

# WHEN PUBLIC SERVICES CONTRACTS ARE POORLY MANAGED: AN ANALYSIS OF MALAWI'S SERVICE LEVEL AGREEMENTS

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## ABSTRACT

*This paper contributes to the debate about the understanding of contextual factors in contracting out public services in developing countries. It argues that contractual relationships that the Ministry of Health enters with faith-based health service providers in Malawi are not effective due to poor design, implementation and management arrangements. As a result the contracts have become more mechanisms for quantitative increase and access to services rather than tools for ensuring quality and accountability in service delivery. Although the arrangement contributes to the increased access to health services, it is not cost-effective and the quality of services in church health facilities remains low, because the process is filled with management and governance challenges. Meanwhile, the Ministry of Health is often accused of delaying payments to the church health service providers thereby sustaining the efficiency and accountability malaise.*

**Keywords** - Accountability, Contracting, Health Service

## INTRODUCTION

The objective of this paper is to unearth the importance of having well structured, managed, monitored and implemented contractual arrangement for the delivery of health services by external organisations and the consequences of the absence of the same. The focus is on service level contractual agreements that public health institutions enter with faith based organisations. According to the new public management paradigm, contracts are supposed to be well designed and managed for them to be effective in achieving the required service outcomes (see Peters, 2010). Yet in most cases, especially those involving faith based organisations in developing countries, contracts are informal and trust-based without any serious specification of performance standards (Batley and Larbi, 2004). What is agreed upon is the generalised view that “when NGOs are engaged in service delivery, the major focus is on financial and performance accountability” (Brinkerhoff, 2003:14). For faith based organisations, trust and confidence that these

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organisations command mean that the fulfilment of accountability requirements in service delivery is taken for granted. In this realm, Pulmer (2006: 237) observes that “rightly or wrongly there is less concern that faith-based groups may behave opportunistically or fraudulently”. But this paper finds that although the contractual relationship between district health offices and faith based providers has been instrumental in increasing access to health services, there have been many accountability and service delivery challenges. This is particularly the case in contracts that have been poorly designed, implemented and suffer from a lack of strong management provisions. The problem has been that the success in increased access has been so overwhelming that the problems of accountability on the part of the service-providing church-based organisations have been overshadowed. In particular, due to their being faith based, the participating church providers are granted trust and confidence. As a result, appropriate management and monitoring measures to ensure increased accountability have not been put in place. Over-invoicing, transparency and governance problems abound, risking the quality of services offered and the cost effectiveness of the whole arrangement. In order to unearth these issues the paper is guided by the following research questions:

- What are the management challenges in contracting out of health services in Malawi
- What are the accountability and transparency challenges in contracting out of health services in Malawi
- What are the implications of the challenges on cost effectiveness and quality of services

## METHODOLOGY

This paper is chiefly based on empirical qualitative and secondary data. Empirical data was collected through in-depth individual interviews and focus group discussions carried out with Ministry of Health (MOH) headquarters officials, District Health Management team members, and Christian Health Association of Malawi (CHAM) hospital officials in five districts in the country. Malawi is divided into three administrative regions within which are districts. Two districts were purposively sampled in the Southern Region, two in Central Region and one District in the Northern Region. In each district, a CHAM facility and a MOH facility was chosen to carry out focus group discussions and interviews. Together, 10 focus group discussions (FGDs) were done in CHAM hospitals (5 FGDs) and MOH facilities (5 FGDs) with nurses and technicians. In addition 8 in-depth interviews were done with various officers at CHAM facilities while those from the MOH were 12. It was not possible to interview patients who were the beneficiaries of health services due to ethical challenges. The qualitative data is supplemented by secondary statistical data. Secondary data was sourced from academic publications, government reports, and CHAM reports. For ethical purposes, as much as possible, the analysis ensured anonymity of the respondents. In this regard, the codes used for responses do not directly correspond to abbreviations of any district in the country.

