

SYSTEMATIC REVIEW

Open Access



Community participation and contracting between state and non-state actors in primary care: A scoping review of evidence

Zoheb Khan^{1,2*}, Frederico Haddad¹, Vinodkumar Rao³, Jith J. R⁴, Parvathy Breeze³, Surekha Garimella⁴ and Leslie London⁵

Abstract

Background Health systems worldwide increasingly involve non-state actors in governance and service provision, often to address perceived limitations in public sector capacity to achieve or maintain universal health coverage. Contracts are a key mechanism for structuring such cooperation, enabling governments to define public priorities, specify the resources and services required to achieve them, establish performance requirements for contractors, and define accountability mechanisms. Moreover, community participation in the design and monitoring—or governance—of contracts could enhance the effectiveness of contracting by making services more locally responsive and accountable. This article reviews the global evidence on contracting out—with and without community participation—and its effects on access to primary care services, the quality of these services, and equity in health.

Methods A scoping review was undertaken following the PRISMA checklist for evidence synthesis. A common search string was applied to five databases – SciELO, LILACS, EBSCOhost, Scopus, and Google Scholar – to search for articles relating to our research questions in English, Spanish and Portuguese, with no restrictions on publication date. After three rounds of review, 81 articles were selected from a universe of 3,276 articles and subjected to full data analysis. These were complemented by 14 handpicked articles meeting our study criteria and 26 supplementary references.

Results We find that community participation in the governance of contracting is rare, but can promote access and quality. However, it requires a contracting environment that supports transparency, cooperation from governments and providers, and resourcing commitments. More generally, contracting is often associated with access gains, but the evidence on quality and equity is mixed.

Conclusions Contracting of non-state providers in pluralistic primary care systems that incorporates the participation of communities in its governance could be a feasible policy to promote universal health coverage while also effecting democratic rights of citizens to participate in healthcare governance. Primary research is required to better understand how to promote meaningful community participation, and to identify the contractual details and features of specific contractual environments that are connected to better outcomes.

Keywords Contracting, Primary care, Plural health systems, Universal health care, Equity

*Correspondence:

Zoheb Khan

zoheb@cebrap.org.br

Full list of author information is available at the end of the article



© The Author(s) 2025. **Open Access** This article is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License, which permits any non-commercial use, sharing, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if you modified the licensed material. You do not have permission under this licence to share adapted material derived from this article or parts of it. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc-nd/4.0/>.

Resumo

Contexto Sistemas de saúde de diversos países têm incorporado atores não estatais na governança e na prestação de serviços, frequentemente para superar limitações percebidas nas capacidades estatais de atingir ou manter a cobertura universal de saúde. Contratos constituem um mecanismo-chave para estruturar essa cooperação, permitindo que governos definam prioridades, especifiquem serviços e aloquem recursos, estabeleçam parâmetros de desempenho e instituem mecanismos de responsabilização e transparência. Além disso, participação comunitária na governança dos contratos pode fortalecer a efetividade das contratações, promovendo serviços mais responsivos às necessidades locais. Este artigo apresenta uma revisão das evidências globais sobre contratação de serviços de atenção primária, com e sem participação comunitária, analisando seus efeitos no acesso, na equidade e na qualidade nos serviços de saúde.

Métodos Foi realizada uma revisão de escopo seguindo os parâmetros do PRISMA para síntese de evidências. Artigos relevantes em inglês, espanhol e português foram procurados em cinco bases de dados – SciELO, LILACS, EBSCOhost, Scopus, and Google Scholar – sem restrições relativas à data de publicação. Após três rodadas de revisão, partindo de um universo de 3.276 artigos, foram selecionados 81 artigos. Esses artigos foram complementados por 14 artigos selecionados manualmente a partir dos critérios de relevância e 26 referências suplementares.

Resultados A revisão indica que, apesar de rara, a participação comunitária na governança de contratos pode promover acesso e qualidade. Contudo, para que isso ocorra, é necessário um ambiente de contratação que fomente transparência, cooperação entre governos e prestadores e comprometimento de recursos. De forma mais ampla, a contratação de serviços de atenção primária é frequentemente associada a incrementos de acesso, mas as evidências relativas a efeitos sobre qualidade e equidade são dúbias.

Conclusões A contratação de agentes não estatais em sistemas de atenção primária plurais que incorporam participação social em sua governança pode ser uma política apta a promover a cobertura universal de saúde, bem como a perseguir direitos democráticos de cidadania relativos à participação na governança de saúde. O aprofundamento de pesquisas primárias se faz necessário para entender melhor como promover a efetiva participação comunitária e para identificar aspectos e características de relações e ambientes contratuais relacionados a melhores resultados.

Resumen

Antecedentes Los sistemas de salud en todo el mundo involucran cada vez más a actores no estatales en la gobernanza y prestación de servicios, a menudo para superar limitaciones percibidas en la capacidad del sector público para alcanzar o mantener la cobertura universal de salud. Los contratos son un mecanismo clave para estructurar dicha cooperación, permitiendo a los gobiernos definir prioridades, especificar servicios e asignar recursos, establecer requisitos de desempeño y mecanismos de rendición de cuentas. Además, la participación comunitaria en la gobernanza de los contratos podría aumentar su efectividad, logrando servicios más receptivos y responsables localmente. Este artículo analiza la evidencia global sobre la contratación externa —con y sin participación comunitaria— y sus efectos en el acceso, la calidad y la equidad en los servicios de salud.

Métodos Se realizó una revisión exploratoria siguiendo la lista de verificación PRISMA. Se buscaron artículos en inglés, español y portugués en cinco bases de datos —SciELO, LILACS, EBSCOhost, Scopus y Google Scholar— sin restricciones de fecha. Después de tres rondas de revisión, se seleccionaron 81 artículos de un universo de 3.276. Estos fueron complementados con 14 artículos seleccionados manualmente en base a los criterios de relevancia y 26 referencias suplementarias.

Resultados Encontramos que la participación comunitaria en la gobernanza de la contratación es poco frecuente, pero puede promover el acceso y la calidad. Sin embargo, esto requiere un entorno de contratación que favorezca la transparencia, asegure la cooperación de gobiernos y proveedores, y establezca compromisos claros de recursos. En términos más generales, la contratación suele asociarse con mejoras en el acceso, pero la evidencia sobre calidad y equidad muestra resultados mixtos.

Conclusiones La contratación de proveedores no estatales en sistemas pluralistas de atención primaria que incluye la participación comunitaria en su gobernanza podría ser una política viable para promover la cobertura universal de salud y, a la vez, hacer efectivos los derechos democráticos de los ciudadanos en la gobernanza de la salud. Se requiere investigación primaria para comprender mejor cómo promover una participación comunitaria significativa, e identificar los detalles contractuales y las características de entornos contractuales específicos que están vinculados a mejores resultados.

Introduction

Contracting out by public authorities to non-state providers of primary care services is a mechanism said to improve access to and quality of healthcare, reduce inequalities, and promote accountability and transparency. The involvement of community representatives or organisations in the contracting process is often expected to facilitate these positive outcomes. In this paper, we review the evidence about the extent to which contracting out in its various forms—with and without community participation—has fulfilled these expectations.

Primary care—defined by the World Health Organisation (WHO) as the cornerstone of sustainable health systems [1] — provides the setting for our analysis. “Contracting out” in primary care refers to a governmental entity recruiting a non-governmental entity – such as a private company managing a hospital, a non-governmental organisation (NGO) running a clinic, a community-based organisation (CBO) running a small healthcare unit, or even a group of private professionals – and then supervising it, to deliver a set of public services on its behalf, using infrastructure which may or may not remain publicly owned [2–4]. Primary care focuses on the preliminary stages along the spectrum of care – that is, health promotion (such as handwashing, exclusive breastfeeding, and other behavioural change programming like smoking cessation); prevention (regular screening, promotion of safe sexual and reproductive health practices, immunisation) and treatment of uncomplicated illnesses and injuries. Its capacity to forestall more expensive and complex treatment and curative care can bring down the overall costs of public health and allay catastrophic out of pocket expenditure (OOPE) for individuals and families. Moreover, many primary care services can be delivered effectively without complex infrastructure. While advanced primary care centres may include diagnostic equipment like x-ray or ultrasound, even basic clinics can provide essential preventive and curative services that reduce costly hospitalisations [1, 5, 6].

This capacity to deliver effective care at varying levels of complexity helps explain why primary care is often viewed as amenable to delivery by non-state providers, such as CBOs. Expanding the range of healthcare providers providing public services through contractual arrangements with the state could, in theory, take pressure off the state in the pursuit of universal health coverage (UHC): the achievement of access to high-quality, affordable, and easily accessible care services for all, from health promotion and prevention through to treatment and palliative care. It is an ambitious goal: while gains in service access have been recorded around the world since 2000, as of 2021, the regional UHC service coverage index stood at 43% in sub-Saharan Africa, 59% in South

Asia, and 76% in Latin America and the Caribbean [7]. Catastrophic OOPE also remains high and, in most countries, is growing (*ibid*).

The increasing incidence of contracting out to non-state actors also reflects ideas related to the governance of plural health systems, and a political discourse that frames state and non-state actors as having complementary strengths and weaknesses. For example, this discourse often frames governmental provision as suffering from inordinate red tape and a lack of responsiveness, with non-state actors typically seen as more flexible and innovative. At the same time, the state is regarded as unique in its power to regulate, to enforce legislation, and to consolidate public objectives. This points to roles for the state in coordinating often fragmented service provision by multiple actors, and in safeguarding and promoting the public interest by defining provider roles and responsibilities and public health targets [3, 4, 8–11].

One way to operationalise these roles is through contracts. Ideally, contracts could define shared standards for performance, align these standards with the public interest, and organise the provision of care accordingly. Where agreed-upon standards are not met, the state could theoretically revert to public provision or find another provider (though this incurs costs for the state) [8, 12, 13]. Transparent contracts with well-defined indicators for service quality could also facilitate performance monitoring by and accountability to communities, and build engagement and trust in the health system [3, 14]. Community involvement in the actual elaboration and monitoring of the contracts could also lead to a service environment that reflects and accounts for local needs and priorities [15–17]. In all, this could improve the standard or quality of care. Moreover, this different model of governance could help to rebalance decision-making power in favour of the people who rely on these services. This could be a useful counterweight to the potentially collusive interests of governments and private actors [18].

Indeed, a number of reviews have identified many challenges arising from growing private participation in the health sector, whether this participation relates specifically to contracts in primary care [2, 4, 19–22] or to public private partnerships more broadly [23–27]. These challenges include inadequate regulation and/or its indifferent enforcement by public bureaucrats; rising administrative costs; progressive deterioration in state capacities to directly deliver services; and limited human and financial resources devoted to monitoring the quality of privately provided services, to building functional information systems, and to building capacities to design and implement contracts in the public sector.

This review therefore explores the evidence about how community participation affects contracting between

state and non-state actors in primary care, and how contracting more broadly—whether including community participation or not—shapes access, equity, and service quality. We break this broad objective into four research questions. Our primary question focuses on community participation, based on a smaller portion of the literature:

- a) How is community participation conceived and embedded in contracting systems in primary care and how does it influence the performance of contracted services?

While community participation in the governance of contracts is identified as a potential mechanism for producing more accountable, higher-quality primary care (see for example [14, 20, 22, 28]), most of the contracting literature addresses other mechanisms for doing so. Many examine payment models used to deliver the services or the enforceability of contractual provisions (for example [29–32]), while others approach accountability as achievable through a process of building trusting relationships between contracting parties (for example [13, 14]). Contextual features of the specific contracting environment are also frequently highlighted (as in [33–36]). Our next step was therefore to examine this broader contracting literature - where community participation is typically absent - to identify the conditions under which contracting succeeds or fails. This analysis points to possibilities for where and how community participation could be integrated. We answer the following questions:

- b) What kind of contracting arrangements for primary care exist across the world?
- c) How do these contracting systems affect access, equity, and quality of health services?

Finally, in several countries, rights of ordinary citizens to participate in the health sector policy process (and by extension, in contracting) are constitutionally guaranteed—as in Brazil—or have been otherwise coded in legislation, for example in South Africa, India, and Thailand [37–39]. Participation is a mechanism to fulfil the more fundamental citizenship right to health, for which states have obligations under international human rights law. In achieving the highest attainable standard of health, states are also required to take “steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities [23]”. Contracts—in their design, implementation, and monitoring—could be useful tools to codify, promote and realise the rights to health and to participation.

Our final research question is therefore:

- d) To what extent are these contracting systems placed within a human rights framework?

In the next section, we outline the methodology applied to these research questions, which is followed by an analysis of the results, ordered from research question (a) to (d). We conclude in the discussion section, where we summarise the major insights from the limited literature relating to community participation in the contracting of primary care around the world. We then speculate as to how the answers to questions (b) to (d) from the broader contracting literature could be useful in the design and implementation of future contracting interventions that involve communities more meaningfully. In addition, we highlight the most convincing evidence about how payment modalities; types of contracts, and contracting environments may be related to access, equity, and quality.

Materials and methods

We carried out a scoping review using the framework of Arksey and O'Malley [40]. We supplemented this framework with the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews) checklist to enhance transparency and reporting quality [41], included as an additional file (“Additional file 1”), and updated methodological guidance provided by the Joanna Briggs Institute (JBI) for scoping reviews [42, 43]. A scoping review is a descriptive study that systematically and comprehensively maps the evidence on a particular subject using a variety of academic and non-academic sources. It is useful in identifying research gaps and exploring the usage and application of concepts [44]. Community participation in contracting systems is still a relatively under-researched phenomenon and is an area of study that could therefore benefit from such a methodological approach.

The review followed the five key stages outlined by JBI: (1) identifying the research question(s); (2) identifying relevant studies; (3) selecting studies; (4) charting the data; and (5) collating, summarising, and reporting the results. The search for published studies was carried out in July and August 2023, with no initial limit on the publication date. A protocol for the scoping review is available at <https://complusconsortium.org/wp-content/uploads/2024/11/COMPLUS-Scoping-Review-Protocol.pdf>, and is also included as an additional file (“Additional file 2”). This protocol references the work of our research consortium—Community Voices in Health Governance: Translating Community Participation into Practice in a World of Pluralistic Health Systems, or “COMPLUS”—which focuses on strategies to expand community voice in the

governance of primary care in large cities in India, Brazil, and South Africa. This scoping review is one of three undertaken by COMPLUS to support this project.

