World Health Organization

Private Sector Landscape in Mixed Health Systems

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Private Sector Landscape in Mixed Health Systems

This is a conference copy

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Abbreviations

ADB	Asia Development Bank
AfDB	Africa Development Bank
AFRO	WHO Regional Office for Africa
AHME	African Health Markets for Equity
AMC	Advance Market Commitment
ANC	Antenatal care
ARI	Acute Respiratory Infection
BCC	Behaviour change communication
BMGF	Bill & Melinda Gates Foundation
CHE	Current Health Expenditure
COP	Conference of the Parties
COPD	Chronic Obstructive Pulmonary Disease
CSO	Civil society organizations
CVI	Childhood Vaccine Initiative
CVP	Childhood Vaccine Program
DFID	Department for International Development
DHS	Demographic and Health Surveys
DOH	Department of Health
DRG	Diagnosis Related Group
EMRO	WHO Regional Office for Eastern Mediterranean
EURO	WHO Regional Office for Europe
FP	Family Planning
FBOs	Faith Based Organisation
GAFTM	Global Fund to Fight AIDS, TB and Malaria
GFF	Global Financing Facility
GHED	WHO Global Health Expenditure Database
GIIN	Global Impact Investing Network
GP	General Practitioners
GPPP	Global Public-Private Partnerships
GPW	General Programme of Work
HIC	High Income Countries
HIES	Household Income and Expenditure Surveys
HMIS	Health Management Information Systems
HMO	Health Maintenance Organization
HNP	Health, Population and Nutrition
HSS	Health System Strengthening
HQ	Headquarters
IAVI	International Aids Vaccine Initiative
IFC	International Finance Corporation
iNGOs	International non-government organizations
ITNs	Insecticide-Treated Nets
LMICs	Low- and middle-income countries
MDSR	Maternal Death Surveillance and Response
MICS	Multiple Indicator Cluster Surveys (MICS)
MOH	Ministry of Health
M4P	Markets for the Poor
MM4H	Managing Markets for Health
MMV	Medicines for Malaria Venture
MVI	Malaria Vaccine Initiative
NHA	National Health Accounts
NCDs	Non-Communicable Diseases
NMDS	National Minimum Data Set
NGO	Non-government organizations
NHI	National Health Insurance
NMDS	National Minimum Data Set
NORAD	Norwegian Agency for Development Cooperation
NTP	National Treatment Programmes
OECD	Organization for Economic Cooperation and Development
OOP	Out of Pocket
ORS	Oral Rehydration Salts
PAHO	Pan American Health Organization
PBF	Performance Based Financing
PHC	Primary Health Care
PHSA	Private Health Sector Assessment
PPA	Patient Pathway Analysis
PPM	Public Private Mix
PPPs	Public Private Partnerships
PSE	Private Sector Engagement
PSI	Population Services International
PPD	Public Private Dialogue
RDTs	Rapid Diagnostic Tests
RH	Reproductive Health
RMCNH	Reproductive, maternal, child and nutrition health
SARA	WHO's Service Availability and Readiness Assessment
SDG	Sustainable Development Goals
SEARO	WHO Regional Office for South East Asia
SHI	Social Health Insurance
SHOPS	Sustaining Health Outcomes through the Private Sector
SM	Social Marketing
SPA	Service Provision Assessment
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TMA	Total Market Approach
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WHO	World Health Organization
WHO HGF	World Health Organization Health Governance and Financing Department
WONCA	World Organization of Family Doctors
WPRO	WHO Western Pacific Regional Office

Foreword

In 2019, the World Health Organization set up an advisory group on the Governance of the Private Sector for Universal Health Coverage. The group was formed with the primary goal of providing advice and recommendations on the regulation and engagement of the private sector in the context of WHO GPW goal of 1 billion more people benefiting from Universal Health Coverage, and in particular outcome 1.1.4, "Countries enabled to ensure effective health governance".

