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## Public healthcare and contracting out: can it work? Global review presents some answers

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Universal health coverage – ensuring everyone can get quality, affordable healthcare when they need it – is one of the targets of the Sustainable Development Goals.

But progress towards meeting this target has been elusive, especially in developing countries. In recent years, existing weaknesses in public health systems have been magnified by the COVID pandemic, strained public budgets, rising public debt and climate change-related risks.

An increasingly common governmental strategy for universal health coverage is to contract private companies or non-profit organisations to provide healthcare services on its behalf. Known as “contracting out”, it is often seen as a way to bypass perceived public sector inefficiencies and rigidities, and to use existing private sector infrastructure and resources to expand public service provision.

Some proponents of contracting out also believe that introducing competition and innovation would improve the quality of healthcare services. Those are principles often associated with markets.

But how does it work in practice? And does contracting affect opportunities for community participation, a cornerstone of primary healthcare and of democratic governance?

Our team of researchers in South Africa, Brazil and India conducted a global review of the evidence, analysing over 80 peer reviewed studies from around the world. We wanted to understand, firstly, whether contracting improved access, quality and equity in primary care. Health systems grounded in strong primary care typically perform better.

Secondly, we wanted to find out whether involving local communities in the governance (design and monitoring) of these contracts made a difference.

Our review painted a complex picture. On the positive side, the evidence was clear that contracting out often improved access to primary care. This was particularly true in peripheral or remote areas where the state’s reach and resources were limited.

However, the impact on service quality was far less clear.

On the community question, our research found that when communities had a real say in designing and monitoring contracts, the results were better. It helped to improve access and make services more responsive to local needs.

This global evidence has implications for South Africa as it grapples with extreme inequalities in health and the proposed introduction of the National Health Insurance (NHI) scheme. This envisages a healthcare system in which healthcare would be bought from a mix of public and private providers. Our research points to what the government would need to put in place for this to work.

## **Defining and measuring quality – and what we found**

The complexity of the results in relation to quality is partly due to differences in how various studies and programmes measure it.

Ideally, quality should be measured by the effectiveness and relevance of services. In other words, whether they solve the healthcare problems they intend to and tackle actual needs. But often, service quality is assessed on the basis of whether contractors meet a set of narrowly defined targets, like numbers of patients seen and services delivered, rather than what the services achieve.

Quality can also be defined from the perspective of cost effectiveness, rather than public health objectives. This can produce incentives for contractors to cut costs and avoiding treating sicker patients.

In some cases in our review, as in parts of Brazil and India, contracting was associated with impressive improvements in health outcomes, such as reduced infant mortality. In others, quality stagnated or even declined from this perspective.

We also found that profiteering can take root when for-profit companies assume control of service provision and success is defined primarily in terms of shareholder value. In Brazil, contractors have to be non-profits for this reason.

An important influence on service quality is the state's capacities in contract management. Is it able to design good contracts, quality indicators, payment systems and incentives? How well does it manage relationships and enforce terms?

## **The benefits of community participation**

The most compelling evidence came from Brazil. It has set up legally mandated health councils composed of community members and health workers. They have powers to veto health plans and budgets.

Councils have often helped non-profit health providers to understand local needs, remove access barriers, and anticipate service delivery challenges.

Similar successes were noted in Iran. The country has set up “people’s boards of trustees” at health centres. These contribute to planning and outreach.

In Bolivia and India, initiatives involving community participation in the governance of services delivered by non-profit organisations were linked to improved maternal and child health outcomes.

However, effective participation requires resourcing, and the political will to ensure participation enables real influence.

States need to provide transparent, high-quality data on contractors’ performance, and invest in upskilling community partners to interpret complex contractual terms.

Community actors may also lack the confidence to engage with government and corporate officials, who are usually more powerful. Too often, participation is frustrated by technical glitches in fragmented reporting systems, a lack of cooperation from officials, and a focus on auditing finances rather than health outcomes as well.

## **What this means for South Africa’s NHI**

The [NHI Bill](#) envisions the state as the single purchaser of healthcare services, buying care from a mix of public and private providers. This is, in essence, a massive nationwide contracting exercise.

Our research suggests that for it to succeed, two things are essential: state capacity needs to be built; and public participation must be embedded in the system.

For the NHI scheme to work the following is therefore needed:

1. **Building state capacity:** The success of the NHI hinges on the state’s ability to contract effectively. This requires skilled officials who can design watertight contracts, manage complex supplier relationships, and monitor performance based on health outcomes, not just expenditure. Throughout our review, the dangers of weak or inexperienced purchasers of healthcare services are clear: spiralling costs, poor quality, and weak accountability.
2. **Embedding public participation:** The NHI should adopt a rights-based, democratic approach to contracting rather than solely a technical one. Meaningfully involving the people that use contracted services improves those services. South Africa has a rich history of community governance structures and civil society advocacy in health. The NHI should give communities a formal role in setting priorities and holding service providers and organisations to account.