, physical resources utilisation and limiting duplication of services (Aljunid, 1995; Mills et al. 2002; Bustreo, Harding and Axelsson, 2003; Thaver et al. 1998).

The foregoing suggests that contracting out is one of the principal mechanisms that some governments are using to harness private health sector resources in order to achieve national health policy goals (Taylor, 2003). In a contracting out arrangement between public sector

agencies and private health care providers, money is transferred from government as purchaser to a private healthcare provider in exchange for the delivery of specified health care services. However, like in all other contractual arrangements, there are bound to be goal conflicts within government between various public agencies and between the government (purchaser) and private health care providers (agents), but if the potential gains from private provision of health care services are sufficiently large, due for example, to availability of qualified staff, modern medical facilities, infrastructure and superior private provider efficiency, then contracting out could produce a better outcome.

Despite contracting out being widely used by public agencies to procure a wide range of public service, they suffer a number of limitations such as introducing new categories of cost (Chalkley and Malcomson,2000), due to the cost of awarding, managing and monitoring contracts. There is a risk therefore that contracting out may end up being more expensive than the traditional procurement mechanism. Similarly, given that private providers may have various motives when going into such contracts, some view such transfer of public resources as benefiting or enriching the private providers at the expense of the general populace. However, in the absence of best alternatives these private providers are used in an attempt to meet public health goals through a combination of public financing and private means (Harding and Preker, 2003). This therefore suggests that contracting has potential benefits as well as limitations and risks.

Rationale for the Study

The overall aim of this investigation was to explore and better understand contracting out of maternal and child health care provision under SLA and its implications for access and utilisation of maternal and child health care services at CHAM institutions. Understanding the stated and revealed objective functions of the government agencies, CHAM and development partners and how these three actors interact through SLA contracts will improve knowledge and understanding of factors that facilitate or impinge the success of SLA. This knowledge and understanding may help health policy makers in identifying ways to encourage the factors that facilitate contracting out health care services and strategically address factors that impinge on the success of health care provision contracts. This will facilitate the use of appropriate public and private health care provider contracting out arrangements that could improve access, utilisation and quality of health care services.

Significance of the study

The study aimed at being scientifically and socially significant. The scientific significance lies in the application of principal agent model and Transaction cost economics (TCE) in the contracting out of health care services in a developing country setting. As discussed in the previous section, there already has been some attempt to apply principal agent model and TCE analysis in the health sector. However, there has been limited use of TCE in situations involving low income countries. To warrant a fruitful application in contracting out in low income countries it is necessary to understand the specific characteristics of private not for profit organisations that can be taken into account in these context.

The social significance can be found in the analysis of alternative institutional arrangements at the local government level. Currently, the general tendency is towards contracting out to private health care providers. The contracting out arrangement was being implemented in the expectation that they will perform more efficiently than public provision of health care services. The question is whether this is really the case, especially when not only production costs are taken into account, but also transaction costs. Furthermore, the social significance can be seen in informing choice between alternative governance structures in the provision of healthcare services through better understanding of welfare losses due to transaction costs.

Methodology

The participants for this study were drawn from both the public health sector (District health management team- DHMT) and CHAM institution managers and key personnel. The data was collected from 9 facilities in 8 districts around the country. The districts, facilities and respondents, were sampled purposively to represent a range of sizes, facilities expected to be available and geographical area of the country. The data was collected from August 2010 to July 2011. The participants (facilities, districts and respondents) in the sample were approached and informed of the study, and their consent requested to participate.

Data collection tools and methods were adapted from Nigenda and Gonzalez, (2009), McPake et al. (1999) and Asenso-Okyere et al. (1997) whereby open ended and closed ended questionnaires were employed to get information on service level agreements and a survey questionnaire was administered at selected CHAM institutions in the sample, followed by In-

depth interviews, focus group discussions and detailed case studies of 5 CHAM facilities that had signed SLA contracts.

Open ended and closed questionnaires in the survey provided information on the number and type of CHAM institutions e.g. hospitals, clinics, health centers, diagnostic centers and pharmacies to indicate their capacity to provide health care services, the number and type of CHAM facilities located and operating in the urban areas like city centers, municipals and towns and rural areas. This is an important variable, as where a CHAM facility is located, has consequences for access, equity and quality due to factors like distance and availability of skilled health personnel, equipment and medical supplies. The survey also provided information on the kind of health services that CHAM facilities provide under SLAs and information on how health workers and clients (patients) perceive SLAs.