In late 2020, the advisory group finished a new strategy designed to help WHO facilitate a new way of governing mixed health systems by building consensus around the means and strategies of engaging the private health sector in health care service delivery. This new strategy focuses on the governance of the whole health system - both private and public – to ensure that all people have access to quality health care without suffering financial hardship, irrespective of where they seek care.

The eight studies in this volume were commissioned by WHO to help the advisory group to complete its work on the new strategy. Each of these studies also contributes valuable information to broader discussions about the role of the private sector in health care and the growing momentum to using cross-sector partnerships to achieve the health-related SDGs.

> The eight studies in this volume were commissioned by WHO to help the advisory group to complete its work on the strategy to facilitate a new way of governing mixed health systems.
>
> David Clarke, Health Systems Governance Department, WHO

Introduction

All 193 Member States of the United Nations have committed to working towards the goal of universal coverage (UHC)(*1*). Increasingly, health services are delivered through mixed health systems of public and private providers, where the private health sector is an essential source of health-related products and services, including for the poor. So the private health sector is a crucial partner for work on UHC. However, the private health sector will not self-regulate and the three dimensions of UHC: ensuring coverage, access, and financial protection are unattainable without effective governance of the private sector(*2,3,4*).

Increasingly, health services are delivered through mixed health systems of public and private providers.

While mixed health systems are a reality in many countries, challenges to the achievement of health objectives are becoming more pressing, and it is clear that some governments are ill-equipped to steer mixed health systems. They lack policy frameworks for private sector engagement, have inadequate information about the private sector, or lack the expertise to develop and manage strategies to influence and collaborate with the private sector. Governments also inherit unfavourable legacies of mistrust, a focus on vertical programming and an over-reliance on certain forms of engagement (for example regulation).

While some countries have successfully navigated these challenges, many have not, and the behaviours and tools of government necessary for the governance of the private sector, such as dialogue, contracting, policy and regulation, have not been high on their list of priorities. Instead, many have fallen back on a reflexive approach focused on managing the public health sector and ignoring the private. This situation creates an essential and urgent need for governments to evolve their governance role. Hence, the decision to develop a new WHO's Strategy Report.

The COVID-19 pandemic has served to starkly reinforce the need for the strategy to help deliver more robust governance of the private sector as part of global, regional, and national health security efforts. The pandemic has exposed the limitations of not having a governance strategy or the corresponding resources necessary for effectively engaging with the private sector in health care service delivery.

The COVID-19 experience has revealed best- and worst-case health system scenarios, with the trajectory (whether negative or positive) being primarily determined by the state of countries pre-existing relationships between public and private sectors and by the strength of its governance of the private sector. Countries with robust governance arrangements for the private sector have been able to leverage them in their response to the pandemic through strategic action. In contrast, those with weak governance arrangements have not. This is why it makes sense to pursue strategic action to improve health systems governance. It is also why the formalisation of effective public-private engagement is critical if we are to make progress on longer-term health goals, including UHC, which is why the new WHO's Strategy Report and these eight studies are so important.

David Clarke, Health Systems Governance and Financing Department, WHO

1 https://undocs.org/en/A/RES/74/2

2 Morgan, R., Ensor, T. and Waters, H. Performance of private sector health care: implications for universal health coverage. The Lancet. 2016. doi: 10.1016/S0140-6736(16)00343-3

3 Nabyonga-Orem, J., Nabukalu, J. B. and Okuonzi, S. A. Partnership with private for-profit sector for universal health coverage in sub-Saharan Africa: opportunities and caveats. BMJ Global Health. 2019. doi: 10.1136/bmjgh-2018-001193

4 Clarke, D. et al. The private sector and universal health coverage. Bulletin of the World Health Organization. 2019 doi: 10.2471/BLT.18.225540.