## THEORETICAL UNDERPINNINGS

### Contracting Out

Contracting out of public services has been one of the most attractive alternative ways of service delivery in the past decades for both developed and developing countries (Batley and Larbi, 2004). No wonder there is little contention about its definition as most studies (see for example McNamara, 2006; Siddiqi et al, 2006; Khan, 2009) settle for Taylor's (2003:158) formulation that regards contracting out as a "purchasing mechanism used to acquire a specified service, of a defined quantity and quality at an agreed-on price, from a specific provider, for a specific period". In this respect, services that were previously provided in-house by the public sector are outsourced from nongovernmental or other public providers. Theoretically, contracting out is mostly construed within the New Public Management (NPM) rhetoric of ensuring the purchaser/provider split (Ferlie et al, 1996; Sirverbo, 2003; Peters 2010). This is underpinned by the transaction cost theory; property rights theory; and principal agent theory (see Bruttel, 2005; Batley and Larbi, 2004). The transaction cost theory in terms of contracting out alludes to governance mechanism that ensures efficiency and cost effective means of service delivery. The property rights approach in contracting looks at the dilemmas of common ownership by advocates for contracts as "firms in private ownership are expected to work more efficiently because efficiency gains are directly attributable to an individual" (Bruttel, 2005). The principle agent theory is about accountability for results where contracts are seen to provide a mechanism where the contractor works in the interest of the contractee by delivering the agreed upon performance targets and results. In this realm, penalties and rewards are distributed based on the extent to which contractual agreements are achieved.

It is in this context that contracting out encompasses a number of approaches whose underlying philosophy is paying for contractor performance and receiving results and outcomes. The specific variants include paying for performance/results (P4R) where a contractor is rewarded for quality improvements with higher payments (Keenan and Kline, 2004; Damberg et al, 2005); results based financing (RBF) where a "principal entity provides a financial or in-kind reward, conditional on the recipient of that reward undertaking a set of predetermined actions or achieving a predetermined performance goal" (Mumssen, Johannes and Kumar, 2010:3); and output based aid, which delegates "service delivery to a third party under contracts that link payment to the outputs or results delivered" (Smith, 2001). In short the operative theme in contracting out is paying for performance and getting results or outcomes. Although the common understanding is that contracting only goes to NGOs or the private-for-profit bodies, this is a fallacy as public or quasi-public entities can also be allowed to bid for and win contracts. This is the case as the contract is blind to the background of the provider and the only preoccupation is that the provider delivers what has been agreed to.

### Management of Public Services Contracts and Accountability Challenges

It must be noted that the availability of contracting arrangements alone is not enough to ensure effectiveness and accountability in service delivery. Proper management of the

contract ensures that the required contract deliverables and value for money are attained (House of Commons, 2009). In most cases contracts fail to deliver the promised results due to management problems. Contract management requires choosing a contractor, designing contracts, monitoring the contractor and supervising quality control and penalties if results are not achieved (Prager, 1994). According to Doherty et al, (2014:165), the management competencies for effective execution of contracts include the “ability to embody service level agreements into contracts with performance and quality targets to monitor whether or not services are being delivered in accordance with the contract”. This is emphasised by Brown et al (2006:325) who highlights that the basic management skills required for effective contracting include planning and coordinating service delivery; negotiating with vendors; monitoring task completion and executing incentives. Management capacity in this regard in terms of designing, implementing and managing contract arrangement is necessary for the effective realisation of contractual ends. Batley and Larbi (2004: 167) highlight the necessary managerial antecedents in this regard which include the following:

- The internal organisational factors needed to undertake contracting and managing contractual relationships, including human resources and incentive systems, management systems, roles and relationships, capital and financial resources;
- Coordination and clarity of relations between the task network of organisations that together are responsible for contract design and implementation; and
- The external environment and how it affects (enables or constraints) the mobilisation and deployment of personnel and organisational capacity, including the public sector institutional context of rules, regulations, laws, policies and power relationships and the broader social, economic and political context within which public institutions and partners have to act,

In developing country contexts, effective management of contracts has been seen to yield the planned results in Rwanda, Cambodia and Democratic Republic of Congo (see Soeters et al, 2006; Meessen et al, 2010). In these countries managing contracts effectively has led to greater accountability, improved efficiency in service delivery and spill-over effect where it has helped to address several structural problems facing service delivery (Meessen et al, 2010). In the same vein, poorly designed and managed contracts result in inefficient service delivery and accountability challenges on the part of the service provider. As Peters (2010: 298) elucidates, contracts may be “desirable from an economic perspective, but they present their own administrative challenges, especially control and accountability”. Here, contracting has “important implications for accountability because such a process may increase services but dilute government control and accountability” (Johnston, 1999:387).