In-depth interviews and focus group discussions provided information on the perspective of health care managers and policy makers on the performance (access, quality and efficiency), challenges in implementing the policy (negotiation of contracts, non-renewal of contracts, non/delayed payment, prioritization issues at the district health office, perverse behaviors by both CHAM and government representatives) and how SLAs can be improved (monitoring and evaluation, training and commitment by all involved). Case sites provided information on specific service offered, utilization patterns, amount of financial resources the government is remitting to CHAM facilities and issues specific to facilities.

Results

In identifying principal - agent relationships, the study relied on the flow of financial resources and interview data with policy makers, DHOs, facility managers and frontline health care providers. Principal agency relations were traced at three levels: upstream relationships between MoH and district health office officials, midstream between district health office and CHAM facilities and downstream between CHAM facilities and frontline health care providers.

The principal agent relationship between district health officials and CHAM facilities emerged from two perspectives. While both CHAM facilities and district health officials claimed to share a common objective of providing maternal and child health care services to

a needy population, this contrasted with an understanding of varying 'revealed' objective functions of CHAM facilities and government agencies which contained a range of arguments. The objectives of the government and CHAM were key factors in explaining and understanding access, equity, quality and efficiency of healthcare services offered through SLA, as the objectives affected the relationship between CHAM facilities and district health officials. The decision by district officials to contract out CHAM facilities exposed an agency problem. CHAM facilities were consistently accused of inappropriate claims by inflating utilisation figures and over prescribing medication. Due to weak monitoring and evaluation district health officials were unable to ascertain whether the person treated under the SLA arrangement warranted the service e.g. allegations of 'ghost' patients in some facilities. CHAM facilities on their part argued that the district health office did not provide the requisite services for SLA patient's e.g. timely transport for complicated cases to get to referral facilities and provision of essential drugs and medical supplies. The foregoing indicates that there were information asymmetries which resulted in uncertainty and mistrust between CHAM facilities and government agencies. The implications of the uncertainty and mistrust are reflected in the difficulties in the implementation and management of SLAs.

In addition to varying objective functions, by contrasting the stated and revealed objective functions of CHAM and government agencies in relation to SLAs, the results from the contracting out policy indicated that some revealed objective functions within CHAM and government as well as between government and CHAM were contradictory. The contradictions between stated and revealed objectives partly explain the challenges faced in the implementation of SLA. For instance, there were indications in some cases suggesting that the objective of CHAM facilities in providing health care services included generating financial resources that could be used to pursue and promote their missionary activities, and not strengthen the health system. Similarly, there were indications suggesting that government objectives included political, and growing public sector activity rather than to achieve population health objectives. The problem of conflicting stated and revealed objective functions among SLA actors was exacerbated by the presence of multiple agency relationships within CHAM and government.

The analysis of multiple agency relations in government and CHAM, involving various actors with disparate stated and revealed objectives, provided an understanding of how these actors shaped each other's incentives. The lessons learnt are centred on how the actors

reshaped each other's incentives through various mechanisms such as bureaucratic systems, unpredictability of financial flows and capacity problems. Some of the mechanisms used to reshape incentives as described here, had unintended consequences or side effects which acted as constraints and raised concern about the effectiveness of SLAs. This suggests that, the failure to achieve intended SLA policy outcomes, is not entirely due to lack of knowledge about the process and outcome among health care managers and decision makers, but rather optimizing agents face incentives and constraints that deviate their behaviour from their stated objectives and intended outcomes.

The foregoing suggests that, by imposing some constraints on each other, the stakeholders under each of the two major categories (government and CHAM) exert some influence over resource allocation in SLA. Given that the relationship between these actors follows the principal agent framework, the expectations were that those actors considered as principals, would have control over resources, and be able to impose penalties that would shape the incentive environment of their agents. The results indicated that CHAM facilities and government imposed such penalties and constrained each other. For instance, the Ministry of Health did not pay some facilities and some CHAM facilities ceased providing SLA services. However, in some instances the penalties were not strictly adhered to, owing to political and economic considerations embedded in CHAM and government relationships. This challenges the principal agent framework in that, both CHAM facilities and MoH did not impose strict penalties on each other, fearing that doing so would impact negatively on their economic and political objectives respectively.