To define the scope of our review, we structured our objectives using the Population, Concept, and Context (PCC) framework [42] as follows:

Population (P) includes all stakeholders involved in primary care governance and contracting processes, specifically:

- Community members and their representatives (for example, CBOs, community health workers, and citizen health councils).
- Public health authorities, policymakers, and bureaucrats.
- Non-state actors and providers (such as NGOs, private companies, and healthcare professionals).
- International or national funding bodies involved in primary healthcare contracting.

Concept (C) involves the contracting out of primary care services, examining specifically:

- The extent and forms of stakeholder (particularly community) participation in the design, implementation, and monitoring of contracts.
- The effects of various contracting arrangements on access, equity, and quality of primary care.
- The integration and operationalisation of human rights principles within contracting processes.

Finally, context (C) refers to pluralistic primary healthcare systems globally, characterised by a diverse set of service providers and encompassing diverse socioeconomic, geographic, and policy contexts.

Search strategy

The first step of the review process—identifying the research questions—is explained in the introduction. For the identification of studies (step two), we used a common search strategy across five databases—EBSCOhost, Scopus, Google Scholar, SciELO, and LILACS—using the search string shown in Table 1:

Exactly the same English-language keywords were used across the five databases, with results in English, Spanish and Portuguese considered for review. Modifications to syntax were made based on the different requirements of each database (placement of brackets, asterisks etc).

Study selection

In the selection of studies from the databases (step three), we included peer-reviewed journal articles and book

Table 1 Search string

("mixed health**OR"uni* health**OR"plural* health**OR"primary health**")
AND
("incentive**OR"performance"OR"motiv**OR"payment"OR"behavio**OR "quality"OR"access"OR"equity"OR"right**OR"justice"OR"participation"OR"accountability"OR"monitoring"OR"community**")
AND
("contract**OR"purchas**")

Table 2 Search results per database

Database	Number of articles obtained in the first search using the string directly
EBSCOhost	876
Scopus	191
Google Scholar	218
SciELO	2,082
LILACS	573
Total articles from the five databases	3,940
Duplicate articles deleted	664
Total unique articles	3,276

chapters, as well as original research reports from recognised organisations (such as the World Bank and the Health Foundation). We excluded conference papers, editorials, and commentaries. In the first round of study selection we included articles that presented empirical data or conceptual analyses related to the contracting out of primary care services by public authorities to non-state providers, and that enabled us to answer one or more of our four research questions.

For the selection, databases were divided among reviewers, and the following numbers of articles were obtained (Table 2):

To eliminate articles that were not relevant to the scope, all articles were reviewed by their title and, where title did not clearly indicate the purpose, by abstract. Relevance was decided based on evidence of contracting of primary care services by a public body to a private body. At the end of round one, 399 articles were tagged as included; 150 as maybe.

In round two, the exclusion criteria were further tightened and articles with the following attributes were discarded, with reference to the work of our wider research consortium. The review focussed only on abstract, but where abstracts did not clearly indicate attributes around these criteria, the entire article was reviewed to reach a decision. We excluded:

1. Studies that had no urban component and that did not involve primary care.
2. Studies of financial performance of health systems without reference to any contracting.
3. Studies in which contracting is used analogously to registration, such as when a patient registers at a general practice and “contracts” with a certain physician.
4. Studies not involving state or public health services as one of the parties to the contract.
5. Because public private partnerships expanded significantly in the late 1990s [45], we selected the year 2000 as the starting point for our review. This ensures a focus on the period when contracts would have become a prominent policy tool, while also capturing more recent developments in the field.
6. Studies addressing “contracting in” or “internal contracting”, where a public agency staffed by government employees takes a contract, or where contracting is used as a managerial tool as part of a decentralisation process. This is because our primary interest is in the contracting of non-state providers to deliver primary care in plural health systems characterised by a diversity of providers, as a potential tool to coordinate disparate actors around public health objectives, notwithstanding our recognition that internal contracting between different state actors may occur.

Exceptions were made where articles provided useful conceptual or other insights. For example, Palmer and Mills [13] is a study of rural South Africa, but its discussion and application of the concept of relational contracts, as well as the insights about accountability, were highly relevant and transferable to our research context.

For round two reviewing, no reviewer was assigned articles they had reviewed in round one. By the end of this round of screening, application of the above criteria left us with 273 articles.

By the end of the third round of screening, which entailed review of the full text of each of the 273 articles, 81 articles remained. To the 81 shortlisted articles identified using our search strategy, 14 handpicked articles relevant to our research questions were added, based on the prior knowledge of the authors. Because of the relevance to our research questions, these 95 articles were then subjected to data extraction, where reviewers extracted relevant answers to each of our four research questions. This approach aligns with scoping review guidance [for example, 41,42,43], which explicitly recommends identifying additional sources through prior knowledge when systematic searches miss important material. Finally, 26 supplementary references provide definitions, methodological guidance and contextual grounding. These 26

sources were not subjected to data extraction, because they did not directly contribute to answering our research questions [42, 43].

Data charting and extraction

Data were extracted and charted (step four) using a structured Microsoft Excel-based data extraction matrix specifically developed for this review. The title row of the matrix comprised a series of columns corresponding to key analytical dimensions. Reviewers populated these columns with short, synthesised paragraphs for each included study, facilitating thematic synthesis.

The following fields were included in the extraction tool:

- Study focus and scope: Study objectives, relevance to the review questions, type and design of the study, and countries or regions covered.
- Study population: Description of the actors or groups involved in the study (for example, communities, policymakers, providers).
- Findings and contributions: Key results, findings, and recommendations.
- Conceptual and contextual information: Key concepts and definitions used in the study, and the type of contracting arrangements described.
- Rights-based orientation: Whether and how the contracting systems were situated within a health and human rights framework.
- Equity and quality considerations: How contracting systems aimed for and/or achieved equitable access and quality of health services.
- Community participation: Whether and how the article addressed community participation in contracting processes.
- Accountability mechanisms: What forms of accountability were described and how they were embedded in the contracting systems under study.

Summary of the data

In a table included as an additional file (“Additional file 3”), the studies under review are summarised according to the research questions to which they contributed data and insights (step five). In this section, we provide a descriptive overview of the articles. 17% of articles reviewed and subjected to data analysis were published between 2000–2009, 54% between 2010–2019 and 28% from 2020 onwards. Using the World Bank national income classifications [46], four, 16, 35 and 31 articles included data and analysis of Low Income Countries (LICs), Lower-Middle Income Countries (LMICs), Upper-Middle Income Countries (UMICs), and

High-Income Countries (HICs) respectively. Ten articles cited data from countries across economies. Brazil is the most represented country, covered in 16 studies, followed by the United Kingdom (UK) with 15 and South Africa with 8.

The reviewed articles were largely qualitative case studies and cross-sectional assessments, with a small minority tracking changes in healthcare indicators quantitatively over time. Nine studies were review-type articles, including four systematic reviews and two scoping reviews. The majority of articles (over 90%) are from peer-reviewed journals, and the remainder were published as reports by international/academic organisations (five) and as a master's thesis (1).

Figure 1 summarises the scoping review steps.

Results

Introduction

We begin the results section in sub-section (a) by providing an overview of how community participation in various contracting environments has been covered in the contracting literature. Thirty-one of the total number of articles under review addressed community participation in contracting in some way, with the largest number ($n=11$) of these studies conducted in Brazil. We are primarily interested in the effects of community participation in the governance of contracting. We define this as individuals and/or their representatives being involved in one or more of the following ways: having inputs in defining the goals of contracting, in negotiating the details of the contracts themselves—such as service and reimbursement levels—or in monitoring the contracts. A small minority of studies are detailed examinations of the contexts of effective or ineffective community participation in contracting in this sense. In other studies directly examining community roles, CBOs deliver services, acting as contracted service providers. The remaining studies addressing community participation in contracting did so tangentially rather than as a primary focus. These include: (1) analyses where participation arises incidentally—for example, as a minor element of the contracting environment (for example, mention is made of research on patient satisfaction); (2) studies that mention it only in recommendations; or (3) research examining indirect participation or influence, such as the pressure exerted by the need to maintain positive community-provider relationships. In the results, we therefore separate the findings according to these three different approaches.

In sub-sections (b) to (d), we review the broader literature on contracting out to understand the different forms contracts have taken; how contracts with non-state providers have influenced access to, equity in, and quality of

primary care services, and how human rights have been incorporated into different types of contracts.

The role of community actors in contracts and mechanisms of accountability

Direct roles in governance

Barboza et al. [47] argue that effective community participation in governance requires more than just a legal right to it—it depends on the state creating an enabling environment. This enabling environment is sustained by strong information systems, transparency, and a cooperative attitude from policymakers. Even in Brazil, which has a strong legal framework for community participation in governance, these conditions have not always prevailed: the authors document how low-quality data and often the withholding of information by government and service providers have impeded effective community participation. They further highlight that accountability fundamentally depends on access to reliable information about the performance of contractors. This requirement has not been fully satisfied in the state of São Paulo, according to a parliamentary commission of inquiry (ibid).

The frequent withholding of information is argued by some to be a reflection of unsustainable private interests in public healthcare [22, 48]. In Rio de Janeiro, private companies contracted to introduce management information systems (MIS) to track the performance of contractors developed software that was prone to glitches, to the extent that the information produced by the new systems was not deemed trustworthy by any of the contracts' stakeholders [28]. Significant information technology (IT) glitches have affected the performance management systems of other Brazilian states as well. When this coincides with weakly specified penalties in contractual provisions, this expands moral hazard and potential opportunistic behaviour among providers [49]. The São Paulo parliamentary commission referenced above also revealed substantial shortcomings in contracted services, despite a large expansion in the service network. The findings documented multiple irregularities, including diversion of public resources, favoritism, failure to meet agreed goals, and “serious deviations” in expenditure earmarked for health services. But contracts have not been terminated at a rate that matches the frequencies of these irregularities. Moreover, the commission argued that fragmentation of service delivery – that is, lots of contracts with many different entities – further complicates social and governmental monitoring functions [47]. These information asymmetries work to the detriment of community participation.

In addition, despite being entitled to participate in decision-making bodies in the health sector through

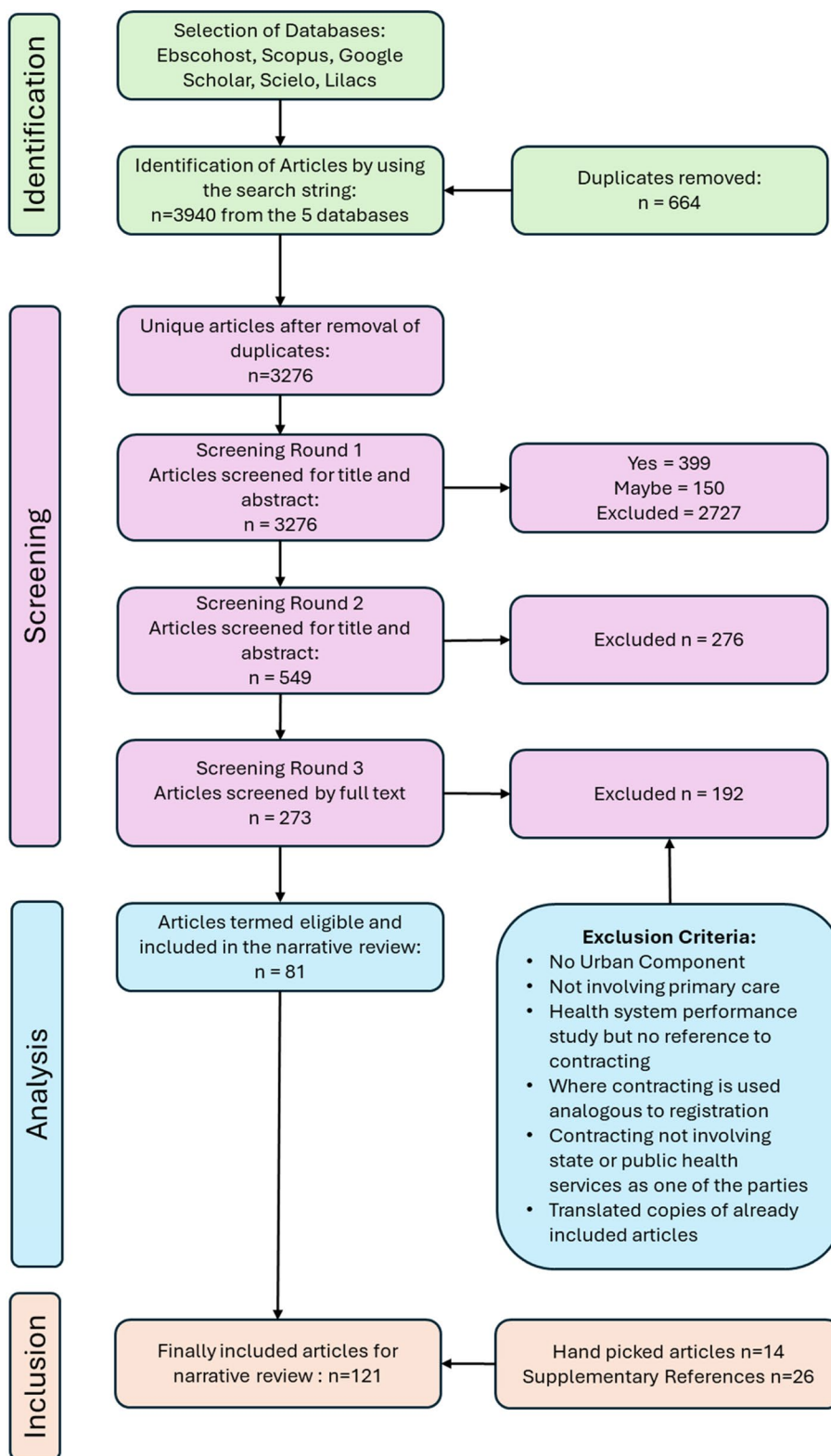


Fig. 1 Study selection process

“social control” structures, community members are often not involved in the design of contracts and the targets underlying them [9, 50]. Citizens’ roles in health system reform have also been limited by a policy design that codifies participation of institutions rather than individuals, and that imposes “enormous” supervisory responsibilities without always ensuring that the required capacities (time, skills, experience) are in place to carry them out effectively [51]. Finally, accountability is often limited to audit and expenditure control (ibid).

