

# Contracting Out of Health Services for Province-level Integration of Healthcare System: Effect on Equity

Theo Prudencio Juhani Z. Capeding, MD, MPM,<sup>1,2</sup> Ma-Ann M. Zarsuelo, RND, MSc,<sup>1,2</sup> Hilton Y. Lam, MHA, PhD,<sup>1,2</sup> Ma. Esmeralda C. Silva, MPAf, MSPPM, PhD<sup>1,3</sup> and Michael Antonio F. Mendoza, DDM, MA<sup>1,4</sup>

<sup>1</sup>University of the Philippines Manila Health Policy Development Hub

<sup>2</sup>Institute of Health Policy and Development Studies, National Institutes of Health, University of the Philippines Manila

<sup>3</sup>College of Public Health, University of the Philippines Manila

<sup>4</sup>College of Dentistry, University of the Philippines Manila

## ABSTRACT

**Background.** The recently enacted Universal Health Care (UHC) Act prioritizes the provision of a comprehensive set of quality and accessible services. However, the devolution of health services has led to inequitable investments in healthcare resulting to disparities in health outcomes between areas. One of the strategies considered that could minimize these differences is the contracting out of health services to the private sector. This review focuses on mapping equity-related issues and concerns with regard to contracting out health services.

**Methods.** A modified systematic search of literature using published journal articles through PubMed and Google Scholar and other pertinent reports and manuals was conducted on issues of equity and health service contracting.

**Results and Discussion.** There is currently a dearth of literature on the effect of contracting services on health equity outcomes, particularly on the impact of contracting out on equity. Limited studies showed that contracting out can potentially improve equity by increasing service utilization. Mechanisms on how contracting out could potentially affect equity were also found.

Results mainly suggest that concrete steps should be taken to ensure equitable access and improvement in health outcomes among population subgroups. To provide a framework in applying possible insights from the review, discussion of the literature review was framed in the context of establishing performance-based contracting. It was emphasized that including representatives from the underserved populations and patient groups during stakeholder consultations were crucial to provide localized context for the inclusive development of contracting arrangements. Other strategies that were highlighted included: establishing monitoring systems that disaggregate data between groups, selecting contractors that have the capacity to reach and provide services to the underserved, and making sure that these contractors are also open to data sharing for economic evaluation of services.

**Conclusion and Recommendations.** Despite the paucity of data on the impact of contracting out services on equity, mechanisms explaining the effect of contracting on equity were put forward and illustrated. These findings can be considered by policy makers and program developers in the operationalization of service agreements between the public and private sectors.

*Key Words:* health equity, contract services, health services

## INTRODUCTION

The Universal Health Care Act or Republic Act (RA) 11223 mandates that a comprehensive set of quality, affordable, and accessible services be delivered to all Filipinos, through the creation of health service delivery networks integrated at the province or city level.<sup>1</sup> The law aims to improve healthcare access in geographically isolated areas

Corresponding author: Theo Prudencio Juhani Z. Capeding, MD, MPM  
UP Manila Health Policy Development Hub  
National Institutes of Health  
University of the Philippines Manila  
623 Pedro Gil St., Ermita, Manila 1000, Philippines  
Email: tzcapeding@up.edu.ph

as well as for disadvantaged population subgroups. This goal is challenged by the current reality of maldistribution and inequities of health services and goods.<sup>2</sup> On the side of the government, one of the reported causes is the unequal allocation and distribution of health investment among the local government units (LGUs) with the implementation of devolution of health services as prescribed in the Local Government Code of 1991, otherwise known as RA 7160.<sup>3</sup> The devolved set-up might have been lauded for its aim to provide services closer to the people. However, from the time it took effect, persistent problems have arisen, particularly in inequitable distribution of tasks, funding, and the LGUs' capacity to deliver services.<sup>4</sup> Rural areas have remained lacking in health facilities, and where there are health facilities, resources such as health workforce, supplies, and medicines remain insufficient for the demand of the population.<sup>5</sup> As the implementation of the Universal Health Care Act moves forward, it is a must to examine country experiences on decentralization to draw out the best fit model from the gaps and challenges.<sup>4</sup>

The need to build up infrastructure and improve availability of health services has propelled the government to partner with private providers to augment this gap.<sup>6</sup> In general, public-private partnership involves collaboration between government and private organizations, including non-government organizations (NGOs), to attain a common goal through the sharing of pooled resources. Arrangements may range from non-formal to formal. This falls under the scope of public-private partnership stratified by contract types such as service, management, and lease contracts, among others. Scope and level of engagement depend on the needs of the public sector to satisfy the health needs of the same captured population.