Transaction costs in SLA

The aim of this section is to tease out the nature of the elements of transaction costs involved in the administration of SLA contracts between DHOs and CHAM facilities. Transaction costs may arise due to bounded rationality and opportunism of either party to the transaction. SLA involves contracting between government agencies and CHAM facilities under conditions of imperfect information. The economics of contracting is based on transaction costs which arise from the costs of seeking out purchasers and providers arranging, policing and enforcing contracts in an environment characterized by imperfect information. Three concepts related to imperfect information are bounded rationality, opportunism and asset specificity. These are discussed next in relation to SLA contracts.

Bounded rationality in SLA

Bounded rationality recognises the cognitive limitations of the human mind to completely evaluate all consequences of possible decisions and future contingencies. In the context of SLA, the impact of bounded rationality was demonstrated in part by the knowledge and skills CHAM facilities and government agencies had in specifying, selecting appropriate contract partners and managing as well as controlling the relationship.

For instance, one of the most important factors in the contractual relationship between CHAM and government was the price of SLA activities. There was a general observation that the prices of contracted services increased sharply after SLA contracts were signed due to inflation and devaluation of the Malawi kwacha. Failing to provide for this eventuality reflected bounded rationality in the periods prior to contracting-out. According to the theory of bounded rationality, the complexity and uncertainty associated with long-run decisions does not allow a complete specification of the problem at hand. Since information is costly and the decision process cannot go on indefinitely, the result of bounded rationality is that agent's *satisfice,* that is, they stop at whatever decision rule meets the minimal requirements. In the case of SLA contracts, the currency crisis came in August 2003 when the currency was devalued by 35%, followed by another devaluation of 30% in March 2005. In terms of US dollar, the exchange rate rose from K60 to K108, between June 2002 and August 2003.The stability of the Kwacha however only lasted until March 2005 when a series of adjustments saw the Kwacha resting at K123 against the US dollar (Simwaka, 2011). The initial responses of the reserve bank of Malawi were substantial increases in its base interest rate to fight devaluation and reduce its pass-through to inflation. The responses of the reserve bank led to inflation, especially on goods/services that used imported materials, including drugs, medical supplies and transportation costs.

In addition to prices, utilisation of SLA services in most CHAM facilities was higher than anticipated by both government and CHAM. The consequences of misspecification, inability to predict changes in the economy, specify utilisation figures, contract inappropriate health care providers and failure to manage as well as control the relationship have been contract renegotiations and termination. These consequences generate extra costs that can be classified as transaction costs.

Opportunism in SLA

The conceptualisation of opportunism posits that people act in self interest with guile; this is mostly due to incomplete or distorted disclosure of information which results from "calculated efforts to mislead, distort, disguise, obfuscate or otherwise confuse" (Williamson, 1985, pp.47-48).

This suggests that either party to a contract can use loopholes in the contractual relationship to their advantage. In the context of CHAM facilities and government agencies in SLA, there are signs of opportunistic behaviours being pursued by both parties. This opportunism may prevent implementation of the policy program by another party, for instance the resistance of some DHOs to enter into SLA agreements, despite central level official approval of the policy. This is likely to occur if those at the implementation level suspect that implementing the policy may erode their authority or otherwise undermine their interests. This was observed in the reluctance of some government agencies to work in harmony with CHAM facilities, rather than to concentrate on growing the public service with a view to expand their influence.

Similarly, opportunism on the part of CHAM was manifested in the practice of inappropriate numbers provided for payment and through overcharging government for transport as claimed by government informants, while from the government side, opportunism was manifested in the delay and non payment of SLA bills in the full knowledge that facilities have provided the services. In addition to this, government agencies had capped prices and delayed payments in full knowledge that most CHAM facilities will continue to contract with government, as there are few or no alternative purchasers of their services.

Both CHAM facilities and government agencies understand their organizational roles in implementing the SLA policy but given that individuals representing the two organisations may have objectives different from those of the organisation they represent, they act in ways that prevents effective implementation of SLA, through non- payment or renewal of SLA contracts as illustrated in the results chapters. Examining the multiple agency relations within which the SLA policy is implemented it is easy to observe and identify agents that behaved opportunistically and prevented proper implementation of SLA by acting in ways that constrained the contracting out policy.

The result of bounded rationality and opportunism as illustrated here is the probability that a party to a contract, CHAM facilities or government agencies will exploit their information advantage. This implies that the imperfect information in the SLA contract enabled CHAM and government to operate opportunistically by exploiting any information asymmetry (e.g. about the true cost of services or quality of services provided).