Other evidence suggests that contracting in Brazilian primary care prioritises operational considerations over community needs. Service provision is often planned primarily around supply factors, such as the availability of medicines and installed capacity, rather than demand-based factors, or the existing health needs in the region. This leads to the imposition of a standardised, highly uniform model of primary care services that is disconnected from community needs, effectively reverse-engineering needs to fit existing resource supplies [49, 52].

Nonetheless, various additional studies point to the benefits of functional community participation in the governance of contracting.

Zermiani et al. [53] analyse the participation of local health councils in defining the goals of contracting non-state providers and in influencing the work processes of primary care teams, through interviews with municipal health employees, in Curitiba, Brazil. The councils are composed of an equal split between service users and other community members, which include health workers, municipal employees, and professionals. Most interviewees saw the councils as having very little input in negotiating contracting goals. However, influence over work processes is perceived to be greater, with staff noting the usefulness of the information provided by the councils in helping providers to understand community characteristics, anticipate service delivery challenges, and formulate access improvement strategies.

In Gharaee et al. [54], contracted primary care services in Iran included a “people’s board of trustees” in the governance of each health centre. These boards of community members contributed to operational planning, assisted in operations, and did active community outreach to increase the uptake of services. Analyses of stakeholder interviews show a common perception that access to primary care has improved, especially among poorer communities, though the link with the workings of the boards is not explicitly made. In a review of quantitative studies, Loevinsohn and Harding [3] find that in Bolivia, NGOs were contracted to address high local maternal and infant mortality rates, and community members were enlisted to participate in contract management along with officials from the municipality and

health ministry. Through an impact evaluation, the project was evaluated as successful in improving the quality and coverage of care, but whether this success is partly attributable to the inclusion of communities in governance, rather than the contracting model, is not addressed.

Direct roles in service delivery

In other cases, community-based entities are contracted to deliver primary care services, for example indigenous community-based care organisations in Canada, New Zealand and Australia [20, 55, 56]. Lavoie further highlights the role of indigenous communities in governance in Australia, through Regional Aboriginal Health Boards [20]. These models were designed to produce more contextually relevant and responsive care by incorporating local priorities into service delivery, and they have often been successful in this aim. However, this success is often undermined by standardised, centralised and inflexible governmental contracting requirements and performance measures. The administrative burden this imposes—particularly on smaller CBOs with limited resources—frequently exceeds their capacity, forcing them to divert effort from core service delivery. This has led to accusations of the state knowingly discharging its responsibilities onto entities ill-equipped to fulfil them, a critique that resonates in South Africa [57]. The disruptions to service provision exacerbate the healthcare gap between indigenous and non-indigenous populations. Inequitable and often short-term, highly competitive funding models exacerbate these problems and inhibit the CBOs’ longer-term planning.

In the review by Loevinsohn and Harding [3], a Senegalese community-based nutrition intervention run by groups of unemployed youth in their communities is highlighted as another form of community participation. These community workers received training and supervision from an NGO. An impact evaluation found the model to be successful in improving nutrition outcomes. Similarly, in a successful initiative in India, the Urban Slum Healthcare Project incorporated community participation by engaging women community health workers (CHWs) to gauge local health priorities and oversee the everyday functioning of Urban Health Centres [58]. In South Africa, CHWs delivering health and social services through contracts with NGOs are argued as potentially having an important role in improving the quality of and equity in service provision, by mediating between the community and the health system in governance [57, 59]. Finally, in Peru, the once widespread use of CBOs to manage primary healthcare centres has been associated with higher levels of user satisfaction (which is itself higher in centres with a higher representation of community members in the governance structure alongside medical staff and public officials) [17]. This model is also

associated with declining rates of infant mortality in the country through the 1990s, though no direct causal relationship is established (*ibid.*).

Tangential engagement, indirect influence, and recommendations

In this subsection we highlight the studies of contracting in primary care that address more indirect forms of community participation, and/or those that recommend it without direct empirical study of its effects. Macq et al. [60], in a critique of contracting systems in four Central American countries, note scarce evidence of these systems having enabled users of health services to voice their opinions, or of having created exit mechanisms allowing users to choose between providers. This contrasts with Tynkkynen et al. [61], where the presence of consumer choice in the contracting out of primary and elderly care services in Finland is taken as a measure of indirect public participation in shaping the healthcare market. In Tanzania, Kuwawenaruwa et al. [62] highlight this indirect role in the process of accreditation and contracting of new non-state providers to public insurance schemes, which can begin with requests from healthcare users, who often prefer non-state and especially faith-based providers.

Sometimes, studies recommend that service users and/or the general public should be consulted about their experiences of contracted primary care services, and that this feedback should be accounted for by healthcare management and incorporated into ongoing planning to improve the quality of care and build closer relationships between providers and communities [63, 64]. Kien-drébéogo et al. [65] relate that the government of Burkina Faso, with support from donors, has established Customer Service Units through which citizens can provide feedback and lodge complaints about the quality of services they have received from contracted providers in its strategic health purchasing scheme; while Kalinichenko et al. [66] note that pay for performance contracts in Portugal often include measures of user satisfaction—which while not denoting participation exactly, implies that community perceptions of primary care services are accounted for in the system. This contrasts with an experience from the UK, where contractual provisions for community influence on healthcare activities failed to materialise in practice, largely due to service providers' lack of familiarity with participatory processes and inadequate capacity to implement them [67].

In a review of (broadly successful) experiences of contracted logistical services for primary care in LMICs, Agrawal et al. [68] further suggest that the public should take more active, participatory roles in the evaluation process, beyond more passive roles as research informants. This would include involvement in the development

of key performance indicators (KPIs) and the monitoring of these KPIs. Potential co-developed, citizen-centred indicators could include the availability of medicines when needed; their affordability; and travel times to obtain them. An important role is cited for “civil society”—ostensibly referring to CBOs—in this process, in marshalling and representing public opinion. This type of community participation would constitute an active role in the governance of contracting, but it is not a current feature of any of the contracting environments reviewed by Agrawal et al. [68].

Another set of studies examines an indirect influence of communities in the contracting context, highlighting how doctors and service providers—motivated by pressure to maintain good community relations—may improve service quality. Palmer and Mills [13] describe how, although communities do not have any direct say in contracts entered into between provincial governments in South Africa and rural general practitioners (GPs), the proximity between GPs and communities exerts pressure on GPs to maintain services of a high quality to maintain their professional reputations. But this proximity is limited as an accountability mechanism in remote locations where an undersupply of medical professionals forecloses easy substitution of underperforming GPs. In China, family doctor contract services enhanced patient-doctor relationships, improved patient satisfaction [69, 70], and the comprehensiveness and continuity of care [71]. The model involves individuals or families signing contracts with doctors for comprehensive, personalised healthcare. These doctors provide primary care, act as gatekeepers for specialised services, focus on preventive care, and are integrated into a wider health system for collaborative and continuous care. Communities could thus indirectly improve contractual performance through improved patient-doctor relationships and better articulation between different parts of the health system. However, direct engagement of communities in the design and operation of these systems appears limited.

Contracting forms and arrangements

Payment modalities

We now move into the broader literature on the effects of contracting in primary care which typically does not include any reference to community participation, to analyse the various types of contracts that have been implemented. In this literature, the most commonly used payment mechanisms are capitation, fee-for-service (FFS), and pay-for-performance (PfP). Each is associated with different incentives for healthcare providers, though as noted by Álvarez et al. [72] in their review of primary care in 14 countries, Habicht et al. [73] in their review of 30 years of primary care reform in Estonia, and Tobey

et al. in a study of payment reform for primary care in the United States [74], most systems combine different payment systems in hybrid models. Below we describe these systems and their theoretical incentives, based in particular on the work of Álvarez et al. [72], Jegers et al. [75], Vengberg et al. [29] and DeVoe and Stenger [30]. We compare this with the evidence later in this review.

In capitation models, service providers are paid a lump sum per patient in a certain period, based on forecasts or historical records of how many patients the provider is expected to serve and of the anticipated costs of different types of healthcare services. The total income for the service provider then depends on the numbers of patients on these lists, regardless of how many activities or contacts with the patient take place. Some argue that such input-based payment systems do not prioritise the quality of the services that the public receives (outputs) and the ultimate effects of these services (outcomes). In many jurisdictions, efforts have thus been made to reorganise the delivery of social services around outcomes (shorter term effects of services like a lower incidence of disease) and impacts (longer term effects like improved population health and fewer resources spent on curative services). In Pay for Performance (PfP) payment models, payments are based on the achievement of outcomes previously determined during the initial contracting phases. In practice, because outcomes are further away than the services (that is, the outputs) that are produced (conceptually and temporally, from the inputs in the service delivery chain), and tend to be influenced by many more factors beyond the direct actions of the service provider, outputs are often used as performance targets instead (or a mix of outputs and outcomes is used).

In cases such as this, Fee for Service (FFS) and PfP systems resemble each other. In Fee for Service (FFS) models, service providers are paid based on the number of services that are provided. Unlike the *prospective* capitation system, but like PfP, FFS is retrospective: the payment to the provider depends on what the provider does. Total income thus varies according to how many services are provided, with providers needing to prove this number at the end of the relevant budgeting period. Financial risk here is transferred to the state or the purchaser of services.

Capitation is expected to result in motives for service providers to decrease the costs per patient and to promote efficiency. This could be achieved by not providing unnecessary services. Health prevention and promotion might also be prioritised as this is generally more cost-effective than treatment. Another benefit is that because costs per patient are usually known in advance, and because service providers do not need to account for service levels after delivery, the administrative burden

on HCWs is reduced relative to FFS and PfP systems. In capitation models, financial risk tends to flow away from payers and towards providers, as they need to ensure that they do not expend more of their own resources on the provision of care than can be covered by the fixed budget.

More negatively, the incentive to reduce the cost per patient could lead to underservicing of patients in need of care. The quality of care might also suffer due to the incentive to reduce the number of follow-up consultations. Providers could also employ risk selection strategies, such as cream skimming and cherry picking – where less complicated conditions and/or patients with fewer health problems are prioritised over those who are relatively sicker. Another form of risk selection is for doctors and service providers to refer more complex patients to other providers. All of this could be summarised by the idea that providers put in less effort when there is no financial motive to put in more effort, the combined result of which is stagnant or declining public health, and in turn deteriorating public trust in the healthcare system over the long term [30].

In practice, policymakers have attempted to reduce risk selection by introducing risk adjustments, which are slightly higher payments that are determined in advance for more vulnerable categories of patients (such as those with specific chronic conditions, the elderly, or people living in vulnerable economic circumstances).

In FFS systems, providers face strong incentives to provide more services, even if these services are unnecessary, unhelpful or harmful for patients. At the same time, the incentive to reduce costs per extra unit of care exists, leading to the same sorts of risk selection strategies as in capitation-based systems. In addition, services and associated fees that are not defined in advance (similarly to risk-adjusted capitation) could mean that patients requiring care along these dimensions do not receive it. Relatedly, “upcoding” can be a challenge, where service providers fraudulently classify a specific service requiring reimbursement in a different, higher-paying category. However, benefits of FFS could include better access to care and potentially more equitable healthcare outcomes, especially if FFS is defined for services delivered to vulnerable groups. This is also true where the demand for services in the context of implementation is great.

However, the quality of services is not expected to be a priority in this model: from a purely financial perspective, it makes sense to provide as many low-quality (and low effort) services as possible to as many people as possible. This contrasts with PfP models that link health outcomes to payments, by measuring and compensating for the actual effects of service provision. PfP thus theoretically incentivises providers to prioritise service quality over quantity. Outcomes-based payment approaches also

typically do not have fixed requirements for how providers should combine inputs and outputs or deliver services. This flexibility could enable HCWs to innovate and respond more agilely to emerging contextual conditions to ensure that performance targets (and in turn public health improvements) are met.

However, as in capitation and FFS models, HCWs are still motivated to employ risk selection: for example, neglecting sicker patients who are less likely to contribute to meeting performance targets. They could also neglect areas of care that are not attached to specific performance targets. Gaming strategies are also a distinct possibility, where, during the contract negotiation period, service providers provide misleading information to contracting authorities about what outcomes are realistic, thus leading to the setting of unambitious targets that might not truly reflect the needs of the service population.

Theories of contracting: classical and relational contracts

The preceding discussion assumes financial incentives contained in a specific contract are the primary motivations for the actions of HCWs. But as we found during the review, non-financial motivations, and the broader context within which contracts are implemented, may also be important. The distinction between classical and relational contracts that is made by some authors is useful in illuminating these issues.

Theoretically, contracting non-state actors into public health systems is a strategy nested within a broader reform agenda relating to “New Public Management” (NPM), where introducing market principles of competition, efficiency, and target-driven service delivery is seen as a solution to the perceived inefficiencies of the public sector—notably its lack of competitors and often large, unwieldy bureaucracies that can be slow to accommodate change in service delivery models as population needs change [3, 8, 13].

Palmer and Mills [13] argue that this theoretical backdrop creates a “paradox”: NPM is grounded in neoclassical economics, which has little explanatory power in understanding why and how contracts are applied, nor the effects of the contracts. Several authors [3, 8, 13] note that in many countries the ideal conditions for contracting do not exist: for example, there are no competitive supplier markets, and the state does not have adequate capacity for contract design, including target setting, monitoring, and performance evaluation. As Chapman [76] notes, this lack of capacity is often the result of policy choices: the same neoliberal political orientation that regards private sector provisioning as more efficient, and which often drives privatisation or contracting, often goes hand in hand with interventions to scale back and

underfund the state. This could then constrain the state in its proposed role as an enforcer and regulator in the contracting environment.

In analysing the effects of contracting, a neoclassical economic approach would look at the terms of the contracts—and specifically the payment mechanisms—to predict how HCWs would respond to various financial incentives—seeing participants in contracts as utility-maximising, rational agents [29]. But financial incentives are only one subset of broader motivation: socialisation, opportunities for promotion, education and training, professional experience, ethics, historical practices, and cultural norms all influence behaviour too. The relative weights of these different kinds of incentives are rarely considered in the literature.