Increased accountability problems are seen as arising from contracting poorly managed contracting out arrangements. As Van Slyke (2002: 502) observes, the “ever-present political problem of accountability in public administration is only compounded with the addition of nongovernmental organizations carrying out the public’s work”. In this regard, the complexity of contracting arrangements, institutional requirements, transaction costs and new management skills needed pose a challenge in so far as the account-

ability questions are concerned. This is compounded by the absence of competition in contracting out activities especially in developing country cases where markets are underdeveloped and the motivation for contracting out is to service underserved area rather than competition. In this case, mere strategic location of the non-governmental providers in such areas is seen as a guarantee for providing the service. It is in this realm that Johnston and Romzek (1999:386) warns that the “absence of a competitive provider environment requires particularly strict attention to accountability mechanisms because market discipline is lacking”. Therefore, the contracting relationship is feared to “create serious public management and accountability problems for which public administration theory fails to prepare us” (Van Slyke, 2002: 500). These accountability challenges are not only limited to the public sector but also the contracted non-governmental providers (Johnston, 2004). The daunting challenge for contracting management therefore is to cultivate the performance promises of contracting out scenarios without compromising on accountability (Brown and Potoski, 2005: 326).

### **CONTRACTING OUT OF HEALTH SERVICES IN MALAWI: SERVICE LEVEL AGREEMENTS**

Banda and Simukonda (1994:67) noted that the Malawi Ministry of Health (MOH) has “neither the manpower nor the material resources to fulfil its mandate of raising the health of all Malawians by reducing the incidence of illness and death in the population”. This is proven by the fact that it provides 60% of health services while the remaining is covered by church based (37%) and other private (3%) providers (Malawi Government 2004). Government services are for free while other providers place a charge. Faith based health service providers operate under the umbrella organisation called Christian Health Association of Malawi (CHAM). The individual providers under CHAM belong to various church denominations and operate independently of each other, making autonomous business, managerial and operational decisions depending on their location and need.

Most of the CHAM hospitals operate in rural areas where government health services are unavailable. Paradoxically, in these rural districts, most people are too poor to afford payment at the CHAM health services. Specifically, poverty in Malawi is “widespread, deep and severe” (Malawi Government, 2002), with 52.4% of the population living below the poverty line (Malawi Government ,2006) and the majority of these living in rural districts, accounting for 59.9% (World Bank, 2007). The unavailability of MOH services in the context of poverty in these areas means that the majority of the people would not have access to health services. For example it was noted during the study at Embangweni CHAM hospital that women were paying K200<sup>1</sup> for normal delivery but many could not afford it and were choosing to deliver at home.

It is for this reason that the Malawi Government entered into contractual agreement with CHAM hospitals to provide health services to the poor. These contractual arrangements are also referred to as Service Level Agreements (SLA). In this respect, the Memorandum of Understanding articulates that “service agreements shall be established wherever possible as a mechanism for maximising efficiency in the management of health service

and maximising access of the population at large to hospital services” (Malawi Government and CHAM, 2002:7). These agreements are made with individual CHAM and government district hospitals depending on the services the hospitals provide. The arrangement made is that people access the health facilities without paying, and CHAM facilities bill MOH through District Health Offices. In addition, the MOH supplements salaries of medical staff member at government rates. On its part, the Government commits itself to “provide financial assistance in cases where service agreement is in operation” (Malawi Government and CHAM: 2002: 8). It also encourages District Health Officers to “enter into service agreements or contracts with CHAM facilities (and indeed other providers of health services) where appropriate, in order to facilitate communities accessing EHP services free of charge in line with government policy” (Ministry of Health, 2005: 16). Although the scale of services differs from district to district, not all services are currently covered under this arrangement. In most cases, the services covered are those classified under Essential Health Package (EHP) framework. According to the World Health Organisation (2008:2) the EHP framework “in a low income countries consists of a limited list of public health and clinical services which will be provided at primary and/or secondary care level”. For Malawi, the EHP framework comprises of services that address major causes of death and disease which include: vaccine-preventable diseases; malaria; Adverse maternal and neonatal outcomes (including family planning); tuberculosis (TB); acute respiratory infection; acute diarrhoeal diseases; sexually transmitted infections (STI), including HIV and AIDS; schistosomiasis; nutritional deficiencies; eye, ear and skin infections; and common injuries (Ministry of Health and Population/UNICEF, 2002).