Asset specificity in SLA

Opportunism in a contractual relationship like SLA becomes a threat particularly due to asset specificity. While it was relatively straight forward to approximate the transaction cost attributes of opportunism and bounded rationality to SLA contracts, the adaptation of transaction cost attributes of asset specificity was not. To capture asset specificity, the thesis used information on the reported investment by CHAM facilities in the existing and additional infrastructure required to provide SLA services. The seeming reluctance by government to review prices and renew SLA contracts, but not explicitly stop people from demanding SLA services from CHAM facilities which had expired SLA contracts, point to the holdup scenario that is often associated with asset specificity.

Williamson (1985) highlighted asset specificity as a prime condition for "holdup" in contracting. In the context of SLAs, CHAM facilities have no immediate alternative party with whom to contract without net costs that equal or exceed those resulting from acceding to the opportunistic government demands. For instance, the existence of specific assets in SLA contracts such as the investment by CHAM health facilities in infrastructure resulted in opportunism and increased transaction costs, in the sense that, CHAM facilities capacity (infrastructure) has a significantly higher value within SLA contracts than outside SLA. This is so, as most CHAM facilities are located in remote and rural areas, where there are less or no commercial activities that can utilise the infrastructure, other than the public sector. Therefore, if government decided to stop all SLA contracts, CHAM facilities capacity used for SLA could not immediately and costlessly be transferred to the production of alternative services. The difference in value within and outside the SLA relationship is equal to the SLA specific element of CHAM facility assets.

The economic relevance of specific assets is that they create the potential for opportunism through hold up. For instance, after some CHAM facilities had made their SLA specific capacity investments, government threatened to stop SLA contracts with these CHAM

facilities and imposed a capital cost on CHAM facilities equal to the value of the SLA-specific elements of CHAM facilities' capacity investment. Given that government knew that CHAM facilities could not immediately and costless transfer their capacity to alternative use, government agencies had, in principle capped prices, by negotiating to maintain the 2006 prices of SLA services. Consequently, because CHAM facilities expected that they could lose a share of the return on their specific investments if they withdrew, this has resulted in a hold up. One of the economic costs associated with holdups involves the reduced incentive of both CHAM facilities and government agencies to make efficient SLA contractual relationships, For instance, government not prioritising resource allocation towards a mechanism that may help streamline the prevailing challenges in SLA contracts, including monitoring and evaluation.

Some of the elements that were thought to be generating transaction costs in SLA contracts were acknowledged as: the cost of time staff spent attending meetings and briefings, travel costs, accounting and legal fees, consultancy fees and transitional costs such as the setting up of HMIS and staff training. The staff cost is attributable to preparation and negotiation of contracts and was mostly reported by CHAM facilities as being the most significant cost. However, the most noticed transaction cost element for all parties involved appeared to be the opportunity cost of time spent by both management and physicians in gathering information prior to and during the contract negotiation phase**.**

The bureaucratic nature of the SLA process entails that the opportunity cost for some professionals is high. Since the cost of time spent in meetings by various actors does not form part of the cost of the contracted services under SLA, the opportunity cost of time as presented here may be considered as a transaction cost. Following from this explanation it is possible to discern that time is among the main types of transaction costs; while the others are information search costs, bargaining and decision costs, policing and enforcement costs, as all these activities involve time. Negotiation for SLA contracts is in most cases prolonged, implying that SLAs are generating significant transaction costs.

Despite their seeming presence, transaction costs were largely overlooked in the proposal to involve private health care providers through contracts, especially in SLA policy design to contract out CHAM facilities to provide maternal and child health. Although transaction costs can occur during contracting (period 1) or post contractually (period 2), it is usually not

feasible and practical for the contracting out parties to address both types of cost at the initial contracting stage (period 1) due to bounded rationality. The equilibrium or outcome in this case typically does not maximise access or efficiency.

Interpreting implications of SLAs through principal agent model

In trying to understand the implications of the contractual relationship between CHAM facilities and MoH officials, principal agent model seem to provide some insight into the objectives and behaviour of the actors involved, how they constrain each other and how in the process of constraining each other they affect health care services provided through SLAs.

The results of the study suggested that some revealed objective functions within government and CHAM as well as between government and CHAM are contradictory. The contradictions between stated and revealed objectives partly explain the challenges faced in the implementation of SLA. In addition, the results in this study have shown that contracting out health care provision in a multiple agency setting, with similar kinds of conflicting objectives can result in opportunistic behaviours by one or both parties, high bargaining contract costs, failure to achieve objectives and contract termination. These results in contracting out experience points to the significant transaction costs of such arrangements and the need for strong and capable contracting units within the health ministry.