It is also important to look beyond incentives at the individual level in the rational actor model, as they are often tied to the performance of healthcare units (clinics, hospitals). This raises the question of how group-level incentives affect individual behaviour. In addition, healthcare has been theorised as a “complex adaptive system” [77], where behaviour is not a simple function of action and reaction, or cause and effect. Individual actors respond continually to multiple, predictable and unpredictable influences, and actions have a cumulative effect such that it can be difficult to pinpoint the exact moment or factor that led to a significant change. The continued, iterative model of relationships over time, rather than their being defined by a contractual setting, also suggests that building relationships with patients, communities and funders could be a better long-term strategy than responding to the shorter-term incentives that a specific contract introduces. Understanding healthcare as a complex adaptive system also reveals the limitations of neoclassical economics in accounting for the significant transaction costs involved in designing, implementing, and monitoring contracts, as it assumes “costless transacting, perfect foresight and complete information” [13 p1,006].

A useful distinction is thus made in some studies between “classical” and “relational” contracts to more meaningfully account for the real-world characteristics of the contracting process and the extent to which these characteristics are incorporated into the contracts themselves [13–15, 55]. Theoretically, classical contracts cover transactions of limited scope, and that are anonymous, clearly measurable, and unlikely to be repeated. Relational contracts, however, govern typically repeated relationships where exactly what is required from service providers is difficult to define and monitor. When the services under contract are more specialised (asset specificity), it can be harder to predict and manage future outcomes (bounded rationality), which increases the odds of

either party acting self-interestedly at the other's expense (opportunism). This makes contract management more complex [13]. The effects of these types of contracts are discussed in the following sections.

The influence of contracts on access, equity, and quality of healthcare

Introduction

In this section we analyse the effects of contracting in primary care on three fundamental dimensions of health system performance: access to services, equity in the services provided, and the quality of services. Access is often indicated by coverage, that is, the proportion of the population with health services that are within reach. Utilisation of services is another measure of coverage. Quality is a more complicated construct [78], with many different measures, including customer satisfaction, the skills of professionals and managers, the effectiveness of services (whether they solve the healthcare problems they intend to), the efficiency of services (if service provision uses scarce resources optimally), the relevance of services (whether they tackle the actual needs of the people where they are delivered) and the extent to which the operating environment for the providers of the services respects their workplace rights and other aspects of their well-being. Finally, equity can refer to both access (is coverage and utilisation of services fairly distributed between different groups of the population?) and to quality (are the services that different groups receive of comparable quality?).

This section begins with a discussion of the generally positive evidence linking contracting with gains in access and equity, before delving into the more mixed effects on service quality. Because effects on service quality vary substantially, in the last subsection we explore the influences of different payment systems, contracting types and implementation environments, and broader contextual factors on contracting effectiveness.

Access and equity in contracted services

In most cases, contracting out is associated with improvements in access to primary care services. Public officials in Iran perceive this to be true after adopting contracting out, especially among poorer communities—thus implying improvements in equity as well [54]. In Portugal, longitudinal analyses of a set of primary care indicators show improvements in accessibility and service coverage, and utilisation of family planning and cancer screening services [12], with access and quality improvements also supported by qualitative work [79]. In a review of contracting out based on studies using at minimum a pre- and post-test analysis, usually comparing contracted out services with normal public delivery, Loevinsohn and Harding [3] show significant access

improvements, often with service provision to millions of beneficiaries. One study in this review specifically addressed equity: in Cambodia, contracts included targets for groups of poor people, leading to better-quality service provision to them, which in turn reduced inequalities as the poor benefited disproportionately from a better distribution of services. In systematic reviews by Liu et al. [2], access improves generally, and in Ghoddoosi Nejad et al. [19], equity in terms of service quality for different groups and affordability of services tends to improve as well. Equity is also enhanced through pro-poor targeting and utilisation in Afghanistan [15] and additionally, through reducing OOPE in Bangladesh [16, 80].

Quality of contracted services

In Loevinsohn and Harding [3] quality—indicated by the effectiveness of services and the standard of care—improves in all cases that constitute their review. Large double differences (between contracted and not-contracted units, and between baseline and endpoint) are observed in outcomes that are amenable to short-term change, like immunisation and antenatal care coverage, while smaller changes are seen in those requiring behavioural change, like family planning and institutional delivery. Contracted services in this study are also typically cheaper from the perspective of the state, and even where they proved more expensive than governmental delivery, lower OOPE for users of contracted services was achieved.

But usually, and unlike the case of access, the evidence for the benefits of contracting on service quality—including cost—is less unequivocal, as noted in Liu et al.'s systematic review [2]. Below, we discuss some of the trends in the literature.

Subsequent to Loevinsohn and Harding's review, several cases of contracting out have shown impressive statistical results. Coelho and Greve [8] find, using representative survey data, that between 2001 and 2016, municipalities in the state of São Paulo with a greater proportion of indirect hiring (a type of contracting out), reduced hospitalisations for conditions sensitive to primary care, infant and child mortality, and hospitalisation for acute respiratory infections. These quality improvements were achieved at the same time as significant expansions in access to services, especially in peripheral urban areas with high concentrations of multi-dimensional poverty. Similarly, the Urban Slum Healthcare Project, where primary care was contracted out to NGOs in Andhra Pradesh, has been linked to a 42% decline in the infant mortality rate (IMR) and a 6% increase in the institutional delivery rate; performance far exceeding the state averages [58], while a long-term public–private partnership for primary care in

Bangladesh modelled along the same lines is associated with reduced child mortality and incidence of sexually transmitted infections [81].

Some qualitative studies also show promising results. In Tanzania, contracted non-state providers (NSPs) participating in state-run social insurance funds improved the quality of their services partly through better staffing of skilled HCWs at facilities serving insurance beneficiaries. Improvements may also have been driven by both a competitive supplier environment and the ability of beneficiaries to select (and presumably deselect) healthcare providers [62]. In the absence of competitive provider markets, many states introduce contracting primarily as a managerial tool to introduce a performance-oriented culture. In Iran, stakeholders perceive that this new focus on monitoring has the desired effects on service quality, with one potential causal pathway being increased motivation among HCWs who rally around new, or more concretely specified, shared objectives [54].

But in a review of contracting out in Afghanistan, Bahrain, Egypt, Iran, Pakistan, Jordan, Lebanon, Morocco, Syria and Tunisia, the effect on the quality of services is far less straightforwardly interpreted than that on access, which typically improves [4] (access improvements in terms of service utilisation are reiterated in a later systematic review on the positive effects of contracting out in the region, with quality not addressed in this later review— [21]). Quality may frequently be assumed by stakeholders to have improved, but this is often difficult to verify. Accreditation of providers, which could be used as a way to benchmark and guarantee service quality, is a process that similarly suffers from a lack of transparency [4]. This may explain results in Pakistan, where despite access improvements, there are no discernible quality improvements, while in Lebanon, contracting out has led to spiralling cost and marked inefficiencies (*ibid*). Cost-effectiveness is also questioned in studies of experiences in Portugal, the UK, Spain and Australia [82, 83], where the authors argue that the true costs of contracting are never fully known, and typically end up being higher than anticipated during contract design, due to ongoing and significant transaction costs. Yet in a systematic review of (just two) studies analysing a statistical counterfactual [84], the only positive effect of contracting out is reducing OOPe for patients, with contracting out making little or no difference relative to government provision in immunisation rates for children, or antenatal care visits and use of contraceptives among women. In Pakistan, the influence of contracting out to NGOs relative to non-contracted control units was evaluated along 20 performance indicators, with only patients' inclination for facility-based delivery showing a positive, statistically significant improvement in contracted units [85].

Another interesting finding is that contracts have sometimes introduced new logics of productivity, competition and performance management into the public service that are not always compatible with the logic of providing care to people. For example, contracts signed in Rio de Janeiro set minimum numbers of home visits for each professional per week, and also shifts for teamwork, health monitoring, and administration tasks. This has restructured the work of these HCWs, with less time available for health “mobilisation and education”, that is, the preventive work in communities through education about the social and other determinants of health. Similarly, HCWs report needing to work more quickly on home visits now, which reduces quality time with patients and makes it more difficult to build and maintain relationships with patients: they do the minimum that is set down in the contracts. This leaves less time to gauge and respond to real community needs, or to what is causing illness. HCWs increasingly report dealing with symptoms, undermining the focus on primary health [9]. Performance-based contracts in the context of home-based early childhood development programming in Cape Town had similar effects, though these perceptions were at odds with quantitative measures of the improved quality of services [86]. In the same results-based initiative, a separate project targeting primary care for expectant mothers fell apart as negotiators failed to agree on targets to measure high-quality antenatal care, with HCWs insisting that qualitative, relational factors between HCWs and women were as important in the delivery of services but less measurable than quantitative targets (*ibid*).

Some studies highlight the limitations of broadly successful projects. In Iran, quality improvements were bounded by structural determinants of health that are often the purview of other government departments, with intersectoral action regarded by health sector stakeholders as difficult to initiate and sustain [54]. Relatedly, Indian NGOs successful in delivering primary care services began to face demands from communities for services beyond their capacities—chiefly for more complex hospital-based care [58]. Additionally, efficiency and operational gains from contracting out can sometimes be gained at the expense of primary care staff. In Brazil, flexibility in hiring at facilities managed by social health organisations (a type of NGO) has been linked to worsening working conditions, leading to high turnover of staff [87]. The pursuit of contractual goals that are detached from local needs has also been observed in various settings [85, 87].

Melo et al. [48] highlight an important distinction between the achievement of contractual goals and the quality of healthcare. In their systematic integrative

review of this relationship, they argue that most studies about contracting do not explicitly conceptualise the quality of healthcare. Instead, studies often assume that meeting contractually-defined indicators or targets is equivalent to delivering high-quality services. In two of just four included studies, no causal relationship between achievement of contractual goals and the quality of the services in question is established. In the other two studies, the authors argue that a relationship cannot be determined, because the measurement methods and indicators for quality used in the studies are different from those that are established in the contracts. The conclusion reached is that there is no evidence that contractualisation directly improves the quality of healthcare services.

In contrast, the effectiveness of contracting non-clinical services is unambiguous in Agrawal et al. [68], a review of contracting out in healthcare supply chains in Senegal, with reference to similar successful projects in South Africa, Kenya, and Nigeria. In Senegal, hiring a private third-party logistics provider (3PL) led to large reductions in distribution costs and the elimination of stock-outs of vaccines and medicines—with the latter being a previously common occurrence. This was combined with the introduction of an inventory management system and new data tracking methods, by another private contractor. In these less complex services (in relation to clinical care services), which could perhaps be governed by more classical-type contracts, key theoretical advantages of contracting out seem more achievable: competitive supplier markets of more agile private logistics companies supplying knowable quantities of goods of directly observable quality. Success factors across the countries analysed include a willingness to enforce terms of contracts, retraining of government staff away from logistics roles, and transparent tendering processes. Fourth-party logistics providers (4PLs) are suggested as a solution to taking the administrative burden of managing multiple contracts off the state, but this can be expensive.

Factors influencing the performance of contracting Payment systems

In Colombia, health system reform in the 1990s established social insurance schemes (a contributory regime for the employed, and a non-contributory, basic package for those outside the labour market), which contracted private insurance companies on a capitation basis. These insurers then contracted private facilities and professionals to provide healthcare services to their members. This led to spiralling costs, argued to be a result of both capitation and FFS [88]. Professionals were typically contracted using FFS, which incentivised over-charging and an over-subscription to complex services. In addition, insurers were found to maintain inaccurate records

of their members. Those who ended their membership, lost their jobs, or died were not immediately removed from member databases, which permitted insurers to continue to receive full capitation payments. At the same time, many members had low levels of literacy and/or knowledge of their rights, which was exploited by some insurers. Enrolled members were often made to pay for the free services to which they were entitled, or denied services altogether, despite providers receiving full capitation payments. This trend calls into question statistical findings of increasing access to primary healthcare when access is measured by membership or affiliation to an insurance plan: actual utilisation of services may not correspond [88].

Vengberg et al. [29] compare incentives at individual and unit level arising from different models of contracting out primary care to NSPs in the Stockholm and Gothenburg city regions, and the extent to which HCWs responded to these incentives as predicted by rational choice theory. Stockholm had a blend of FFS for patient visits (60%) and risk-adjusted capitation for age and socioeconomic status (40%), while Gothenburg's system was characterised mainly by risk-adjusted capitation for age, diagnoses, sex, socioeconomic status, and the location of the primary care centre. In Stockholm, during the research period the system was adjusted, with an inversion in the proportions attached to different payment systems (capitation was given the greater weight). FFS rates for GP visits were also reduced by 52%, while registered nurse rates stayed the same. The study is especially useful because it shows variation in the same country where many contextual features could be assumed to be constant, and in one case (Stockholm), change in the system during the course of the study. It is also a rare comparative study of capitation and FFS.

In Stockholm, the initial dominance of FFS led to greater production of patient visits, particularly shorter, repeat, and in-person visits with less sick patients, with many of these visits regarded by the HCWs themselves as unnecessary. This was aimed at moving more people through the unit per day, and thereby increasing provider income. This strategy was not found in the capitation-focused Gothenburg. In Stockholm, HCWs also prioritised easier tasks, knowing that payment for more complex work and services was the same. The rebalancing towards capitation led to GPs and managers spending more time with patients, focusing more on quality, and ensured greater coverage of difficult cases. It also reduced the incentive to upcode: in the previous system, many GP consultations were recorded when registered nurses had in fact delivered them.

In Gothenburg, risk adjustment for diagnoses was perceived positively by HCWs, but coding of visits to

satisfy risk adjustment criteria was felt as an administrative burden. Also, in some cases, “imaginative” diagnoses were recorded by HCWs, unlike in Stockholm where risk adjustment didn’t happen on the basis of diagnoses. Risk adjustment for other factors also tended to be viewed positively because they enabled proper care for the more vulnerable and the sicker, crowding out simpler and unnecessary consultations. But some groups were not reimbursed sufficiently, which affected the perceived standard of care and their prioritisation relative to other risk-adjusted groups.

The conclusions are that unit-level incentives “trickle down” to the individual level, regardless of the fixed individual salaries received by many physicians and RNs. In addition, the implication seems to be that capitation is a better model: risk adjustment by diagnosis was the only factor HCWs could directly control, hence the upcoding as one of the only negative outcomes. At the same time, risk adjustment along a range of external factors (like socioeconomic status and age) promoted access to care for more vulnerable groups. So risk adjustment (on which payment depends) based on data from elsewhere would be less likely to change behaviour and to lead to upcoding.