One of the strategies under public-private partnership that LGUs tap is the contracting out of health services.<sup>7</sup> In the current Philippine health system, a *service contract* is illustrated as "government hires a private company to carry out specific tasks of services for a period."<sup>8</sup> This arrangement is observed in hospitals complying to the No Balance Billing (NBB) Policy of the Philippine Health Insurance Corporation (PhilHealth) wherein diagnostics, medications, and supplies are sourced out to the health care institution, provided that all options have been exhausted. Consistent with RA 10606, PhilHealth implements NBB Policy wherein indigent patients shall pay no other fees during confinement. In 2017, the NBB Policy implementation was strengthened, including expansion of the covered beneficiaries to indigents, sponsored clients (through Point of Service), domestic workers, senior citizens, and lifetime PhilHealth members.<sup>9</sup> This government program ensures the financial protection of economically disadvantaged subpopulations of the country, thus mitigating health service access inequities across wealth quintiles.

The World Health Organization has proposed that successful private and public partnerships could result to

improvement of health outcomes.<sup>10</sup> However, there has been apprehension with the increasing involvement of the private sector in health service provision. The issue revolves around the concern that this reduces the responsibility of the government to health. The scenario is not ideal, as expansion of the private sector could result to inequity of health outcomes, and this has already been observed, at least for secondary care services.<sup>11</sup>

In contracting out services, there is a purchaser-provider split seen by some stakeholders as being too focused on efficiency while giving little attention to possible inequity.<sup>12</sup> However, those who support private contracting have claimed that the overall benefits of contracting outweigh the costs of establishing and maintaining the services.<sup>13</sup> While the weight of evidence on service contracting already seems to support efficiency, not much has been said about its impact on equity. This review attempted to add to the evidence-based literature, with the specific focus of mapping equity-related findings and concerns with regard to contracting out of health services. Specifically, this paper presents a modified systematic literature review which aimed to: (1) examine the impact of contracting out to health outcomes; (2) gather proposed mechanisms on how contracting out affects health outcomes; and (3) put forth recommendations about future initiatives on contracting out.

## METHODS

The modified systematic literature search was conducted (from August 17, 2019 to October 3, 2019) covering published articles and grey literature from electronic sources MEDLINE and Google Scholar databases. The retrieved journal articles and grey literature were screened based on the applicability of the results, conclusions, and recommendations to the focus of the review. For the MEDLINE database, search terms "Contract Services[MeSH] AND Health Services[MeSH]" generated 2,330 results. To narrow down the search results the terms "Contract Services[MeSH] AND Health Services[MeSH] AND Health Equity[MeSH]" were used but only generated one article. The search terms were revised to "Contract Services[MeSH] AND Health Services[MeSH] AND Equity" which generated 19 articles. After reviewing the titles and abstracts, 5 articles were selected. After reading the full text of the 5 articles, 4 were included and 1 was excluded. For the Google Scholar database, search terms "contracting AND equity AND 'health services'" were used and generated 19,600 results. Screening of applicability of the titles were arbitrarily limited to the first 10 pages of the returned results (total of 100 sources), due to the enormous amount of initial results. After screening of titles, the abstracts of 51 sources were examined, of which 38 were selected for full-text reading. A total of 18 articles were initially included. Snowball sampling was used when other relevant articles came up during the process of review, as well as after examination of references, which added four more

articles in the review. For repository of policies, the Official Gazette was explored while reports from official websites of related national government agencies were also cited.