Liu, Hotchkiss and Bose (2008) have stated that contracting out may give rise to significant administrative costs, fragmentation of the health system and that government with weak capacity to manage the contracts may not benefit from it, as they might not be able to properly monitor private providers. Similarly, the results also highlight that, in circumstances where the public sector has contracted out services that are complex, public sector managers expose themselves to risk of contract failure, although it is worth pointing out that these same transaction costs can threaten delivery of internally produced services. Furthermore, the study found that incentives have great influence on both government agencies and CHAM facilities and that perverse incentives coupled with uncoordinated policies could exacerbate transaction costs, inequality and inefficiency in health care provision through SLA.

The success of contracting out public services lies heavily on understanding the objective functions of the contracting parties and management of contractual relationships by defining

the functions, procedures and supporting processes. In general, public sector organization have more restrictions in their contractual relationship which create gaps between them and the contracted out service providers. The public sector organization may emphasize implementation of policies rather than seeking maximum benefit.

CHAM facilities objective functions are varied, for instance maximise surplus over the contract period, in this case, if a CHAM facility find new opportunities as the contractual relationship unfolds, they will seek to capture them. However, if the contract is properly drafted, the scope for such opportunities will be limited. Despite this there is still some scope to engage in this form of opportunistic behaviour. The implications of such opportunistic behaviour by these providers might help them to extract gains through SLA contracts. These concerns were reflected for instance in reports of over prescribing and claiming SLA payments for *"ghost"* patients. Analysis of incentive structures can be extremely complex; however, many of the incentives operating in health care sector between purchasers and providers can be influenced at least potentially, by monitoring mechanisms and regulation (Mills et al. 1997).

The reality that government and CHAM facility objectives functions conflict is not a surprise, however, despite the differences, if the potential "gains from contracting out" are sufficiently large due, for instance, to superior CHAM facility's efficiency, SLA could produce a "win-win" outcome. Nevertheless, a number of factors associated with the provision of health care, especially contracting out its provision involve greater complexity and uncertainty. The complexity and uncertainty generates extra costs through activities such as renegotiation of the contract. These costs may be large and reduce the likelihood of the government achieving its goal of increasing utilisation and coverage of health care services, as the government agency may not have adequate financial resources as well as human capacity.

Although there was a systematic increase in the proportion of people utilizing health services after SLAs were introduced, the increase in utilization was not always sustained overtime. In part this appears to be because the removal of user fees through SLAs was not accompanied with additional procurement of drugs, recruitment of health personnel and expansion of infrastructure to cover the anticipated increase in demand for services. This imbalance of demand and supply factors have lead to several problems including: drug shortages which

have resulted in people seeking medical service from private providers thereby exposing themselves to financial risk.

In addition, the study found evidence that SLA improved the probability to seek care when ill; however, other factors such as living far from CHAM facilities (transport, cost of food and accommodation) still acted as obstacles and deterred individuals from seeking care. Furthermore, there were some indications that SLA mechanism set up to reimburse facilities for the services provided did not translate into additional and timely cash at facility level. Most facilities reported experiencing major cash flow problems due to delay in income from SLA reimbursement

Conclusion

Government contracting out of health care service delivery to private sector providers is increasingly seen as a feasible strategy to improve access, equity and quality in service delivery. Findings from this study raise some critical issues; first, it sheds light on what determines maternal and child health care services contracting out. This study also offers a precautionary note on countries where contracting out of health care services is ushering in ingenious ways of promoting universal health care coverage. The disproportional high utilisation rates due to SLA in Malawi may also hold some lessons for the many countries contemplating or having contracting out arrangement with a similar mix of providers. From policy point of view, the research results on contracting out of health care provision also raises concerns about the sustainability of SLA given that the health sector is largely donor financed. Future study could focus on the transaction cost implication associated with contracting out health care provision.

The main policy implications of the study are that, the objectives of the contracting parties (CHAM and government) and their capacity (financial, skilled personnel and infrastructure) are of greater importance in achieving the goals of SLA. There are also conflicts with individual actors in CHAM and government who seek to achieve their objective and so doing affect SLAs.

Importantly, the incompleteness (due to information asymmetry and opportunistic behaviour) of SLA contracts and the role played by dynamic responses of the government

agencies and CHAM facilities helped to explain the complexity of the contractual relationship in SLA. The responses of government and CHAM to each other transformed their intended objective of providing health care to underprivileged Malawian and focused on surplus and budget objectives respectively.

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