However, capitation—and particularly capitation that is adjusted for risks and other contextual features—requires strong information systems. In Argentina, social insurance is found to outperform private insurance in terms of efficiency and quality not only due to the relatively higher proportion of payments based on capitation rather than FFS, but also because robust monitoring and information technology proved to be useful coordination mechanisms of multiple provider, insurer and regulatory bodies around public health goals [89]. Similarly, Costa Rica’s experience with contracting out to cooperatives demonstrates how effective governmental oversight can achieve cost efficiencies, notably through reduced referrals to specialists, while simultaneously expanding primary care service provision and maintaining provision of essential care [90]. But in South Africa, the scope for introducing capitation was limited by inadequate information systems in public health departments, as well as the reluctance of private GPs to work for public salaries. Instead, FFS provided some GPs with incentives to see many patients as quickly as possible; incentives reinforced by low reimbursement rates for services [13]. However, in a comparison between salaried public service doctors and contracted FFS-based private GPs in Norway, contracted doctors provided more services without increasing inefficiencies or compromising patient satisfaction [91]. In Brazil, like in South Africa, public salaries that are much lower than those in Norway have limited GP participation in the public primary care system, with incentives

instead to contract to provide more complex and expensive services (presumably on a FFS basis— [92]).

The benefits of risk-adjusted capitation have been found elsewhere [31, 93], with its absence linked with opportunistic GP behaviour in Croatia [94]. In the scoping review by Bitton et al. [93], FFS combined with PfP was also deemed useful, although the benefits of both systems were found to be short-lived in most cases. No reasons for this are offered: it could be a reflection of contractors becoming used to a set of static incentives over the longer term and not pushing the boundaries of service provision beyond these incentives. In addition, the underlying studies typically do not compare capitation with FFS, but rather the introduction of one of these systems in a contract that previously did not have either, or two contracts with one of either type of payment model and the other with neither. Finally, interpreting effects is sometimes complex: in a study in Northern Ireland, capitation models created incentives for dentists to see patients less frequently and to do less when they came in, but the authors cannot determine whether this is a result of less over-provision of unnecessary services relative to FFS, or more under-provision of necessary services relative to FFS [95].

Regarding Pfp, tracking outputs rather than inputs proved administratively simpler in Haiti (3) where performance bonuses were introduced, while performance incentives introduced in China [96] and Ukraine [97] for the treatment of diabetes and tuberculosis respectively improved the quality of care. A tentative conclusion from Liu et al. [2] is that when Pfp incentives are introduced, results of contracting are better, though it may be important to continually update performance incentives [98]. One of the most convincing studies of the benefits of Pfp comes from Egypt [63] where the effect of discontinuing provider incentives in family planning, maternal health and child health was assessed on associated outcomes, and compared with performance against non-contracted outcomes (performance areas not linked to Pfp targets). Using a difference in differences model, they find that discontinuing the incentives (offered to all health workers, up to 275% of their base salary) negatively affected non-contracted outcomes, such as prevalence of acute respiratory infection in children, suggesting a spillover effect of the introduction of Pfp incentives in other areas. However, several improvements in contracted outcomes were maintained over time, suggesting that performance targets induced long-term changes in behaviour (the study data is from 2001 to 2014; with discontinuation of Pfp happening roughly halfway through the period).

Drawbacks of Pfp include performance targets not being relevant to the local context in which they are implemented, which is sometimes regarded as a

consequence of limited local interaction and participation in the target-setting process [99]. Interestingly, in the UK, evidence suggests that while PfP in the contracting of GPs has led to better doctors being retained over time as they compete to participate in higher-quality practices, a reduction of effort was also recorded by these GPs in areas attached to incentives, due to a desire to not be seen to be reducing effort in areas *not* attached to incentives, or to be seen as greedy for disproportionate effort in incentivised areas [100]. In Italy, contracted GPs and their teams frequently perceived performance management and reporting systems as introducing unnecessary scrutiny and competition (reflected in evidence from Sweden— [101]), but were more likely to perceive PfP positively when systems included a basket of different types of indicators, especially those measuring the quality of care [102]. Other work about contracted GPs in primary care in the UK shows that the presence and size of PfP incentives do not always correlate with gains in health outcomes [32], with maintaining care for the most vulnerable [103], or with efforts made by nurses [104, 105], though effects seem more positive in more narrowly targeted programmes—for example for smoking cessation [106]. In Brazil, performance-based targets (which are actually outputs: the numbers of services delivered) has led to competition between workers and units, and arguably an unproductive focus on meeting targets for their own sake [9].

Types of contracts and contracting environments

Alonge et al. [15] examine the effects of different types of contracts relative to each other and to contracting in (where a public agency is the contracted service provider) of the same primary care services in Afghanistan. Contracts with a fixed budget combined with flexibility in how to use these funds, alongside performance bonuses based on a number of measures making up a balanced scorecard, including utilisation of services, perceived quality of care by clients, and equity (the indicator is a concentration index measuring the relative use of facilities by the poor and non-poor)—are associated with significant increases in attendance at clinics by poor clients. The operational flexibility permitted in the contract, which is relational and incomplete—is argued to provide room to innovate, in ways that were not anticipated before the service delivery period began. Improvements in equity are further supported by increases in the proportion of local CHWs working on site.

Operational flexibility is also associated with quality improvements in Bangladesh [16]; in a systematic review of financing interventions in primary care service delivery in the Asia Pacific region (specifically, flexibility in how a fixed sum of money is used with fixed targets) [31]; Portugal [107]; and in Brazil [87]. In Brazil,

administrative and financial autonomy in the procurement of goods, services and human resources was key to successful contracting relative to government provision. In Loevinsohn and Harding [3], service delivery contracts seem to do better than management contracts at improving outcomes like immunisation coverage in the one study addressing the differential effects of these contract types in Cambodia. This may reflect the greater flexibility afforded to operators in service delivery contracts, where the service provider not only delivers public services, but also supplies the equipment, facilities, medicines, etc. Despite the greater expense of service delivery contracts relative to management contracts and to pure governmental provision, in this single study, OOPE savings for patients were nonetheless recorded. Finally, flexibility in how to achieve fixed targets has been associated with success in other contracting experiences outside primary care—in youth employment and early childhood development programming—in South Africa [108].

In India, staff salaries were fixed at the start of a contractual scheme, and not adjusted later for inflation or to keep up with public sector salaries, while workload on the NGOs increased [58]. This was demotivating and hampered retention of HCWs. Staff turnover was exacerbated by very strict conditions on how disbursed funds could be used, which eroded HCWs' sense of autonomy.

But too much flexibility is also a problem. In Egypt, the use of contracting out in universal health insurance was fraught with difficulties for public officials, due to insufficient guidelines around how to evaluate supplier options and about the decision-making process to be followed [109]. This suggests that at least from the perspective of the purchaser (and particularly bureaucrats charged with implementing policy decisions made at higher levels of government), more rather than less regulation is required. Similarly, public managers in a study in Brazil relate a lack of capacity and knowledge in fulfilling purchasing arrangements. They also note a great dependence on the private sector given the local public network's inability to offer certain types of services; a dependence that can lead to opportunistic behaviour on the part of private providers in proportion to their greater bargaining power and knowledge of specialised care. This is evident for example in performing high-cost tests as conditions for patient admission to private facilities, or over-charging for other services [110]. Finally, an official inquiry in São Paulo found that contracts are often too open and imprecise, which makes comparison of performance between public and private sectors difficult, and hinders the accountability function [47], as highlighted above as an impediment to community participation in governance.

Monitoring the delivery, relevance and effectiveness of healthcare services is inherently complex, and public

officials require experience and skills, alongside robust, unified regulatory frameworks, to navigate this complexity [111–113]. Space for opportunism by NSPs is opened by the absence of these conditions. In Tanzania, generic contracts with ample room for local-level modification contained weak and incompletely specified contract enforcement mechanisms, and monitoring meetings and performance reviews were not held consistently. In this context, contractors used higher prices than those listed on government guidelines for medicines and this was only perceived by the state much later [114]. The state may not be sufficiently interested in conducting effective oversight and applying sanctions for underperformance or malpractice, which may be linked with corruption. On the other hand, inadequate performance management has also been found to be demotivating for providers that perform *above* expectations [115]. Other aspects of poor contract management—like inconsistent payment and unstable definitions of eligible groups and service packages—can also lead to opportunistic, and perhaps rational, provider responses to prioritise fee-paying patients, intensifying inequalities in access [116, 117].

Some studies [14, 57, 101] call for efforts to strike a balance between flexibility and rigidity; between the ideal relational and classical contracting types. In a study of Aboriginal Community-Controlled Health Services (ACCHSs) in Australia, Dwyer et al. [14] find the contracting environment to be unduly complex and inflexible, with ACCHSs having to deal with multiple contracts (an average of 26 each) from multiple purchasers of primary care services, with different timelines and reporting requirements. Taking a more relational approach that recognises the “mutual dependence” of the contracting parties is recommended, where purchasers attempt to build relationships with contractors over the longer term and build trust, rather than assuming and maintaining a confrontational and punitive attitude. Better relationships also require state recognition of the importance of the work that is contracted out. In South Africa, provincial governments have long contracted out certain services to NGOs staffed by underpaid CHWs, with inadequate efforts to introduce unified monitoring and governance systems or to integrate contracts into core (stable, long-term) funding models rather than discretionary budgets [57].

The effects of context

Odendaal et al. [84] note in their systematic review that it is very difficult to generalise study findings in relation to contracting out because its effects are so context dependent. The very mixed findings on quality discussed above likely reflect these contextual influences.

For example, in South Africa, where GPs from the private sector were contracted by the state to deliver

services in public facilities that were part of pilot districts for the proposed National Health Insurance, a study could not attribute small improvements in service utilisation or in uptake of antiretroviral drugs to the contracting model. This is because the study period coincided with large-scale public interventions to increase public awareness of and access to HIV treatment, alongside the peak in morbidity due to untreated HIV. In this context, the public could be assumed to be well aware of the public health issue. The study could not separate contracting from these larger contextual features [34]. Similarly, the same contract and financing intervention undertaken in different places – for example the implementation of capitation in primary care in Indonesia [33] – can have very different effects based on the differing capacities of different regional governments, differing accountability mechanisms, and the degree of autonomy afforded to local providers to adapt services to local needs and particularities. An interesting recommendation—based on the design of a new performance assessment model in Portugal—is that environmental factors can be incorporated into performance management and contracts using different factor weightings, such as the contracted entities’ number of years of experience, local population density, and the local burden of non-communicable diseases such as diabetes [66]. This would overcome what has been found in some studies to be the lack of local relevance of performance targets.

In a qualitative case study of contextual influences on the contracting of private GPs in (mostly rural) small South African towns, mutual dependence is argued to be the key factor explaining why these contracts are entered into: the state needs to contract with GPs to deliver primary care services in areas where these GPs are frequently the only feasible providers, and the GPs themselves often depend on the extra income that these contracts in poor and sometimes remote areas make available to them [13]. This context means that neither party, but especially the state, has a real interest in terminating the contracts, even where performance is sub-standard. What would constitute sub-standard performance is itself not explicitly defined in broad, under-detailed contracts; contracts that many interviewed GPs did not know the details of or in many instances were even able to produce. Therefore, in these relational contracts, conflict minimisation and preserving an ongoing relationship are more important than the written terms of the contract and the strict monitoring and enforcement of those terms.

Although mutual dependence may explain the continuance of contracts, the authors maintain it does not explain varying service quality or the behaviour of GPs. This is influenced by social and individual factors, like a

personal commitment to the people of the community and a desire to abide by professional standards of care. The relative importance of these non-financial incentives in PfP contracts has been observed in the UK's National Health Service (NHS) as well [35].

A final, critical contextual point to consider is the profit-driven nature of the non-state provider that is contracted. The studies under review typically relate to nonprofit organisations. Where profit-making entities enter the picture, results are typically not very positive. The quality of services in contracted out and/or privatised facilities in the UK—facilities often including profit-making entities with corporate shareholders—seems to unambiguously deteriorate [36, 118]. In Costa Rica, while successful contracting out initiatives have enlisted profit-making cooperatives, cooperatives are required to reinvest profits into health services, are prescribed by law in their functions (the provision of healthcare services only), and shareholders are all employees of the cooperatives [90].

The absence of rights language and perspectives in contracts and their design

Partnerships with the private sector—including contracting arrangements—are promoted by international organisations like the United Nations and the World Health Organisation as a key strategy to achieve universal health coverage (UHC). UHC requires health system reform to ensure (1) access to a set of essential healthcare services, for (2) the whole population, (3) without imposing financial hardship on users (referred to in the Sustainable Development Goals as the avoidance of “catastrophic out-of-pocket health spending”). It is a utilitarian concept that tries to maximise availability of and access to services on an equitable basis. It differs from the rights-based conception of healthcare underlying universal health systems (UHS), where citizens are entitled to comprehensive care whenever needed, that is free at the point of use [119].

In many instances in our review, contracts are introduced with the explicit motivation of accelerating progress towards national commitments to UHC. New Public Management-related ideas about the optimal role of the state in healthcare and broader public service delivery also feature prominently, as described above.

Although UHC is sometimes articulated in terms of the human right to healthcare in ways that align UHC with the UHS idea (see for example [76, 120, 121], in the operationalisation of UHC in contracting, this grounding in rights seems to disappear: in none of the studies analysed is the right to health explicitly mentioned. In one case, social justice is linked explicitly with UHC among policymakers and regulators interviewed in Iran

as a motivation for contracting with NSPs, though it is unclear to what extent the concept of justice figures in the contracts themselves [54]. In Australia and Brazil, contracting with CBOs and the inclusion of citizen health councils in governance are recognised as a strategies to further communities' rights to self-direction in primary care policy, while in Peru, increasing social participation was employed as a strategy to secure the legitimacy of the state after a long period of civil conflict [17]. But again, it is unclear if rights are explicitly covered by the respective contracts. Finally, in Brazil, where community participation in health sector governance is a constitutional right, evidence suggests that capacities are required for its effective realisation, as discussed previously.