**Selection Criteria**

Since the paper aimed to focus on evidence related to both the impact and mechanisms behind contracting out, literature that were included either presented a study in which impact on equity of contracting out was assessed, or a possible mechanism of effect on equity was proposed. Literature included reviews, single studies, and analytical or position papers. For studies that examined interventions, contracting arrangements should have been made with non-government bodies. All types of studies - quantitative, qualitative, or mixed methods - were included.

Excluded records in the review were: 1) studies that focused on other forms of public-private partnerships; 2) sources such as books and other documents that were not fully accessed online; and (3) research articles published in a language other than English. Figure 1 shows the article search strategy using PRISMA diagram.

**RESULTS**

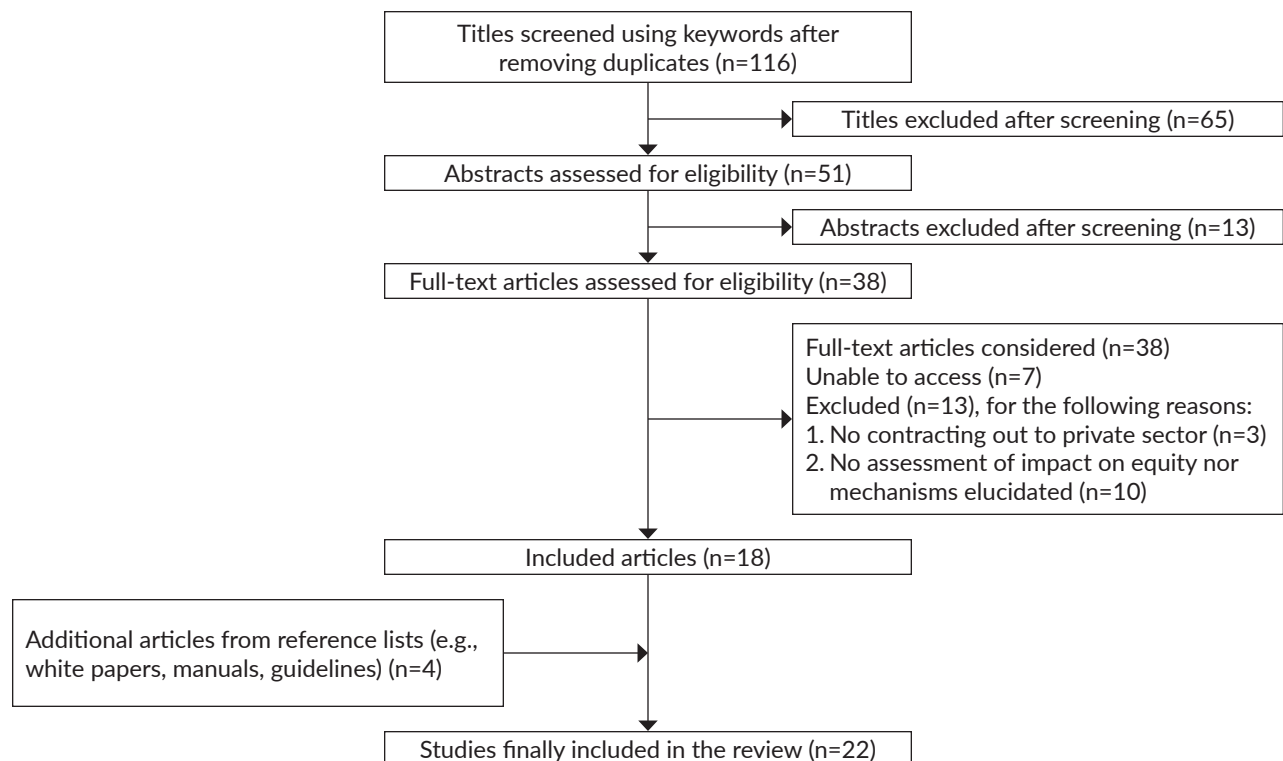
**How is the effect on equity measured by studies?**

