Building trust or buying results?

In August, 2005, the Lancet and Social Science and Medicine published papers with diametrically different positions about health-service delivery in developing countries.1,2 However, both articles maintain that there is a very limited body of evidence on the role of contracting and trust in health-system performance.

The building of health systems through contracting bodies is not based on the same values, and perhaps not on the same paradigms, as that through trusting bodies. Contracting bodies believe in the importance of competition and the ideology of performance.3 They see that the health system is an economic activity and use the positivist paradigm to assess experiences. Trusting bodies emphasise the importance of confidence in the health system and see it as a “vital element of the social fabric”.4 They use a constructivist paradigm to understand the world and provide evidence.

In their Lancet article, Benjamin Loevinsohn and April Harding (Aug 20, p 676)5 present in detail the strengths, weaknesses, and ideology of contracting approaches to the delivery of health services in developing countries, but their conclusions are flawed. I have already pointed out6 the features underlying the proposed contracting intervention model and the limited role of the state, and highlighted the lack of convincing data about this approach. There is not “enough evidence supporting contracting” and this is precisely why this is not the time to “[try it] on a larger scale”.7 More caution is needed and it is still essential to ascertain the merits of such an approach in different contexts.

Loevinsohn and Harding draw conclusions from only ten studies in developing countries, and the methodological limitations are huge. The evidence from the contracting experience in Cambodia, which is always presented to support this perspective, is not strong enough, and I have already discussed some of its limitations.8 Additionally, a book not cited by Loevinsohn and Harding9 describes the contracting experience in five developing countries and shows that there is not enough evidence about contracting in general, or performance-based contracting in particular. In Afghanistan, for example, where the World Bank leads the use of this approach in a post-conflict country for the first time, non-governmental organisations (NGOs) bidding to become contractors submitted a ridiculous budget to win the competition. As a perverse effect of an approach based on competition instead of trust, some NGOs tried to deal with each other to share the market.

Health-service delivery for profit is not good for your health, as has been shown for instances of hospital care in the USA. Under such an approach, equity is not important to contractors because they have to focus on effectiveness.

Why not test an approach based on trust for efficient and equitable health-service delivery in developing countries?

I declare that I have no conflict of interest.

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Authors’ reply

We certainly agree with Valéry Ridde in his call for the assessment of different approaches to improving health-service delivery. Assessment implies some agreement on the outcomes of interest, and our sense is that poor people in developing countries want low-cost, accessible, and effective services. They are not likely to be interested in academic debates of positivist versus constructivist theories. Whereas Ridde thinks that being concerned about health-system performance is an ideology, we believe that most people in low-income countries, if they had sufficient voice, would express their concern about the presence of skilled health workers in the nearby clinic, the availability of drugs for tuberculosis, and the opportunity to have their children immunised. These are the kind of performance indicators that have been successfully incorporated into contracts.

Ridde eschews any kind of competition in health services. However, the type of competition that we see coming out of contracting is different from the win-lose competition between commercial enterprises. When different non-state providers have contracts in different provinces or districts, they are not competing over market share but about who can best deliver services to the community. What could be better than everyone being spurred on to deliver the best possible health services to poor people in underserved areas?

Ridde interprets the evidence we presented to conclude that “health-service delivery for profit is not good for your health”. Since we only found assessed instances of contracting with not-for-profit providers, we do not believe that it is possible to draw conclusions about the effectiveness of contracting with for-profit providers in developing countries. We have not seen any evidence that the contracted-for-profit provision of primary care (as in Denmark, Canada, Belgium, the Netherlands, or the UK) has led to demonstrably poorer health for their populations. Hence, we are not persuaded that this model should always be ruled out in favour of public provision in developing countries.

Ridde seems to have misread our article to imply that equity is not important for contractors. The evidence that
we presented from Cambodia, and more recent work from Bangladesh, indicates that contractors can be influenced to focus on a range of objectives, including equity. If equity-related objectives (eg, access for rural or low-income people) are integrated into the contract and the contracting process, experience shows that these goals are achievable. We have found that non-governmental organisations (NGOs) will do a better job than governments in this regard.