The study revealed that the contracting out arrangement has provided dividends in terms of increased access to health services. This is the case as those that were previously excluded from these services on the account of user fees from CHAM facilities can now access them. To this end, the MOH (2011) even agrees that “evidence shows that the removal of user fees in CHAM facilities has resulted in an increase in the number of patients seeking care in these facilities”. In addition, it has also reduced the workload at government hospitals as some cases that could go to these hospitals in search of free services are now handled at CHAM hospitals. To illustrate these benefits, a case study of a contractual agreement between Namikango Maternity Clinic and Zomba District Health Office is used. Namikango Maternity Clinic went into service agreement with the Ministry of Health on 1<sup>st</sup> May 2008. The objective of the agreement was to partner with government in the delivery of maternal health services and to thereby improve the health status through improved access to maternal health delivery. Below is performance statistics in terms of access before and after the contracting out arrangement.

**Table 1: Performance Statistics for period 1<sup>st</sup> May 2008 to 30 April 2009 (AFTER)**

Service provided	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08	Dec '08	Jan '09	Feb '09	Mar '09	Apr '09	Totals
Ante Natal	112	151	134	124	160	126	114	113	129	136	160	121	1580

Normal delivery	41	42	36	55	66	58	81	81	56	49	79	77	721
Deliver /Suturing	7	9	8	25	14	4	20	17	2	6	11	13	115
Referrals	7	6	13	13	12	12	10	5	4	10	13	13	118
Total No of cases	167	208	191	207	252	200	225	216	191	201	263	224	2534

Namikango Maternity Clinic, 2009

**Table 2: Performance Statistics: Same Period Previous Year (BEFORE)**

Service provided	May '07	Jun '07	Jul '07	Aug '07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	Totals
Ante Natal	60	62	69	43	47	63	65	66	29	42	35	60	641
Normal delivery	38	41	35	47	50	36	45	41	42	35	42	39	491
Delivery /Suturing	-	-	-	-	-	-	-	-	-	-	-	--	--
Referrals	7	12	12	14	6	3	10	13	1	7	6	6	97
Total No of cases	105	115	116	104	103	102	120	120	72	84	83	105	1229

Namikango Maternity Clinic, 2009

As can be seen from the statistics in tables 1 and 2 above, there has been a sharp increase in traffic volume for the Clinic in percentage terms in the period where the contractual arrangement was done. In particular, the overall number of cases seen has increased by 106%, deliveries 70%, referrals 22%, and antenatal 146%. This indicates increased access to health services arising from the contracting out arrangement. Meanwhile, CHAM facilities have increased income which is critical for their sustained operations. For instance, as can be seen in table 3 below, in the case of Namikango Maternity Clinic there has been an up to 62% increase in income as compared to the time when the arrangement was not yet in place.

**Table 3: Income comparison before and after SLA**

PERIOD	Cumulative income (MK)	REMARKS
May '08 to April, '09	1,285,793.00	62% increase over previous year
May '07 to April '08	794,970.00	

Namikango Maternity Clinic, 2009

### Management and Accountability Challenges in the SLA Arrangement

Johnston et al (2004: 158) articulate that the management challenge in government contracting is to “capture the benefits of the contract relationship without losing accounta-

bility. This challenge is not limited to the public sector". It would seem that the high performance record of contracting out in terms of increased access as highlighted above has overshadowed the requirements of accountability especially on the part of CHAM facilities due lack of active contract management. Meanwhile, on the part of the MOH, lack of effective monitoring systems exacerbated by the faith and trust placed on CHAM facilities, owing to them being church based just sustain the situation. In particular it was noted that CHAM facilities over-invoice the MOH and have various governance challenges that undermine their accountability requirements as articulated below.