Discussion

Community participation in contracting

Most of the literature concerning community participation in governance comes from Brazil, which is unsurprising given the country's robust legislation framing this participation in healthcare and other sectors as a constitutional right. The oversight function has been more commonly exercised than the provision of input in the design of contracts. For participation of either type to meaningfully and positively shape the delivery and quality of primary care services, it needs resourcing (ideally from government), in terms of funds (it is an expensive and time-consuming endeavour) and skills (for example in interpreting contractual provisions and in how to engage with public and private actors in typically unequal power dynamics). Relatedly, the studies point to a lack of cooperation from public managers and of transparency in the contracting environment, as well as frequent technical glitches in monitoring systems, that hinder communities' abilities to conduct effective oversight. When publicly available, data tends to focus more on financial dimensions of performance, rather than on changing health-related outcomes, making the effectiveness of contracted services difficult to gauge. But even with full transparency, high-quality information about performance and functional IT systems, it would seem important for training to be conducted in how to interpret the data that is produced. This need is under-addressed in the literature, and seems especially urgent given the consistent finding from the broader literature that even public officials find the navigation of contractual management and information highly difficult. We believe that requirements for resourcing and capacity-building should be explicitly codified in contracts, as mechanisms to effect the rights to participation and to health. There is no evidence in our review that these rights have been integrated into contracts in this way.

Another difficulty is that fragmentation in a pluralistic contractual environment with many different service providers and contracts (specifically, in the state of São Paulo) complicates the oversight function: the volume of information to be processed and sources to be consulted increases, increasing overall transaction costs for the individuals engaging in performance monitoring. But studies also show that the greater the degree of standardisation in contracts, the greater the gap between the envisioned service delivery model and actual local needs. Moreover, theoretically, the more competitive the supplier environment, the easier it becomes for communities and public authorities to compare performance and to sanction underperforming contractors. It would thus appear that encouraging competition among service providers while balancing standardisation and adaptability in contracts could reduce transaction costs and enhance the effectiveness of public oversight and align service delivery with local needs.

In Bolivia, Iran, Australia and Peru, community participation in governance is also associated with successful contracting experiences, where coverage of quality services improved. However—and as in the Brazilian evidence—there is no direct causal evaluation of this relationship; it is usually the effectiveness of contracting, rather than community participation in governance, that is assessed.

Much of the literature frames participation not as governance but as involvement in the delivery of services through CBOs or CHWs, which is not in itself participatory; cases under review where representative CBOs have some say over *how* services are designed and delivered (rather than in delivery of centrally or state-planned services) seem to approximate real community influence. This model is associated with access to higher quality care. But inflexible, strict national control over operations, as well as under-resourcing, can constrain these advantages and exacerbate inequalities in healthcare outcomes between different groups.

A more indirect approach to community participation is conceived as the exertion of an influence on the contracting environment through consumer choice in the selection of providers, or through participation in evaluation of contracted services which then improves future contract design, provided it is taken seriously. Improvement to future contract design would also seem more likely in more institutionalised contracting experiences such as in Portugal, whereas project- and donor-based initiatives may not be sustainable either in and of themselves or as drivers of wider health system change, as in Burkina Faso. Measures of user satisfaction are also likely to gauge the experiences only of those who accessed services successfully unless explicit effort is made to do

otherwise; a reality that renders user satisfaction somewhat unreliable as a measure of quality by potentially occluding problems in accessing contracting services. Finally, in South Africa and China, the proximity between contracted doctors and patients creates a mutual dependence that on the one hand might encourage the maintenance of good relationships through higher-quality service provision, while also doing the opposite due to the knowledge that under-performing doctors (or providers) are not easily substitutable. Furthermore—and as highlighted previously—if contracts and performance indicators are overly standardised, this would override local relationships and perhaps worsen community-related outcomes.

Types of contracts and relationships with access, equity and quality

Moving into the wider scope of the literature that does not explicitly address community participation, contracting does show promise as a tool to promote access to primary care. This is especially true in poorer areas, which improves equity in healthcare coverage and in turn healthcare outcomes. Although the introduction of services to unserved areas would automatically improve access, regardless of the nature of the provider or the mode of governance, we do find that in several cases – for example in Brazilian municipalities and in experiences in the Eastern Mediterranean region – contracting out to private providers is explicitly pursued as a solution to perceived constraints in expanding public provision, for example, expenditure ceilings or hiring regulations imposed by higher levels of government, or limitations in government capacities to rapidly expand infrastructure. The effects of contracting out on the quality of services—including their cost and transparency about this quality—are more mixed. The broader literature on contracting provides insights about the types of contracts and features of the contractual environment that are connected with better service quality. These insights could be useful in the design of interventions that seek to introduce or improve community participation in contracting.

Generally, contracted primary care services are difficult to manage. In the theoretical economic language of contracting, this is due to their high degree of asset specificity (being highly specialised and often applicable to very specific geographies, populations, or service providers), which exacerbates the bounded rationality of contracting parties, or the ability to predict both current and future outcomes, in turn increasing the chances that either party takes advantage of this opacity and acts opportunistically. This makes contract management more complex. This might suggest that an exhaustive, meticulous design phase, paired with vigilant micromanagement of

contractors, is required to develop contracts approximating the classical archetype, which are more conducive to transparency and accountability. But this is not necessarily fruitful: a balance between classical and relational forms of contracting—where contracts are incompletely specified, service providers and HCWs are less closely monitored and controlled, and trust is built through an ongoing relationship—seems better. This seems especially true with smaller and in particular community-based non-state providers.

Contracts that are too rigid risk breeding mistrust, over-standardisation, and sluggishness in responding to changing local needs, while contracts that are too informal impede real accountability and produce confusion about rights, roles and responsibilities of different stakeholders. At the same time, clear, fixed performance targets—coupled with flexibility in how service providers meet these targets—are essential to guide the work of HCWs and to serve as benchmarks against which communities can judge performance and iteratively tweak the longer-term system of priorities and performance management in local primary care delivery. Targets should be developed in collaboration with communities to ensure their local relevance, while retaining a core standard set of indicators measuring service provision and population health to facilitate national comparisons and ensure an equitable standard of care is maintained.

Targets are often linked with the payment system, and the various systems covered in this review all produce incentives for opportunistic behaviour. But the evidence is, again, limited—few studies directly compare payment systems. Nonetheless, capitation with risk adjustment and diagnostic related group payments seem better at reducing the tendency among contractors to provide too many, often unnecessary services while ensuring the vulnerable are cared for. More research is needed to establish when and why financial incentives dominate over others. Low morale could be one reason—the efficiency gains from contracting are sometimes achieved at the expense of HCWs' working conditions. A highly competitive culture of chasing targets has also been observed, often in a way that is disconnected from healthcare needs.

Other aspects of the specific contracting environment can also be improved regardless of the type of contract pursued to enhance the odds of success. For example, public authorities could commit to training bureaucrats and community representatives in contract management and oversight, and to fostering collaboration between health system participants and other sectors, such as transport, education, and social assistance. And in designing specific contracts, it is important to account for the broader market of service provision: are there

alternative providers available? What mechanisms can be used to sanction underperforming contractors if they cannot be replaced? And how will this performance be tracked? Are there sufficient information gathering capabilities in place, technological and otherwise? And what would constitute poor, sufficient or good service?

Limitations and pathways for future research

A common trend in the evidence on the effects of contracting out is that studies tend to assess the effects of contracting as a whole approach to primary care relative to not contracting. The relative effects of different contractual mechanisms (including payment systems, or data management and accountability systems) on the quality of primary care services, and the wider systemic effects of contracting (for example, how does contracting in a specific geographical or service area affect the health system as a whole?) are less commonly addressed. Features of the specific contracting environment are also underexplored, despite this context of contractual design and implementation being critical to understand the potential and actual effects of these arrangements.

In addition, most studies are qualitative in nature, dealing with perceptions of rather than actual improvements in access, equity and quality. Where more quantitative evidence exists, it leans towards *access* as opposed to *equity* and *quality*. This is reflective of the UHC rationale underlying many contracting out policies, which has been criticised in practice for a limited conception of access that underplays both effective utilisation of services and the quality of those services.

Regarding the scoping review strategy adopted here, we recognise that the broad scope of our inquiry may come at the expense of depth, and we did not conduct a formal quality appraisal of each article cited. Nonetheless, we believe that our expansive approach – further achieved by including articles in Spanish and Portuguese – is justified by the novelty of research on community participation in contracting, and the still relatively limited availability of global reviews on contracting more generally.

Next, our scoping review includes studies published up to the end of August 2023. The extensive global scope of our review, encompassing studies in three languages, required a longer analysis period than is typical. However, we do not consider this to have rendered our findings outdated. Access, equity, and quality in primary care are outcomes that typically evolve over medium- to long-term horizons, and the rationales for increasing private and non-state sector involvement in healthcare through contracts have not changed since mid-2023. Similarly, we do not anticipate that the effects of these contracts have significantly changed in this time. Nonetheless, any particularly relevant or noteworthy articles published after August

2023 and identified by our team have been included as handpicked additions to the literature – for example, an analysis of the effects of privatisation in the NHS [104].

Finally, our scoping review covers the literature on contracting out of primary care services to a private entity, and does not address contracting in, where a public entity uses contracts to govern service delivery that is devolved to another public entity. While the use of contracts links these two modes of service delivery, proponents of contracting out would argue that it is the private nature of the contracted entity that makes a difference to the effectiveness of the approach. Specifically, as we pointed out in the introduction, there are theoretical arguments proposing competition effects and greater responsiveness and flexibility in private provision as key to promoting higher-quality services from the perspective of the public; effects for which there is some support in the literature. However, another empirically supported contributor to higher-quality service delivery is the new focus on performance management that the use of contracts and indicators can foster. This would clearly also be possible for services that are contracted *in*. Which effects dominate in any given setting are hard to determine, and this is typically not evaluated. If it is performance management that is the dominant variable contributing to success in contracting out, rather than competition effects for example, then arguments that private entities would be intrinsically more suited to participate in contractual arrangements lose much of their power; it is also conceivable that contracting in could reduce transaction costs for the state, which are often high when coordinating and monitoring multiple private entities. We recommend that future research (a) grapples more with the challenge of determining the contribution of different effects in the contracting environment, and (b) directly compares contracting in and contracting out (as done for example in [3] and [15], where contracting out outperforms contracting in on measures of quality).

Conclusions

Contracting of non-state service providers in the delivery of primary care is an increasingly prevalent strategy used by states in the quest for universal health coverage. Community participation could be a useful coordinating tool to enhance its effectiveness. In the available evidence, community participation in the design and monitoring—that is, the governance—of contracts is often associated with improvements in the relevance, responsiveness and transparency – and thereby the quality and equity—of service provision. But community participation processes require sustained resourcing, strong information systems, and high levels of cooperation from public and private actors in pluralistic primary care ecosystems. It

is generally overlooked as a potential design feature in countries' plans for UHC and is thus not widely featured in the literature.

In the larger literature on the contracting of primary care services with non-state providers that does not address community participation, we find that contracting tends to lead to increases in the numbers of people who are able to access services. This often takes place in poorer areas, implying that primary care has become more equitable. However, the evidence is very mixed on the quality of contracted services, with much of the variation dependent on contextual factors in specific contracting environments. Where contracted services are of low quality, the net effect on equity – where perhaps more equitable coverage is undermined by lower quality care – is difficult to discern. Moreover, it is often not clear from studies on contracting which particular contractual features or clauses are associated with different outcomes.

Our research consortium therefore calls for primary studies that address the meaningful involvement of communities and the broader public in the governance and contracting of primary care services. At the same time, research should examine both the effects of different configurations of contracting features—such as payment systems and the approach to contracting along the classical to relational spectrum – and the effects of the wider implementation context, to identify what works and what doesn't in improving the experiences of primary care, especially among vulnerable groups. In doing so, future research could uncover actionable strategies to simultaneously advance the right to good health and the right to meaningful participation, in turn contributing to more equitable and effective primary care.

Abbreviations

3PL	Third-Party Logistics Provider
4PL	Fourth-party Logistics Provider
ACCHSs	Aboriginal Community-Controlled Health Services
CBO	Community-Based Organisation
CHW	Community Health Worker
FFS	Fee for Service
GP	General Physician
HIC	High-Income Country
HIV	Human Immunodeficiency Virus
IMR	Infant Mortality Rate
IT	Information Technology
JBI	Joanna Briggs Institute
KPIs	Key Performance Indicators
LIC	Low-Income Country
LMIC	Lower Middle-Income Country
MIS	Management Information System
NGO	Non-Governmental Organisation
NHS	National Health Service
NSP	Non-State Provider
OOPE	Out of Pocket Expenditure
PfP	Pay for Performance
UK	United Kingdom
UHC	Universal Health Coverage
UMIC	Upper Middle-Income Country
WHO	World Health Organisation

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12939-025-02567-3>.

Additional file 1. Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

Additional file 2. Protocol for scoping review to understand evidence around community participation and contracting in plural health systems and its relevance in the context of universalised access to health

Additional file 3. Table 3: Contribution of studies to each scoping review question

Acknowledgements

The authors are members of a broader Indian, Brazilian and South African consortium investigating and developing strategies to increase the participation of communities in the governance of contracts in the mixed health systems of large municipalities. We thank the broader team for their guidance and support throughout the process, and in particular Vera Schattan Coelho, for comments on draft versions of this article.

Authors' contributions

ZK (conceptualisation; data curation and analysis; writing - original draft preparation; writing - review and editing); FH (data curation and analysis; writing - original draft preparation); VR (conceptualisation; data curation and analysis; writing - original draft preparation); JR (data curation and analysis; writing - original draft preparation); PB (data curation and analysis); SG (conceptualisation; writing - review and editing); LL (conceptualisation; writing - review and editing)

Funding

This research was funded by the NIHR (NIHR150146) using UK international development funding from the UK Government to support global health research. The views expressed in this publication are those of the author(s) and not necessarily those of the NIHR or the UK government.

Data availability

A reduced dataset supporting the conclusions of this article is included as an additional file ("Additional file 3"). The full data extraction will be made available on reasonable request to the authors.

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Author details

¹Brazilian Center of Analysis and Planning (CEBRAP), São Paulo, Brazil. ²Centre for Social Development in Africa, University of Johannesburg, Johannesburg, South Africa. ³Society for Promotion of Area Resource Centres (SPARC), Mumbai, India. ⁴The George Institute for Global Health, New Delhi, India. ⁵The Division of Public Health Medicine, University of Cape Town, Cape Town, South Africa.