Overall, there is a paucity of studies that examined the impact of contracting on equity outcomes. The main challenge lies on the selection of indicators that could help measure the

above. Most of the measurements utilized in previous studies were on the overall change in health service accessibility for a population. Often, the studies tracked the change in service utilization between subgroups of different socioeconomic status.<sup>14</sup> Two systematic reviews, Lagarde and Palmer, and almost a decade later, Odendaal et al., observed that existing literature were primarily composed of studies that measured equity through secondary outcomes. Studies measured the outcomes by using a baseline analysis categorized by socioeconomic status and compared vis a vis observed increased health access among the disadvantaged groups (Table 1).<sup>14,16</sup> In the literature review of Lui et al., the proponents opted not to look at equity in isolation but instead chose to measure overall effectiveness by assessing its impact on health system performance, including the effects on the dimensions of access, quality, and efficiency.<sup>15</sup>

**Table 1.** Health and economic outcome indicators used in assessing the effect of contracting out services

Odendaal (2018)	Lagarde and Palmer (2009)
Utilization of health services (e.g., immunization of children, antenatal visits, use of contraceptives)	Utilization of health services (e.g. uptake of vitamin A, normal deliveries, bed occupancy, patient visits)
Health outcomes (mortality in children, incidence of diarrhea of under-five children)	Health outcomes (incidence of diarrhea in infants, reporting of patients that they had been sick)
Individual healthcare expenditure	Healthcare expenditure Household healthcare expenditure



**Figure 1.** PRISMA diagram on modified systematic research for literature.

## What is the impact of contracting out on health equity?

Data and reports on the impact of contracting out services to the private sector were limited, and evidence on effects of contract arrangement on equity were non-conclusive.<sup>13,17</sup> A pilot study done in Cambodia showed that there were improvements in efficiency without sacrificing equity.<sup>18</sup> The study involved contracting out interventions to reduce infant, child, and maternal mortality to the private sector. Equity gains were attributed to increased access in the poorer socioeconomic group, possibly because of the closer location of services, and of the reduction in the out-of-pocket expenditure in healthcare due to inefficient services.<sup>19</sup>

It is important to note that though there is substantial evidence on overall improved health access, this does not necessarily translate to an improvement in equity. Contextual determinants of improved access are not always expected to be the same among subgroups or between geographic areas covered by the service.<sup>17</sup> Differences in the pre-existing local availability of health services could confound the impact of contracting out services; hence the performance must be understood in the context by which the contracting arrangements were organized.<sup>20</sup> For example, the aforementioned study in Cambodia was implemented with the goal of replacing the services that were already provided by the public sector. Meanwhile, in other studies documented, services implemented were in areas where either service was provided by both public and private sector or only by the public sector.<sup>15</sup> Another study did not specify the primary health care services observed, making comparisons difficult.<sup>21</sup> Capacity and experience of the contracted providers is another factor in improving access. Most of the studies involved non-government organizations that are either non-profit or are specialized to deliver primary health care packages. Next to be considered are the terms of payment. For example, physicians under capitation contracts seemed to have a promising effect on access and equity outcomes, although evidence is limited.<sup>22</sup> Finally, just like publicly provided health services, local political and environmental factors affect the impact of contracted services on the poor and marginalized.<sup>23</sup> Political instability, and the high out-of-pocket expenditure for transportation to reach services, affect the demand generation of these services, especially for the marginalized.<sup>24</sup> These are barriers for contracted out services just as they are for publicly provided services.

## Possible mechanisms behind the effect of contracting out on health equity

Majority of the concerns on the provision of health services through service contracts delve around their effect on the comprehensiveness of services, especially for the poor and marginalized. This loss of consumer choice could potentially lead to health inequities. As the focus on efficiency is increased, economies of scale tend to favor

the concentration of service provision, which might force inefficient or less profitable services to close. This in turn could lead to potential loss of comprehensive local service provision.<sup>25</sup> This effect was seen in hospitals. With financing grants from the government, even public hospitals may focus on providing profitable services, especially when funding is fixed.<sup>26</sup>

Another observed effect is on the allocation of available resources for health. A contract legitimizes the agreement of exchange of resources and the terms of financing scheme. Therefore, a careful examination of the terms in the contract is crucial, as certain arrangements could divert a considerable portion of available resources to selected interventions. A case study in Zimbabwe showed that a long-term service contract with a private hospital led to the concentration of provincial resources to one district. Unfortunately, provision of unnecessary services resulted from the monopolistic arrangements included in the contract. This was an unintended effect of the contracting arrangement.<sup>10</sup>

