The impact of contracting out on health outcomes and use of health services in low- and middle-income countries

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Contracting out services to non-state providers may increase access to, and utilization of, health-care services. One study included in the review also reported a reduction in out-of-pocket expenditures and improvement in some health outcomes. However, methodological weaknesses and particularities of the reported programme settings limit the strength and generalizability of the findings.

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1. INTRODUCTION

In recent years, in order to improve health-care delivery in low- and middle-income countries, it has been proposed that partnerships between private and public health systems be strengthened (1). It is argued that such partnerships would make government funded health-care services more accountable, transparent and efficient. In this context, public–private partnerships usually involve contracting out the delivery of health-care services to private providers. In recent years, in low- and middle-income countries, strategies involving contracting out of health services have increasing been employed, but firm evidence of their effectiveness is still lacking. This review (2) seeks to evaluate whether contracting out health-care services improves access to health-care services and health outcomes for people in low- and middle-income countries.

2. METHODS OF THE REVIEW

The review authors searched the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE and databases of studies on developmental economics. They also collected information from web sites and online resources of international agencies, organizations and universities. The study period of the review was November 2005 to May 2009.

Contracting out of health-care services was defined as the provision of health-care services on behalf of the government by non-state providers. The authors sought to include studies that had objectively measured at least one of the following outcomes: health-care utilization, health-care expenditure, health outcomes or equity outcomes. Another inclusion criterion was the use of one of the following study designs: randomized controlled trial, non-randomized controlled trial, interrupted time series analysis or controlled before and after study.

3. RESULTS OF THE REVIEW

Three studies met the inclusion criteria. With regard to the use of health services, in one study (a cluster randomized controlled trial conducted in Cambodia) there were differences in two out of eight outcomes measured; an absolute increase of 21% and 19% in use of public facilities and uptake of vitamin A, respectively. In a controlled before-and-after study conducted in Bolivia, there was an increase of 20.8% in
the number of deliveries attended by health-care personnel. However, there was no effect on the duration of hospital stay or bed occupancy. The third study (an interrupted time series trial in Pakistan) showed an immediate increase of more than 130% (144% increase in daily visits and 135% in monthly visits), but the effect faded with time. All three studies were judged by authors of the review to have a high risk of bias.

With regard to health-care expenditure, a reduction was found in the trial in Cambodia, but the size of the effect was difficult to estimate (decrease in the range of US$ 15–56 in annualized individual curative care spending). For this topic too the quality of evidence was judged to be low.

The trial in Cambodia also provided information on health outcomes. The probability of individuals reporting that they had been sick in the past month was reduced. There was also a decrease in the incidence of diarrhoea in infants. The quality of evidence also in this case too was low.

4. DISCUSSION

The review suggests that contracting out of health-care services to non-state providers may increase access to, and utilization of, the services. One study found a reduction in out-of-pocket expenditures and improvement in some health outcomes. However, methodological weaknesses and particularities of the reported programme settings limit the strength and generalizability of the findings. The review authors concluded that contracting out may be an appropriate response to scaling up of service delivery in settings such as fragile states or states emerging from conflict.

In the review, evidence was not presented on whether contracting out was more effective than making an investment in the public sector equal to the cost of contracting out. In addition, the introduction of non-state providers into some settings and not others may give rise to many potentially confounding variables, such as the presence of additional management expertise or expatriate doctors, which may improve drug supply or increase utilization.

4.1 Applicability of the results

There is not enough evidence to make a general recommendation regarding the applicability of the findings of this review in low- and middle-income countries. However, we believe, as the review authors do, that there is still room for public–private cooperation in certain circumstances, such as during natural disasters and emergencies and in post-conflict areas and fragile states. In such situations, the most vulnerable people economically could benefit from the dynamism and efficiency of the private sector.

4.2 Implementation of the intervention

In low- and middle-income countries, two aspects that should be considered in contracting out services are availability of private, not-for-profit organizations to provide the desired services, and capacity available within the public sector to establish and monitor the contracts. Both the private and public sectors should install capacity to manage service contracts in order to achieve best results.

4.3. Implications for research

Evidence supporting wider use of public–private alliance to deliver health-care services still remain to be found (3, 4, 5). Further research on this topic should be done using more rigorous methods to avoid the high risk of bias found in studies included in the review. Additionally, as the review’s authors highlight, studies are needed that assess the cost–effectiveness of contracting out compared with using public funds to strengthen the public-sector services. Given the complexity of the intervention, in many cases it may be very difficult to set up a proper evaluative study. In those cases monitoring of contracting out of programmes should be a priority before scaling up of interventions within the health system.
References


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