According to the contracting out arrangement, patients are supposed to access services from CHAM facilities without payment and CHAM hospitals would then invoice the contracting government district health offices (DHOs) that would pay the amount. The price of drugs and services provided are based on pre-agreed amounts by both the contracting DHOs and CHAM facilities. For example in Mzimba, it was noted that "at the beginning of the service level agreement between Mzimba DHO and Embangweni, a ceiling of money was provided as a standard measure calculated upon the following factors, population (catchment area inclusive) and maternal services provided at the hospital<sup>2</sup>". But the study established that since there are no effective management mechanisms, in most cases CHAM facilities deliberately over-invoice DHOs. In all the sites visited, the problem of inflation of figures by CHAM facilities was reported. For instance, minutes of management team at one site read "there is an observation on monthly increased quotations (invoices) which refers that we are being over-charged<sup>3</sup>". This was confirmed by in-depth interviews in all the sites visited. In this regard, an interview with a District Health Officer at one point revealed that:

Inflation of the figures is the main challenge. When we went to see the actual figures which were referred we said 'ok these were the cases that you said you solved can we go to the referral notes and case note to see if they match'. We found that some issues they indicated that they did were not on the case notes and referral notes so this indicated that some of the figures were inflated (Interview at site Y, 18 May 2009).

This was corroborated by a Hospital Administrator at another site who lamented that

As District hospital, we were expressing dissatisfaction over inflation of figures. Because when they were bringing in retains in terms of the monies we had to pay, we felt that the names were exaggerated or rather the figures were inflated for them to meet some of their operational costs. So they were seeing the whole arrangement as income generating for their activities. This was indeed happening and from every now and then at the hospital meetings we could question why this figure is too high (Interview at cite W, 28 April 2009)

At yet at another site the view was that

The major issue is that you would see that the invoices that come from CHAM hospitals are way off the mark. They over invoice it. I can give you an example where we agreed about K 450, 000 on average per month. But now it's like K 800,000 or K 900, 000 and sometimes a million. It's double as much. So in such



way you find that management in CHAM hospitals is not helping to monitor such activities (Interview with DHO at site A, 17 April 2009).

There were divergent views as to the responsibility of these malpractices within the CHAM institutions. While some respondents held the view that the over-invoicing was a result of individual employee mistakes and benefit seeking, others thought that this was institutional ploy on the part of CHAM facilities to increase their financial standing. For instance, one respondent holding a former view outlined that “I would not think it is within policies of an institution, maybe it is because some workers within the institution who wish to make more money anyway. But it may not have been out the agreement” (Interview with Hospital Administrator at site A, 17 April 2009). Another concurred that “this is more of individual than institutional because when you discuss with their management they deny it” (Interview with site J DHO, 18 May 2009); however, looking at the acute financial problems that the CHAM hospitals face even within the confines of increased financial outlays emanating from the contracting arrangement, it would be more appealing to conclude that these malpractices are organisationally engineered so as to meet their operational cost. CHAM facilities lack the necessary financial resources so that the contracting-out arrangement bails them out. As a Hospital Administrator at site W said, “figures were inflated for them to meet some of their operational costs”. In fact an Administrator at a CHAM hospitals said that “if government pulls out [of the contract], that will also be the end of the hospital. The contracting-out is the area where the hospital is making a lot of money... Those people will not be able to be paying at cost and the hospital will die out. Obviously if that agreement is terminated today the hospital cannot survive, it cannot” (Interview with CHAM Official 10 April 2009). In this regard, responses from the MOH officials were quite revealing. A DHO commented that

From what we saw at place A<sup>4</sup> when clerks were interviewed some said they were just told to do that. The hospital as an organisation says “we do not have funds and what do we do?” Because they know the DHOs have monies for service level agreement and even if they raise the bill the DHO would still pay because they have money there. So the inflation of figures is just to find one way of maximising the tapping of that money (Interview with DHO at site V, 18 May 2009)

An Administrator at another district hospitals visited said that

If you look at the whole issue it would appear that the CHAM hospitals have no resource for them to run. So it would appear that some workers within the CHAM hospitals would see this as a way to finance it. CHAM people look at it as a way of sourcing finances for their operation. You look at CHAM hospital G<sup>5</sup> it was closed because they had no money to run. But we refused them because they came here to lobby their way through so that we can have an agreement but we had some other privileged information about their finances and we said no to them. So what happened was that two, three months down the line they closed. What it meant was that we would enter into a very difficult problem. (Interview at cite J, 17 April 2009).