Another concern is that the perceived overall impact on improved service provision coverage may hide differences on their impact between population subgroups. This could be explained by the lack of awareness of program managers in the differences between the effect of contracting out on the project-level or program-level indicators versus health systems objectives. The target outcomes might be achieved, such as increased service coverage, but it might be at the cost of reduced equity.<sup>15</sup>

Finally, if the contract terms do not meticulously and clearly state the provisions, this could result to contractors gaming the system. In the nature of service contracts financed through capitation payment, there is a risk that private providers, being profit oriented, might be discouraged to provide services that are not cost effective, or to enroll those who are at a higher risk of needing a considerable medical care. For example, capitated primary care physicians might avoid enrolling sicker patients.<sup>27</sup>

Meanwhile, there are also mechanisms that explain the positive effect of service contracting in improving equity. Increasing the availability of cost-effective services to underserved population will increase equity in terms of access and improved health outcomes.<sup>15</sup> Three contractual strategies that may achieve equity were identified: (1) arrangements that encourage providers to target the poor and underserved; (2) contracting established private providers located in underserved areas; and (3) contracting out services that primarily benefit or target the underserved.<sup>28</sup> If the services are focused on improving an almost non-existent primary care system, the effect could be larger. In a study in Uganda which has a decentralized health care system, improved service accessibility was observed through contracting private providers from the private and NGO sectors. Improved health outcomes also resulted from services that were adequately delivered and when public facilities were decongested.<sup>29</sup> Similar effect was also seen in



Afghanistan when NGOs were tapped to provide primary care services just after the collapse of the Taliban, where health infrastructure and services were severely lacking.<sup>30</sup>

### Ensuring equity with contracting out

While it is still difficult to gauge the effect of contracting out services on the quality of care, and in extension its effect on equity outcomes, there are ways to increase the likelihood that improving equity can be one of the effects of contracting out services.<sup>19</sup> Private providers were able to significantly improve access if they were given explicit targets and the responsibility for reaching out to the poor.<sup>12,31</sup> The indicators used to determine these targets should have an established association with the utilization of contracted services.<sup>17</sup> This should also come with an efficient system of monitoring and evaluation to determine effectiveness in terms of health outcomes and population coverage. The most rigorous data were from studies that involved non-government organizations, which have experience in monitoring and evaluation of scaled interventions. Contracting private providers with no prior experience might be a barrier to effective monitoring. Finally, information on costs and quality of the service should be available to both purchaser and contractor and be part of periodic reporting. This data availability on both sides will help improve the ability of the partnership to manage market changes, as well as ensure that proactive strategies that help improve inequities are in place.

## DISCUSSION

Based on the review of literature, mechanisms of contracting out services and its impact on health outcomes are given in Figure 2, specifying the considerations and

perceived barriers. The capacity of the purchaser and the set eligibility of the provider/s based on the stipulated terms of contract will set the formula to attain improved health outcomes through equity, that guarantees accessibility, availability, and efficiency of service delivery.

### Purchaser

#### Stakeholder dialogues for policy development

In expanding the participation of the private sector and non-government organizations in the government’s goal to provide equitable quality service, the composition of stakeholders that would be included in the dialogues mainly rely on the type of services that would be contracted out. This would usually include representatives from the purchasers, the contractors, and clients. It could be valuable to include representatives from the specific underserved populations and patient groups to seek insights on the context of access gaps, and how they would affect improvement in access or quality. The discussion should primarily be guided by the following objectives: 1) discuss equity concerns of stakeholders; 2) identify subgroups of underserved or marginalized population within the catchment population; 3) establish a consensus on the set performance indicators related to equity; and 4) identify strategies and mechanisms that would guarantee equity while providing the interest of all stakeholders.