Ridde contends that NGOs in Afghanistan submitted “ridiculous” budgets to win contracts. The experience so far does not support this assertion. While increasing the number of functioning health centres by two-thirds, tripling the number of outpatient visits, and more than doubling the number of female health workers in rural areas, the NGOs have actually underspent their budgets.

Where we disagree with Ridde most seriously is in the value of the status quo. In very few low-income countries are services being provided adequately to the entire community. Ridde’s approach is surprisingly conservative and he seems to be an opponent of innovation. Our belief is that only through innovation will the Millennium Development Goals be accomplished and health care in the community be strengthened.

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Combination antibiotic susceptibility testing in cystic fibrosis

Shawn Aaron and colleagues (Aug 6, p 463)1 are to be congratulated on bravely conducting a randomised controlled trial in an extremely complicated area. Needless to say, their excellent study raises more questions than it answers.

Their group of 251 patients seemed to have few infective exacerbations (132) over the 4·5 years of the study compared with our experience in the UK. In the year to April 5, 2005, our cohort of 45 patients with cystic fibrosis in Grampian, Scotland, had 142 exacerbations requiring intravenous antibiotics. We agree with F M MacKenzie and colleagues that the results of our study does not support this assertion.

As Aaron and colleagues acknowledge, combination antibiotic testing is normally reserved for patients with more serious infections, often those in whom first-time therapy has failed or whose infections are pan-resistant. These criteria seem to have applied to their group of patients only rarely, suggesting that the study was even more underpowered than they accept. In this context, it would have been helpful to know just how resistant their bacterial isolates were. Also, the pattern of antibiotic combinations used was broadly similar in the two groups studied, suggesting limited practical influence of the combination tests.

In Scotland, we provide a similar centralised service but with crucial differences. It is limited to truly multiresistant strains isolated from patients whose infections fail to respond to conventional therapy. For instance, the mean number of agents active against our Burkholderia cepacia isolates is only three. Feedback from users of the service via a standard questionnaire suggests that clinicians do find the service useful. In 96 exacerbations referred from around Scotland in the past 3 years, only three antibiotic combination tests were found to be unhelpful, all owing to delay in receiving results. 57% of results were helpful in management of the current exacerbation, 86% were helpful in management of a subsequent exacerbation, 38% were helpful in initial choice of treatment, 33% led to a change in treatment, 43% confirmed existing choice (progress satisfactory), and 41% confirmed existing choice (clinical doubt). Another difference in our service is that we analyse our results by the breakpoint index, which allows us to rank combinations in order of activity relative to achievable antibiotic concentrations in vivo.2

So, when used for exacerbations refractory to more conventional therapy, it does seem likely that combination testing is of clinical benefit. This is not surprising since, despite the probable importance of biofilms in cystic fibrosis, free living, relatively antibiotic-susceptible bacteria probably have a role in acute infective exacerbations.

The centralised combination susceptibility testing service is funded by the National Service Division of the Scottish Executive. We declare that we have no conflict of interest.


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2 Gould IM, Milne KE, MacKenzie FM. The breakpoint index—a new pharmacodynamic parameter for assessing antibiotic combinations. Presented at 14th European Congress of Clinical Microbiology and Infectious Diseases; Prague, Czech Republic; May 1–4, 2004 (abstr P1796).

Authors’ reply

We agree with F M MacKenzie and colleagues that the results of our study raise unanswerable questions about the value of combination antibiotic susceptibility testing.

Our cohort of 251 patients with cystic fibrosis were all chronically infected with multiresistant gram-negative bacteria, as defined by infection with a bacterium that was resistant to all agents in two of the following classes of antibiotic: the β-lactams (excluding meropenem), the aminoglycosides, or the quinolones.1 156 (62%) of the 251 patients had at least one exacerbation requiring intravenous antibiotics during the 4·5-year study period, and, of these, 132 were randomised into the study. We enrolled patients only once, at their first exacerbation. 125 of the 132 enrolled patients...