Received: 4 February 2025 Accepted: 19 June 2025

Published online: 09 July 2025

References

- World Health Organisation. Primary health care. Geneva: World Health Organisation; 2025. Available from: <https://www.who.int/news-room/fact-sheets/detail/primary-health-care>.
- Liu X, Hotchkiss DR, Bose S. The effectiveness of contracting-out primary health care services in developing countries: a review of the evidence. *Health Policy Plan*. 2007;23(1):1–13.
- Loevinsohn B, Harding A. Contracting for the delivery of community health services: a review of global experience. Washington DC: World Bank; 2004. Available from: <https://documents1.worldbank.org/curated/en/942051468779450185/pdf/315060HNPOContracting0LoevinsohnHarding.pdf>.
- Siddiqi S, Masud TI, Sabri B. Contracting but not without caution: experience with outsourcing of health services in countries of the Eastern Mediterranean Region. *Bull World Health Organ*. 2006;84(11):867–75.
- Perry HB. An extension of the Alma-Ata vision for primary health care in light of twenty-first century evidence and realities. *Gates Open Res*. 2018;14(2):70.
- Starfield B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. *SESPAS report 2012*. *Gaceta Sanitaria*. 2012;26:20–6.
- World Health Organisation, World Bank. Tracking Universal Health Coverage: 2023 Global Monitoring Report. World Health Organization and the International Bank for Reconstruction and Development / The World Bank; 2023. Available from: <http://hdl.handle.net/10986/40348>.
- Coelho VSP, Greve J. Social health organizations and the performance of the SUS: a study on basic healthcare in São Paulo. *Dados*. 2016;59(3):867–901.
- Carneiro CCG, Martins MIC. Novos modelos de gestão do trabalho no setor público de saúde e o trabalho do agente comunitário de saúde. *Trab educ saúde*. 2015;13(1):45–66.
- Londoño JL, Frenk J. Structured pluralism: towards an innovative model for health system reform in Latin America. *Health Policy*. 1997;41(1):1–36.
- Gorsky M, Sirrs C. Universal health coverage as a global public health goal: the work of the International Labour Organisation, c.1925–2018. *Hist cienc saude-Manguinhos*. 2020;27(suppl 1):71–93.
- Monteiro BR, Cadoso F, Reis M, Bastos S. Analysis of the performance of contractualization primary health care indicators in the period 2009–2015 in Lisbon and Tagus Valley. *Cien Saude Colet*. 2017;22(3):807–18.
- Palmer N, Mills A. Classical versus relational approaches to understanding controls on a contract with independent GPs in South Africa. *Health Econ*. 2003;12(12):1005–20.
- Dwyer JM, Lavoie J, O'Donnell K, Marlina U, Sullivan P. Contracting for indigenous health care: towards mutual accountability. *Aust J Public Adm*. 2011;70(1):34–46.
- Alonge O, Gupta S, Engineer C, Salehi AS, Peters DH. Assessing the pro-poor effect of different contracting schemes for health services on health facilities in rural Afghanistan. *Health Policy Plan*. 2015;30(10):1229–42.
- Heard A, Nath DK, Loevinsohn B. Contracting urban primary healthcare services in Bangladesh - effect on use, efficiency, equity and quality of care. *Trop Med Int Health*. 2013;18(7):861–70.
- Iwami M, Petchey R. A CLAS act? Community-based organizations, health service decentralization and primary care development in Peru. *J Public Health Med*. 2002;24(4):246–51.
- Hipgrave DB, Hort K. Dual practice by doctors working in South and East Asia: A review of its origins, scope and impact, and the options for regulation. *Health Policy Plan*. 2014;29(6):703–16.
- Ghoddosi-Nezhad D, Janati A, Arab Zozani M, Doshmagir L, Sadeghi Bazargani H, Imani A. Is strategic purchasing the right strategy to improve a health system's performance? A systematic review. *Bali Med J*. 2017;6(1):102.
- Lavoie JG. Governed by contracts: the development of indigenous primary health services in Canada, Australia and New Zealand. *J Aboriginal Health*. 2004;(January).
- Zaidi S, Das JK, Jamal W, Ali A, Siddiqui F, Thabet A, et al. Government purchasing initiatives involving private providers in the Eastern Mediterranean Region: a systematic review of impact on health service utilisation. *BMJ Open*. 2023;13(2). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85148551729&doi=10.1136%2fbmjopen-2022-063327&partnerID=40&md5=a129591c5b3ba5375b53a32b07c4816b>.
- Contreiras H, Matta GC. Privatização da gestão do sistema municipal de saúde por meio de Organizações Sociais na cidade de São Paulo,

- Brasil: caracterização e análise da regulação. *Cad saúde pública*. 2015;31(2):285–97.
23. Hallo De Wolf A, Toebes B. Assessing private sector involvement in health care and universal health coverage in light of the right to health. *Health Hum Rights*. 2016;18(2):79–92.
 24. Nishtar S. The mixed health systems syndrome. *Bull World Health Organ*. 2010;88:74–5.
 25. Schuftan C, Unger J. The Rockefeller foundation's "public stewardship of private providers in mixed health systems": a point-by-point critique. *Soc Med*. 2011;1:6.
 26. Tabrizi JS, Azami-aghdash S, Gharaee H. Public-private partnership policy in primary health care: a scoping review. *J Prim Care Community Health*. 2020;11:2150132720943769.
 27. Joudyian N, Doshmangir L, Mahdavi M, Tabrizi JS, Gordeev VS. Public-private partnerships in primary health care: a scoping review. *BMC Health Serv Res*. 2021;21(1):4.
 28. Silva VC e, Barbosa PR, Hortale VA. Parcerias na saúde: as Organizações Sociais como limites e possibilidades na gerência da Estratégia Saúde da Família. *Ciênc Saúde Colet (Impr)*. 2016 May;21(5):1365–76.
 29. Vengberg S, Fredriksson M, Burström B, Burström K, Winblad U. Money matters – primary care providers' perceptions of payment incentives. *JHOM*. 2021;35(4):458–74.
 30. DeVoe J, Stenger R. Aligning provider incentives to improve primary health care delivery in the United States. *OA Family Medicine*. 2013;1(1). Available from: <http://www.oapublishinglondon.com/article/958>. Cited 2023 Jan 11.
 31. Angell B, Dodd R, Palagyi A, Gadsden T, Abimbola S, Prinja S, et al. Primary health care financing interventions: a systematic review and stakeholder-driven research agenda for the Asia-Pacific region. *BMJ Glob Health*. 2019;4(Suppl 8):e001481.
 32. Flectcroft R, Steel N, Cookson R, Walker S, Howe A. Incentive payments are not related to expected health gain in the pay for performance scheme for UK primary care: cross-sectional analysis. *BMC Health Serv Res*. 2012;12(1):94–94.
 33. Tan SY. Bureaucratic autonomy and policy capacity in the implementation of capitation payment systems in primary healthcare: comparative case studies of three districts in Central Java. *Indonesia Journal of Asian Public Policy*. 2019;12(3):330–50.
 34. Mukudu H, Otwombe K, Fusheni A, Igumbor J. Contracting of private medical practitioners in a National Health Insurance pilot district: What has been the effect on primary healthcare utilisation indicators? *African Journal of Primary Health Care & Family Medicine*. 2020;12(1). Available from: <http://www.phcfm.org/index.php/PHCFM/article/view/2563>. Cited 2023 Jan 27.
 35. Marks L, Cave S, Wallace A, Mason A, Hunter DJ, Mason JM, et al. Incentivizing preventive services in primary care: perspectives on Local Enhanced Services. *J Public Health*. 2011;33(4):556–64.
 36. Greaves F, Laverty AA, Pape U, Ratneswaren A, Majeed A, Millett C. Performance of new alternative providers of primary care services in England: an observational study. *J R Soc Med*. 2015;108(5):171–83.
 37. Rajan D, Mathurapote N, Putthasri W, Posayanonda T, Pinrateep P, De Courcelles S, et al. Institutionalising participatory health governance: lessons from nine years of the National Health Assembly model in Thailand. *BMJ Glob Health*. 2019;4(Suppl 7):e001769.
 38. Meier BM, Pardue C, London L. Implementing community participation through legislative reform: a study of the policy framework for community participation in the Western Cape province of South Africa. *BMC Int Health Hum Rights*. 2012;12(1):15.
 39. Ved R, Sheikh K, George AS, Vr R. Village Health Sanitation and Nutrition Committees: reflections on strengthening community health governance at scale in India. *BMJ Glob Health*. 2018;3(Suppl 3):e000681.
 40. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol*. 2005;8(1):19–32.
 41. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Ann Intern Med*. 2018;169(7):467–73.
 42. Peters MD, Godfrey C, McInerney P, Munn Z, Tricco AC, Khalil H. Scoping reviews. In: Aromataris E, Lockwood C, Porritt K, Pilla B, Jordan Z, editors. *JBI Manual for Evidence Synthesis*. JBI; 2024. Available from: <https://jbi-global-wiki.refined.site/space/MANUAL/355862497/10.+Scoping+revie ws>. Cited 2025 May 9.
 43. Peters MDJ, Marnie C, Tricco AC, Pollock D, Munn Z, Alexander L, et al. Updated methodological guidance for the conduct of scoping reviews. *JBI Evidence Synthesis*. 2020;18(10):2119–26.
 44. Munn Z, Pollock D, Khalil H, Alexander L, McInerney P, Godfrey CM, et al. What are scoping reviews? Providing a formal definition of scoping reviews as a type of evidence synthesis. *JBI Evidence Synthesis*. 2022;20(4):950–2.
 45. De Bengy PA. The rising authority and agency of public-private partnerships in global health governance. *Policy and Society*. 2024;43(1):25–40.
 46. World Bank. World Bank Country and Lending Groups. Washington, DC: The World Bank; 2025. Available from: <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>.
 47. Barboza PIB, Vasconcellos M da P, Aith FMA. Transparência nas relações público-privadas para prestação de serviços de saúde no estado de São Paulo. *Cad Ibero Am Direito Sanit (Impr)*. 2021;10(4):125–52.
 48. de Melo MV, Carnut L, Mendes Á. Relação entre cumprimento das metas dos contratos de gestão e qualidade da atenção à saúde: uma revisão integrativa. *Saúde em Debate*. 2021;45(131):1140–64.
 49. Loureiro S, Ferreira Júnior H de M, Mota FB, Freitas LF da S. Uma análise exploratória dos programas de controle da tuberculose da baía e goiás à luz da teoria dos custos de transação. *Saude soc*. 2013;22(1):85–98.
 50. Vasconcellos LAV. O Conselho Estadual de Saúde do Espírito Santo e a gestão hospitalar por uma organização social: o caso do hospital Dr. Jayme Santos Neves. [Rio de Janeiro]: Fundação Oswaldo Cruz, Escola Nacional de Saúde Pública Sergio Arouca; 2016. Available from: <http://bvssp.icict.fiocruz.br/lidbi/docsonline/get.php?id=4545>.
 51. Araujo MAD. Results-oriented management and accountability in the Brazilian unified health system. *Rev Panam Salud Publica Pan Am J Public Health*. 2010;27(3):230–6.
 52. Goya N, de Andrade LOM. O Sistema Único de Saúde e o desafio da gestão regionalizada e contratualizada. *Rev bras promoç saúde (Impr)*. 2018;31(4):1–10.
 53. Zermiani TC, Freitas RS, Pessali HF, Ditterich RG. A participação dos conselhos locais de saúde na contratualização de metas na atenção primária à saúde: a experiência de Curitiba. *PR Interações (Campo Grande)*. 2019;20(4):1115–26.
 54. Gharaee H, Tabrizi JS, Azami-Aghdash S, Farahbakhsh M, Karamouz M, Nosratnejad S. Analysis of public-private partnership in providing primary health care policy: an experience from Iran. *J Prim Care Commun Health*. 2019;10:N.PAG-N.PAG.
 55. Dwyer J, Boulton A, Lavoie JG, Tenbenschel T, Cumming J. Indigenous peoples' health care: new approaches to contracting and accountability at the public administration frontier. *Public Manage Rev*. 2014;16(8):1091–112.
 56. Came H, Baker M, McKenna B, McCreanor T. Strengthening public health contracting: findings of a follow-up nationwide survey from Aotearoa. *Kotuitui*. 2022;17(3):405–21.
 57. Schneider H, Schaay N, Dudley L, Goliath C, Qukula T. The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: A situation appraisal in the Western Cape Province, South Africa. *BMC Health Serv Res*. 2015;15(1). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-84942645754&doi=10.1186%2fs12913-015-1109-4&partnerID=40&md5=23bd7e451860b5ad8eaa040881a4b2be>.
 58. Bhat R, Mavalankar D, Maheshwari S, Saha S. Provision of Reproductive Health Services to Urban Poor through Public-Private Partnerships: The Case of Andhra Pradesh Urban Health Care Project. Ahmedabad: Indian Institute of Management; 2007. Report No.: W.P. No.2007–01–07.
 59. Phaswana-Mafuya N, Petros G, Peltzer K, Ramlagan S, Nkomo N, Mohlala G, et al. Primary health care service delivery in South Africa. *Int J Health Care Qual Assur*. 2008;21(6):611–24.
 60. Macq J, Martiny P, Villalobos LB, Solis A, Miranda J, Mendez HC, et al. Public purchasers contracting external primary care providers in Central America for better responsiveness, efficiency of health care and public governance: Issues and challenges. *Health Policy*. 2008;87(3):377–88.
 61. Tynkynen LK, Lehto J, Miettinen S. Framing the decision to contract out elderly care and primary health care services—perspectives of local