The landscape of the work has changed. UHC cannot be achieved without the private sector. It is essential to re-frame public and private sector engagement as a partnership in health for shared health outcomes

Peter Salama, former Executive Director of Universal Health Coverage, World Health Organization

The eight studies

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2 The Provision of Private Healthcare Services in European Countries ...... Page 27
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“Study 1 looked at the role of the private sector in 65 countries in Latin America, Africa, Europe and Asia to advance the understanding of the importance of private-sector policies, and facilitate the sharing of lessons across countries with similar public-private distributions.

1

Private Sector Utilisation: Insights from Standard Survey Data

Countries often lack data on the scope and scale of their private health sector. This data gap is regularly highlighted as a primary barrier to private sector engagement, especially in low and middle-income countries (LMICs). The challenge in many LMICs is that the public and private health sectors operate in two parallel and separate spheres. Moreover, the private health sector is often fragmented and disorganised.

To better understand this problem, study 1 looked at the role of the private sector in 65 countries in Latin America, Africa, Europe and Asia to advance the understanding of the importance of private-sector policies, and facilitate the sharing of lessons across countries with similar public-private distributions. The study confirms earlier studies that show the private sector remains a dominant source of outpatient care in many countries, particularly in WHOs African, Eastern Mediterranean and South-east Asia regions, and provides significant inpatient care across the same parts of the world. The study finds that:

- the WHO Eastern Mediterranean Region has the most significant reliance on the private sector. Weighted regional results indicate that 53% of inpatient and 66% of outpatient care takes place in the for-profit private sector. With data from Egypt and Pakistan heavily influencing this result;

- in the WHO African Region, 35% of those who seek outpatient care go to the for-profit private sector, while 17% seek care at shops, faith healers and other informal providers. Overall, 26% of care-seeking occurs in the formal private sector (e.g. medical clinics and nursing homes), with an additional 10% with informal providers. The most significant proportion of private-sector care-seeking occurs in Nigeria (52%), while in Cameroon, Uganda and Benin, greater than 40% of care is sought in the private sector.

The study concludes that advances to UHC will in many countries necessitate private sector inclusion in the dissemination and adherence to standards of practice for quality, access, transparency of pricing, reporting of care practices, and the integration of private providers in countries referral systems. It also highlights the importance of WHO's work on the governance of mixed health systems and the importance of WHO developing guidance and actively supporting countries to assure that formal private care providers are well integrated into the overall health system.

2

The Provision of Private Healthcare Services in European Countries

The authors of the first study noted that the type of data used in the study meant that the study poorly represented private sector utilisation in Europe. A second study was commissioned in 2020 to address this limitation. This second study concentrates on European countries which are part of the OECD and places the countries into four categories based on each country's relative level of reliance on the private sector (ranging from mostly private health systems to mostly public).

This second study concluded that there are significant variations in how the private sector is engaged to provide healthcare within European health systems. The variety demonstrates that there seem to be multiple service configurations for delivering effective health care in Europe.

The study concludes that the European experience shows that historical experiences and path dependency may dictate whether the private sector is an essential provider of care in a country. The varied models, and success, of Europe, show that any extant delivery mix can be managed. Well planned national policies and financing can assure effective universal coverage regardless of the delivery structures used (public or private).

This second study concentrates on European countries which are part of the OECD and places the countries into four categories.

The third study is closely related to studies one and two. It hypothesises that the key to understanding the private sector's contribution to UHC is to build the best available picture using existing data

3

Measuring the Size of The Private Sector: Metrics and Recommendations

The third study is closely related to studies one and two. It hypothesises that the key to understanding the private sector's contribution to UHC is to build the best available picture using existing data, while simultaneously investing in multisectoral improvements to standard data availability. The study recommends 12 new metrics to measure the private sector's role in UHC and explores the feasibility of using these metrics in a set of four case studies.

Study 3 concludes that WHO can support countries to bolster their knowledge of the private health sector through:

- the selection of key data and encouragement to report;
- research that advances the knowledge of promising existing data sources; and
- the development of new guidelines on standard data collection on the health workforce and service delivery points.