#### Monitoring and evaluation

Any intervention that introduces change in a system needs monitoring and evaluation to ensure that the goals, challenges, and gaps are addressed in a timely manner with appropriate remedial actions. In the context of this review, this step is the most crucial in ensuring that equity-related

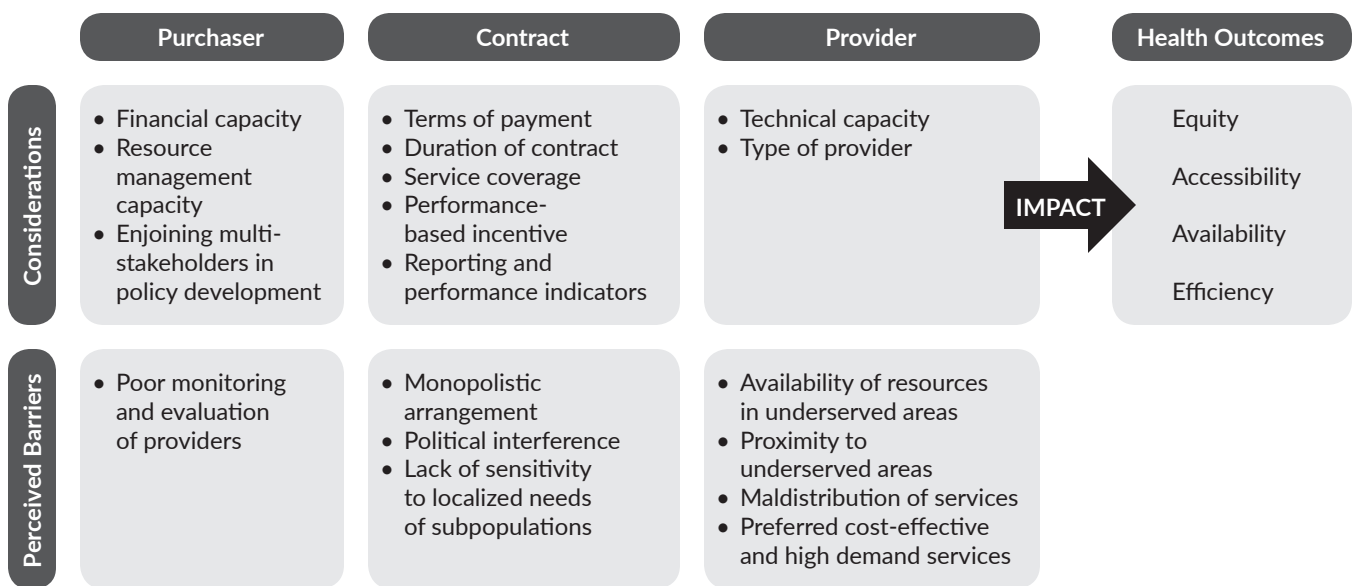


Figure 2. Conceptual framework on the considerations and perceived barriers in contracting out services to attain improved health outcomes.

concerns are addressed, and the underlying determinants of the problems are considered. As would be initiated in the stakeholder discussions, the design of this contracting arrangement revolves around the identified indicators and outcomes for equity. First, the indicators chosen should be objectively measurable and defined as precisely as possible.<sup>6</sup> Second, policy designers should take into consideration what data will be collected by the contractors, by third party assessors, and by the existing national monitoring programs. With the varying aims of the stakeholders, conflict of interest must be examined to guide arrangements for objective data collection. In addition, this aims to avoid duplication of data gathering efforts and the unnecessary use of limited resources, as monitoring and evaluation can take up a significant portion of funds.<sup>18</sup> Third, an initial phase of baseline data gathering is preferred to have a basis for comparing the pre- and post-implementation performance of the contracting arrangements.

For program managers, awareness of the differences between program-level indicators and equity outcomes on health system is crucial, as literature showed that it is possible to attain an overall improvement in access, within a setting of unequitable access among subpopulations. Hence, data analysis on post-implementation performance should also be conducted on the underserved or marginalized populations intended to receive the services. For example, a study on immunization coverage noted an overall improvement in coverage rates for the whole population, but closer examination of data showed a significant gap in coverage between children from the poor and wealthy households.<sup>32</sup> This means that while access or coverage is being tracked by the program, performance distinction between groups such as beneficiaries from higher income quintile versus those from the lower quintiles should also be examined. This is to ensure that improved coverage and accessibility include the subgroups in most need of health investments.