This was corroborated by an FGD participant who observed that

I do not think that this is individual since when the money goes to CHAM is not for the individual processing the transactions that benefits but rather the institution. The cheque goes to the hospital and not the person. Even when you overcharge you cannot separate the payments so that some money should be privately pocketed as this is consolidated and goes as one payment so there is no room for individual benefits. After all they don't pay cash so that one can take the other money out- it is all cheque which is payable to the organisation. So this over-invoicing is more for the organisational benefit (FGD with site V officials, 4 March 2009)

On the government side, there is a lack of monitoring mechanisms that would ensure increased accountability in the system. It would appear that the CHAM institutions are just left alone to operate without deliberate managerial interventions to monitor and control malpractices. In one such institution, an Administrator at one of the district health offices visited hinted that "we are having problems of supervision" (Interview with at site A, 17 April 2009). This was echoed by a participant at a focus group discussion who said that "we do not know if this system was fine-tuned as there are a lot of abuses. How will they know the hospital attended to so many clients and this bill is reflecting the number really attended to? They can charge a person who has actually paid money but put him on service agreement so that there is double charging without us knowing" (FGD with site Y officials, 28 April 2009). Moreover, despite the contract agreements stipulations, there is a marked institutional boundary between the CHAM facilities and DHOs. In this regard, the DHOs, though they are technical managers on health issues in a district regardless of facility ownership, they do not interfere in administrative and managerial affairs. As one DHO articulated,

The DHO cannot do anything in this regard...because there is no direct line administratively. They are a separate entity... The DHO is the overseer of health services in the district regardless of who owns the facility, but as regards to monitoring and disciplining of CHAM facilities-that line is not there...There is a limitation. You cannot go in and dictate to say you have done a,b,c,d things that are not applicable (Interview with DHO at site J, 28<sup>th</sup> April 2009)

The problem is exacerbated by the trust and confidence in church organisations under Malawi command. It would appear that lack of monitoring in the contract arrangement is as a result of trust and confidence that the MOH places on CHAM's faith-based facilities. As one DHO lamented, "CHAM has lost its ethics and it is becoming money hungry facility" (Interview with DHO at site V, 4 March 2009). The problem is that even within the confines of the revelations of accountability malpractices; the religious nature of the organisations makes it difficult for the MOH officials to address the problem. As one hospital administrator said, "how do you confront an institution that is supposedly based on principals of Christianity, so it creates problems" (Interview at cite W, 17 April 2009).

On their part, the CHAM hospital officials complain of under-costing of services in the contracting-out agreements, which points to the problems of poor design and manage-

ment of their contracts. The problem is that prices are not uniform in all arrangements but instead differ from district to district. In most districts, prices are based on government's pharmaceutical arm, the Central Medical Stores (CMS), which are very low compared to most private pharmacies. But in most cases the CMS does not have medical supplies, forcing CHAM hospitals to purchase from private traders at a higher price. In addition, the study found that the contract agreements only consider simple procedures under EHP which are cheaper but not do not go any further with operations in the event of complications. For example, a Director at one CHAM hospital outlined that "the agreement only considers caesarean section so the assumption was everything goes on smoothly there will not be any complications but we have noted that many times the patient would go to theatre maybe more than once because of the complications that have arose from the initial procedure so when we send these other costs they say no, it's not part of the agreement so we are saying aren't we disturbing the agreement" (interview with a Director of a CHAM Hospital, 18 May 2009).

Moreover, CHAM facilities also accuse MOH of not making timely payments, affecting their operations. The problem is that CHAM facilities do not have a reliable source of funding and rely very much on the money from contracts. In this regard, they would like DHOs to pay them instantly. But the system of government funding to district hospitals is so slow and inefficient that the operation of CHAM facilities are adversely affected. With political decentralisation brought into the equation, the flow of monthly government funding moves from the Ministry of Finance to District Councils and then passes to the DHOs. The timing of funding is not constant as cash flow at the Treasury can be unpredictable, and transaction decisions at all stages of funding flow, including the MOH headquarters, can affect the speed at which the DHOs receive funding. In this realm, a DHO commented that "it reaches the 16<sup>th</sup> of the month before we have received funding...funding comes very late and they accuse us of delaying payment. It is beyond our control. Because they have become money hungry and so reliable on government, they do not understand. We cannot pull money from our pockets" (Interview at site W, 4 March 2009). A documentary analysis revealed that while the CHAM facilities complain about delayed funding, the delay is substantial enough to adversely affect their services. For example, while Namikango Maternity Clinic complained that there were "delays in effecting payment which is an adverse effect on our cash flow for our operations,"<sup>6</sup> it can be seen in table 4 below that the average number of days after the facility had issued an invoice to DHOs was 23 days. This is reasonable considering the administrative, transactional, and technical procedures that have to be undertaken as discussed above.