- level politicians and civil servants in Finland. *BMC Health Serv Res.* 2012;12(1):201–12.
62. Kuwawenaruwa A, Makawia S, Binyaruka P, Manzi F. Assessment of Strategic healthcare purchasing arrangements and functions towards universal coverage in Tanzania. *Int J Health Policy Manage.* 2022;11(12):3079–89.
 63. El-Shal A, Cubi-Molla P, Jofre-Bonet M. Discontinuation of performance-based financing in primary health care: impact on family planning and maternal and child health. *Int J Health Econ Manage.* 2023;23(1):109–32.
 64. Pollard K, Horrocks S, Duncan L, Petsoulas C, Allen P, Cameron A, et al. How do they measure up? Differences in stakeholder perceptions of quality measures used in English community nursing. *J Health Serv Res Policy.* 2020;25(3):142–50.
 65. Kiendrébéogo JA, Tapsoba C, Kafando Y, Kaboré I, Sory O, Yaméogo SP. The Landscape of Strategic Health Purchasing for Universal Health Coverage in Burkina Faso: Insights from Five Major Health Financing Schemes. *Health Syst Reform.* 2022;8(2). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85135943957&doi=10.1080%2f23288604.2022.2097588&partnerID=40&md5=7f4d0419b02c857769a2fae7cb1f8828>.
 66. Kalinichenko O, Amado CAF, Santos SP. Exploring the potential of Data Envelopment Analysis for enhancing pay-for-performance programme design in primary health care. *Eur J Oper Res.* 2022;1:1084–100.
 67. Mudyarabikwa O, Tobi P, Regmi K. Public-private partnerships to improve primary healthcare surgeries: Clarifying assumptions about the role of private provider activities. *Prim Health Care Res Dev.* 2017;18(4):366–75.
 68. Agrawal P, Barton I, Bianco RD, Hovig D, Sarley D, Yadav P. Moving Medicine, Moving Minds: Helping Developing Countries Overcome Barriers to Outsourcing Health Commodity Distribution to Boost Supply Chain Performance and Strengthen Health Systems. *Glob Health Sci Pract.* 2016;4(3):359–65.
 69. Feng S, Cheng A, Luo Z, Xiao Y, Zhang L. Effect of family doctor contract services on patient perceived quality of primary care in southern China. *BMC Fam Pract.* 2020;21(1). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85093926514&doi=10.1186%2f12875-020-01287-7&partnerID=40&md5=b81eef5e610daeb702b09cbe0f81f8f7>.
 70. Liao R, Liu Y, Peng S, Feng XL. Factors affecting health care users' first contact with primary health care facilities in north eastern China, 2008–2018. *BMJ Glob Health.* 2021;6(2). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85100923890&doi=10.1136%2fbmjgh-2020-003907&partnerID=40&md5=0aeb2b52f49773a996a1cabb6eb7bd9>.
 71. Li L, Li L, Zhong C, Mei J, Liang Y, Kuang L. Effect of family practice contract services on the quality of primary care in Guangzhou, China: A cross-sectional study using PCAT-AE. *BMJ Open.* 2018;8(11). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85056296934&doi=10.1136%2fbmjopen-2017-021317&partnerID=40&md5=2c8a5b200aac87dcbd5067d658483606>.
 72. Álvarez B. Sistemas de pago a prestadores de servicios de salud en países de América Latina y de la OCDE / Payment systems for health services providers in countries of Latin America and of the OECD. *Rev Panam Salud Publica.* 2000;8(1–2):55–69.
 73. Habicht T, Kasekamp K, Webb E. 30 years of primary health care reforms in Estonia: the role of financial incentives to achieve a multidisciplinary primary health care system. *Health policy (Amsterdam, Netherlands).* 2023;130:104710.
 74. Tobey R, Maxwell J, Turer E, Singer E, Lindenfeld Z, Nocon RS, et al. Health centers and value-based payment: a framework for health center payment reform and early experiences in medicaid value-based payment in seven states. *Milbank Q.* 2022;100(3):879–917.
 75. Jegers M, Kesteloot K, De Graeve D, Gilles W. A typology for provider payment systems in health care. *Health Policy.* 2002;60(3):255–73.
 76. Chapman A. The contributions of human rights to universal health coverage. *Health Hum Rights.* 2016;18(2):1–6.
 77. The Health Foundation. *Complex Adaptive Systems.* London; 2010. Available from: <https://www.health.org.uk/publications/complex-adapt-ive-systems>.
 78. Øvretveit J. The quality of health purchasing. *Int J Health Care Qual Assur.* 2003;16(3):116–27.
 79. Pisco L. Reforma da Atenção Primária em Portugal em duplo movimento: unidades assistenciais autônomas de saúde familiar e gestão em agrupamentos de Centros de Saúde. *Revista Ciência & Saúde Coletiva.* 2011;16(6):2841–52.
 80. Ahmed S, Hasan MdZ, Ali N, Ahmed MW, Haq E, Shabnam S, et al. Effectiveness of health voucher scheme and micro-health insurance scheme to support the poor and extreme poor in selected urban areas of Bangladesh: An assessment using a mixed-method approach. *PLoS One.* 2021;16(November). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85118406354&doi=10.1371%2fjournal.pone.0256067&partnerID=40&md5=afdba536812f9a318280f737a161a05>.
 81. Albis MLF, Bhadra SK, Chin B. Impact evaluation of contracting primary health care services in urban Bangladesh. *BMC Health Serv Res.* 2019;19(1). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85075512634&doi=10.1186%2f12913-019-4406-5&partnerID=40&md5=6444cc549a90cd9e7399785660deb9ca>.
 82. Acerete B, Stafford A, Stapleton P. New development: New global health care PPP developments—a critique of the success story. *Public Money Manage.* 2012;32(4):311–4.
 83. Coleman A, Checkland K, McDermott I, Harrison S. The limits of market-based reforms in the NHS: the case of alternative providers in primary care. *BMC Health Serv Res.* 2013;13(1):S3–S3.
 84. Odendaal WA, Ward K, Uneke J, Uro-Chukwu H, Chitama D, Balakrishna Y, et al. Contracting out to improve the use of clinical health services and health outcomes in low- and middle-income countries. *Cochrane Effective Practice and Organisation of Care Group, editor. Cochrane Database of Systematic Reviews.* 2018;2018(4). Available from: <http://doi.wiley.com/https://doi.org/10.1002/14651858.CD008133.pub2>. Cited 2023 Jan 25.
 85. Rabbani F, Pradhan NA, Zaidi S, Azam SI, Yousuf F. Service quality in contracted facilities. *Int J Health Care Qual Assur.* 2015;28(5):520–31.
 86. Khan Z, Theobald S, Kruger G, Sithole T. Investment Research Report: The Impact Bond Innovation Fund. Johannesburg: Intellidex; 2021. (The Intellidex Social Impact Bond Research Series).
 87. Barbosa NB, Elias PEM. As organizações sociais de saúde como forma de gestão público/privado. *Cien Saude Colet.* 2010;15(5):2483–95.
 88. De Groote T, De Paepe P, Unger JP. Las consecuencias del neoliberalismo. Colombia: prueba in vivo de la privatización del sector salud en países en desarrollo. *Rev Fac Nac Salud Pública.* 2008;25(1):1–12.
 89. Yavich N, Báscolo EP, Haggerty J. Financiamiento, organización, costos y desempeño de los servicios de los subsistemas de salud argentinos. *Salud Pública de México.* 2016;58(5):504–13.
 90. Gauri V, Ceronco J, Briceño R. Separating financing from provision: Evidence from 10 years of partnership with health cooperatives in Costa Rica. *Health Policy Plann.* 2004;19(5):292–301.
 91. Sørensen RJ, Grytten J. Service production and contract choice in primary physician services. *Health policy (Amsterdam, Netherlands).* 2003;66(1):73–93.
 92. Liberatti VM, Pedro DRC, Costa RG, Pissinatti P de SC, Marcon SS, Haddad M do CFL. Percepção de gestores, prestadores e auditores sobre a contratualização no Sistema Único de Saúde. *Trab educ saúde.* 2020;18(3):e00274105–e00274105.
 93. Bitton A, Fifield J, Ratcliffe H, Karlage A, Wang H, Veillard JH, et al. Primary healthcare system performance in low-income and middle-income countries: a scoping review of the evidence from 2010 to 2017. *BMJ Glob Health.* 2019;4(Suppl 8):e001551.
 94. Katić M, Jureša V, Orešković S. Family medicine in Croatia: Past, present, and forthcoming challenges. *Croat Med J.* 2004;45(5):543–9.
 95. Hill H, Birch S, Tickle M, McDonald R, Donaldson M, O'Carolan D, et al. Does capitation affect the delivery of oral healthcare and access to services? Evidence from a pilot contact in Northern Ireland. *BMC Health Serv Res.* 2017;6(17):1–10.
 96. Jin Y, Tian W, Yu Y, Pan W, Yuan B. Incentives promoting contracted family doctor service policy to improve continuity and coordination in diabetes patient management care in China. *Front Public Health.* 2022;15(10):843217.

97. Geliukh E, Nabirova D, Davtyan K, Yesypenko S, Zachariah R. Primary healthcare centers engagement in tuberculosis treatment in Ukraine. *J Infect Dev Ctries*. 2019;13(7.1):835–885.
98. Fleetcroft R, Parekh-Bhurke S, Howe A, Cookson R, Swift L, Steel N. The UK pay-for-performance programme in primary care: estimation of population mortality reduction. *Br J Gen Pract*. 2010;60(578):649–54.
99. Salehi AS, Blanchet K, Vassall A, Borghi J. Political economy analysis of the performance-based financing programme in Afghanistan. *Glob Health Res Policy*. 2021;6(1):9.
100. Fichera E, Pezzino M. Pay for performance and contractual choice: the case of general practitioners in England. *Heal Econ Rev*. 2017;7(1):1–14.
101. Glenngård AH. Pursuing the objectives of support to providers and external accountability through enabling controls - a study of governance models in Swedish primary care. *BMC Health Serv Res*. 2019;19(1):1–14.
102. Barsanti S, Vola F, Bonciani M. Trade union or trait d'union? Setting targets for general practitioners: a regional case study. *Int J Health Plan Manage*. 2020;35(1):262–79.
103. Lowrie R, McConnachie A, Williamson AE, Kontopantelis E, Forrest M, Lannigan N, et al. Incentivised chronic disease management and the inverse equity hypothesis: findings from a longitudinal analysis of Scottish primary care practice-level data. *BMC Med*. 2017;11(15):1–15.
104. McGregor W, Jabareen H, O'Donnell CA, Mercer SW, Watt GCM. Impact of the 2004 GMS contract on practice nurses: a qualitative study. *Br J Gen Pract*. 2008;58(555):711–9.
105. McDonald R, Harrison S, Checkland K. Incentives and control in primary health care: findings from English pay-for-performance case studies. *J Health Organ Manage*. 2008;22(1):48–62.
106. Millett C, Gray J, Saxena S, Netuveli G, Majeed A. Impact of a pay-for-performance incentive on support for smoking cessation and on smoking prevalence among people with diabetes. *Can Med Assoc J*. 2007;176(12):1705–10.
107. do Nascimento Carrapiço EI, Vaz Ramires JH, Borges Ramos VM. Unidades de Saúde Familiar e Clínicas da Família - essência e semelhanças. *Revista Ciência & Saúde Coletiva*. 2017;22(3):691–700.
108. Khan Z, Theobald S, Kruger G. Social impact bonds in South Africa: The risks and returns of innovative finance for social change. 2021. Available from: <https://doi.org/10.13140/RG.2.2.15854.08005>. Cited 2022 Mar 5.
109. Khalifa AY, Jabbour JY, Mataria A, Bakr M, Farid M, Mathauer I. Purchasing health services under the Egypt's new universal health insurance law: what are the implications for universal health coverage? *Int J Health Plann Manage*. 2022;37(2):619–31.
110. da Silva JFM, Carvalho BG, Domingos CM. A governança e a relação público-privado no cotidiano das práticas em municípios de pequeno porte. *Ciênc Saúde Colet (Impr)*. 2018;23(10):3179–88.
111. Mureithi L, Burnett JM, Bertscher A, English R. Emergence of three general practitioner contracting-in models in South Africa: A qualitative multi-case study. *Int J Equity Health*. 2018;17(1). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85054422669&doi=10.1186%2fs12939-018-0830-0&partnerID=40&md5=8449786465ce7e1baea1366389430a6d>.
112. Onoka CA, Hanson K, Mills A. Growth of health maintenance organisations in Nigeria and the potential for a role in promoting universal coverage efforts. *Soc Sci Med*. 2016;162:11–20.
113. Etiaba E, Onwujekwe O, Honda A, Ibe O, Uzochukwu B, Hanson K. Strategic purchasing for universal health coverage: Examining the purchaser-provider relationship within a social health insurance scheme in Nigeria. *BMJ Glob Health*. 2018;3(5). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85058905262&doi=10.1136%2fbmjgh-2018-000917&partnerID=40&md5=bf459fda154123edabf4bba2b26cddd4>.
114. Maluka S. Contracting Out Non-State Providers to Provide Primary Healthcare Services in Tanzania: Perceptions of Stakeholders. *Int J Health Policy Manage*. 2018;7(10):910–8.
115. Abramson WB. Monitoring and evaluation of contracts for health service delivery in Costa Rica. *Health Policy Plan*. 2001;16(4):404–11.
116. Ogbuabor DC, Onwujekwe OE. Scaling-up strategic purchasing: Analysis of health system governance imperatives for strategic purchasing in a free maternal and child healthcare programme in Enugu State, Nigeria. *BMC Health Serv Res*. 2018;18(1). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85044948509&doi=10.1186%2fs12913-018-3078-x&partnerID=40&md5=085ca3962e6ee03671d5b1ee8b54db23>.
117. Kabia E, Kazungu J, Barasa E. The Effects of Health Purchasing Reforms on Equity, Access, Quality of Care, and Financial Protection in Kenya: A Narrative Review. *Health Syst Reform*. 2022;8(2). Available from: <https://www.scopus.com/inward/record.uri?eid=2-s2.0-85138900482&doi=10.1080%2f23288604.2022.2114173&partnerID=40&md5=8428f4ffb9753a0e482f71bea84f8089>.
118. Goodair B, Reeves A. The effect of health-care privatisation on the quality of care. *Lancet Public Health*. 2024;9(3):e199–206.
119. Giovanella L, Mendoza-Ruiz A, Pilar A de CA, Rosa MC da, Martins GB, Santos IS, et al. Universal health system and universal health coverage: assumptions and strategies. *Ciencia Saude Coletiva*. 2018;23(6):1763–76.
120. Ooms G, Brolan C, Eggermont N, Eide A, Flores W, Forman L, et al. Universal health coverage anchored in the right to health. *Bull World Health Organ*. 2013;91(1):2–2A.
121. Perekhodoff SK, Alexandrov NV, Hogerzeil HV. Legislating for universal access to medicines: a rights-based cross-national comparison of UHC laws in 16 countries. *Health Policy and Planning*. 2019;34(Supplement_3):iii48–57.

Publisher's Note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.