## Contract

### *Contract design*

Steps should be taken to ensure equitable access and improvement in outcomes among population subgroups. Performance-based type of contracting can be considered to help assure this. What sets performance-based contracting apart from other types of contracting is its specific focus on the reporting of data on performance indicators, and on setting corresponding sanctions to contractors if performance is below the prescribed quality or standards.<sup>6</sup>

### *Contract objectives*

There is still an ongoing debate on whether contracting out that focuses on efficiency comes at the cost of inequity. The best way forward to address this concern is to establish safeguards and warning mechanisms similar with what has been previously discussed. Policy makers should also

be aware, that while it would be in the best interest for health system managers to provide efficient and effective services, maintaining comprehensiveness of care is still expected to be the accountability of the government. In the case that non-profitable but essential services are not accommodated by the private sector, the local health system then must invest in these services to maintain availability. The contract should be crafted in a way that it will reinforce harmonious relationship among public, private, and non-government organizations' provision of health services.

Therefore, it is vital to develop a clear vision of the target goals, as well as the feasible and context-appropriate means to attain them. In the context of the UHC, there are two main factors to be considered in the operationalization of contracting services by the government. One, contracting is usually done as a short-term solution, as a way to rapidly address coverage concerns and the lack of existing infrastructure and health investment in an area; and two, the UHC Act states that PhilHealth would prefer contracting via networks, and not via facilities.<sup>10,19</sup> This puts forward a possibility that private providers, might establish and expand networks faster than the public sector. If long term arrangements with private provider networks are deemed appropriate and beneficial for the underserved and marginalized, the government should also be cognizant of the fact that if the purchasing role of the government is not periodically re-assessed, it might lose the opportunity to invest in the public health system in the long term.<sup>30</sup>

### *Setting the service coverage*

An assessment of health system gaps on the comprehensive set of services must be conducted before selecting the services to be contracted out to the private providers. The main concern in relation to equity in this step is to take note where and to whom are the services being provided. Much of the documented equity gains from contracting out were attributed to improved geographical access since the facilities of private providers aid in easier access for the underserved subpopulations. In the context of the UHC, it could be worthwhile to facilitate the use of contracting to improve access in these low service utilization areas.

## Providers

### *Selection of contractors*

Thorough assessment of the capability of the contractor to provide services to the underserved or disadvantaged groups is key to the success of contracting arrangements that are sensitive to equity concerns. As seen in the literature, previous global experience with contracting involves NGOs that are mission-driven in nature.<sup>6,15</sup> As such, it is improbable to expect such NGOs to cover all areas, and strategic purchasers might encounter situations that the most cost-efficient option is to partner with organizations that are profit-driven. Given the nature of these organizations, there

is a risk that services that are cost-effective and consistently in high demand might be preferred. This might entail choosing contractors that are closely located to underserved and marginalized areas, and those who commit to serving the hard-to-reach areas. Contractors should also be willing to be monitored and evaluated by a third-party assessor and are open to data sharing for economic valuation of services.

## CONCLUSION AND RECOMMENDATIONS

There is a dearth of current evidence on the impact of contracting out on equity but it seems that impact is highly contextual depending on the environment in which the contract is formed. Hence, this calls for more local studies, stakeholders' forums, and constituting a technical working group, in order to utilize best available evidence in policy development in the light of the implementation of the UHC Act.

Despite this, multiple mechanisms postulating the effect of contracting on equity are identified, such as loss of consumer choice, distribution and allocation of available resources, improvement of service coverage, and the possibility of contractors gaming the system. These mechanisms could play a significant role in planning the operationalization of this specific type of public-private partnership and should be taken into consideration by policy makers. It is imperative to examine both the supply and demand side of service delivery to determine what strategic approaches would augment the gaps in providing services and seeking care, in consideration to the population characteristics. All these work within the built-in environmental framework (e.g. proximity and location, accessibility of transportation, peace and order profile, etc.) of the captured population, which should also be considered.

### Statement of Authorship

All authors participated in data collection and analysis, and approved the final version submitted.

### Author Disclosure

All authors declare no conflicts of interest.

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