**Table 4: Payment Record for Agreement**

Month	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08	Dec '08	Jan '09	Feb '09	Mar '09
Amount due (MK)	6720	7855	7420	90600	10580	83700	10820	10205	82850	80100	118200
Date	12	12	7	8 Sept	13	11	3 Dec	8 Jan	6 Feb	6 Mar	6

In-voiced	Jun '08	Jul '08	Aug '08	'08	Oct '08	Nov '08	'08	'09	'09	'09	Apr '06
Date Paid	26 Jun '08	7 Aug '08	8 Sept '08	8 Oct '08	27 Nov '08	16 Dec '08	19 Jan '09	19 Jan '09	17 Mar '09	15 Apr '09	30 Apr '09
No of days (net)	10	21	23	23	32	28	36	7	29	27	18

Namikango Maternity Clinic, 2009

### MANAGEMENT AND TRANSPARENCY CHALLENGES IN THE -SLA ARRANGEMENT

Transparency as espoused by the requirement to disclose public and corporate financial information to stakeholders is pivotal for reinforcing accountability as it empowers the necessary stakeholders (Solomon, 2007; Larriaga et al, 2002; Coy and Dixon, 2004). In this respect, the transparency requirements for the contract arrangement as stipulated in the Memorandum of Understanding is the need to “disclose in a disaggregated format all sources of external and internal funding received or generated and all expenditure undertaken that pertain to the health sector” (Malawi Government and CHAM: 2002:9). This requirement is assumed to go a long way in ensuring transparency on the performance of CHAM hospitals. This disclosure is both to the MOH through the DHOs and to CHAM headquarters.

But the study found that in most cases the CHAM facilities do not submit the said reports to either organisation. In this regard, the Deputy Executive Director of CHAM has been expressing concern that “units were not submitting accounts to the Secretariat. As of 30<sup>th</sup> September 2004, no units had submitted any expenditure report. He therefore expressed the need for units to submit expenditure reports as they are important for transparency and accountability” (CHAM Meeting Minutes, 22 October 2005:8). In addition, the requirement for disclosure does not only mean financial reporting but also the involvement of concerned stakeholders in the budgeting and planning processes. This is the case as “financial accounts may conceal more than they reveal and, therefore, that accountability requires disclosure of reasons for, and explanations of, actions taken” (Coy and Dixon, 2004:81). The study noted that DHOs expected CHAM hospitals to involve them in their budgeting and planning processes, which they hardly did. One DHO commented that “we are supposed to be open. Our friends (CHAM hospital) are not transparent as regards to their budget. But the service level agreement itself dictates that we should be open, they should know our budget and equally we should know their budget. When we are developing our plans and coming up with our budget we invite them and they are part of the process but when they are doing theirs, they do not invite us”. (Interview at site A, 28<sup>th</sup> April 2009). This was echoed by an FDG participant who underlined that “the CHAM hospitals do not discuss with us their budget; they just tell us what they want. So the management team complains that CHAM is not transparent” (FGD at site A, 28 April 2009).

Even worse, a review of an internal audit report for CHAM facilities portrayed several governance problems that are feared to have massive implications on accountability challenges outlined above. For instance, it was highlighted that in most cases there were delayed appointment of board members for CHAM facilities who are pivotal in enforcing accountability and transparency requirements. In this regard, at one site it was noted that the period for outgoing board members expired on 31 December 2005 and because of delay in appointing new members, their term of office was extended. Letters of new appointments were written on 9<sup>th</sup> July 2008 while the Hospital Administrator was informed of new appointments in a letter written on 7<sup>th</sup> March 2008 (CHAM internal audit report, 21 May 2008:3).

### **DISCUSSION: IMPLICATIONS ON COST EFFECTIVENESS AND QUALITY OF SERVICES**

Accountability and transparency have been proven to be the major problems of contracting in the context of weak management. As Peters (2010:299) illustrates, incompetence on the part of public sector managers present risks of the private providers not being accountable and displaying other ‘unethical behaviours’. This study has unearthed that lack of proper management practices for contracting out has the potential of presenting accountability and transparency challenges. The case of Malawi reveals that lack of performance management measures and agreements may result in losing out on the important aspects of accountability and transparency. This is applicable even in contracts with faith based organisations which by their nature are supposed to be operating even more “fastidiously (than) we expect the public sector to be” (Peters, 2010). In particular, lack of performance agreements upon which the effectiveness of contracts with faith based organisations would be measured imply that there is no management tool to assess the effectiveness of the same. This is juxtaposed with lack of proper monitoring mechanism in terms of how the faith based providers are operating. The House of Commons (2009) elucidates that having “performance measures and keeping them up-to-date is essential for managing supplier performance”. In addition, management challenges arise as there are no punishments and incentives for contracts performance in the SLA arrangements. The SLAs do not stipulate any measures to be taken in accountability issues are not adhered to by both parties thereby encouraging unethical behaviour. This is against the managerial requirement that “good contract management should also include financial incentives to encourage suppliers to improve performance” (House of Commons, 2009).

But this scenario presents implications in terms of the citizens getting the value for money, especially on the aspect of cost effectiveness and quality of services. As per Peters’ (2010:299) advice, “government agencies contracting with the private sector should monitor their contracts as well as they can to ensure that the public gets value for money”. This is against the back drop of the fact that contracting out is also assumed to be a cost effective way of delivering services on the part of government (Liu, Hotchkiss and Bose, 2007; Khan and Ahmed. 2003.). In this respect, the expectations were that there would be savings in the SLA in Malawi, as it would go a long way in saving the MOH from constructing clinics and delivering services in areas where CHAM facilities

operated. But in the context of the accountability challenges outlined above, the whole contracting out arrangement is a remarkably expensive undertaking. It is not cost-effective and the MOH would be in a better position in reducing costs if it engaged on in-house provision than contracting. This compelled the MOH to include a review of costs, cost effectiveness and value for money for SLAs in its 2011-2016 Strategic Plan (MOH, 2011:51). The issue here is that these SLA partnerships are expensive and not cost effective owing to the management and accountability challenges.

In addition, although contracting out has facilitated increased access to health services as outlined above, the resulting accountability challenges have implications for their quality of services. This is the case as the expectations were that CHAM units would be reinvesting the money in the delivery of service so as to cater for the increased demand of 'free' services arising from the contracting arrangement. But this study concluded that the increased financial resources coming from the contracting out are not effectively ploughed back into the CHAM facilities for enhanced delivery of services. Seen from this perspective, there are acute shortages of key staff like medical and clinical officers and critical equipment for health service delivery in CHAM facilities. Doherty et al., (2014:165) illustrates that contracts need to specify "service level to which the public will be entitled" thereby allowing for effective participation of the citizenry in contract monitoring as a quality control measure. With the SLAs in Malawi, quality is also compromised as there are no management systems that would ensure the participation of the client groups as a way of enhancing monitoring arrangements in terms of achieving high quality of services.

## CONCLUSION

In conclusion, contractual relationships that the Ministry of Health enters with faith-based health service providers in Malawi are not effective due to poor design, implementation and management arrangements. Although the contracting out arrangements in the delivery of health services as employed in Malawi has been instrumental in increasing access to health facilities, especially as many previously could not afford them,, any gains attained are fragile due to lack of proper contract management systems. The problem is that due to management limitations in terms of design and monitoring of the contract infrastructure, there are accountability and transparency problems on the part of the service providing organisations. In particular, due to them being faith based, the participating church providers have been rendered a lot of trust and confidence so that appropriate managerial measures to ensure increased accountability have not been put in place. The problem is that this has had massive implications on quality of services offered and the cost effectiveness of the whole arrangement. Meanwhile, the Ministry of Health is often accused of delaying payments to the church providers thereby sustaining the efficiency and accountability malaise.

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## NOTES

- <sup>1</sup> K (Kwacha) is Malawi's currency. As of 7<sup>th</sup> March 2014, USD1 = K450
- <sup>2</sup> Minute 14.1 Mzimba DHO Minutes of Core Management Meeting Held on 24<sup>th</sup> October 2008 Ref No MZ.H/1/3/2).
- <sup>3</sup> Ibid
- <sup>4</sup> Name withheld by researcher
- <sup>5</sup> Name withheld by researcher
- <sup>6</sup> Namikango Maternity Clinic, 2009: Report for Service Agreement Review Meeting, 13 May

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**ISSN** 1662-1387