4

Landscape Analysis: Engagement with the Private Health Sector in the Journey towards Universal Health Coverage

Previous studies and reports have underlined the importance of engaging the private health sector and developed various strategies and approaches for effective public stewardship of mixed health systems. However, actual progress on private health sector engagement across LMICs in different regions remains unclear. Study 4 assesses the level of private health sector engagement in 18 LMICs with the highest overall utilisation of private health providers across six WHO regions. Reviewing official documents, grey literature, and peer-reviewed literature, it completes a landscape analysis of private health sector engagement in the 18 countries using the domains in the World Bank/International Finance Corporation's private health sector engagement assessment framework.

The study finds a general recognition of the private health sector's role in achieving population health goals, though finds that specific policies on private sector engagement and formal dialogue mechanisms remain rare. The study recommends that WHO should develop explicit norms and guidance across all six domains in the World Bank/International Finance Corporation's private health sector engagement assessment framework. The goal is to ensure a more efficient system-wide approach for the effective governance of the private sector within mixed health systems.

Study four assesses the level of private health sector engagement in 18 LMICs with the highest overall utilisation of private health providers across six WHO regions.

Study five discusses "three waves" of private sector engagement activities in global health.

5

International Organizations and the Engagement of Private Healthcare Providers

Study 5 had three objectives:

- to map the current private sector engagement activities of key global health actors, with a focus on the goals, geographical foci, and programmatic approaches, of such activities;
- to assess the strengths and limitations of these activities from the perspective of work on UHC; and
- to analyse how WHO, as a relatively new player in this area of work, can deploy its distinctive strengths to accelerate progress towards UHC.

The study discussed "three waves" of private sector engagement activities in global health, focusing respectively on: social marketing, international public-private partnerships, and market systems in the health sector. The study found that: these efforts concentrated on programme-specific objectives; approaches to engagement used were not well-aligned with UHC; and the initiatives did little to strengthen the governance of mixed health systems.

Study 5 recommends improving the availability of data on the private sector, developing more evidence-based approaches to private sector engagement, and better coordinating private sector activities between global health actors working in the area of private sector engagement.

Study six considers accountability and its arrangements for health service delivery in the context of UHC.

6

Private Sector Accountability for Service Delivery in the Context of Universal Health Coverage

This study considers accountability and its arrangements for health service delivery in the context of UHC. The paper draws on a short literature review, both academic and practice-oriented, on accountability and health service delivery. Primary data was collected through informant interviews with experts working on accountability, health sector governance and service delivery.

The study highlights four critical areas for WHO to work on to strengthen the accountability of the private sector:

- package learning and advice on how to design and implement accountability systems;
- develop diagnostic tools for the private sector and accountability environments in mixed health systems;
- support Member States with the development of transformative accountability agendas, based upon social compacts between sectors, grounded in diagnosis and dialogue;
- research to understand the contextual factors that promote or hinder accountability environments in mixed health systems.

7

Engaging the Private Health Sector to Advance Universal Health Coverage: A Case Study from WHO Regional Office for Eastern Mediterranean Region.

Study 7 is a case study which illustrates how a WHO region can support its Member States work on private sector engagement.

The study discusses the experiences of WHO Regional Office for Eastern Mediterranean Region in developing its "Framework for Action on Effective Engagement of the Private Sector to Expand Service Delivery for UHC". The work on this framework is highly instructive for other WHO regions as well as Member States planning similar work.

Study 7 is a case study which illustrates how a WHO region can support its Member States work on private sector engagement

Study eight analyses lessons learnt from countries which have been able to implement effective governance of mixed health systems.

8

Principles for Engaging the Private Sector in Universal Health Coverage

This study analyses lessons learnt from countries which have been able to implement effective governance of mixed health systems. These lessons were then used as the basis for developing a set of evidence-based principles to orientate the actions of governments working on the governance of the private sector.

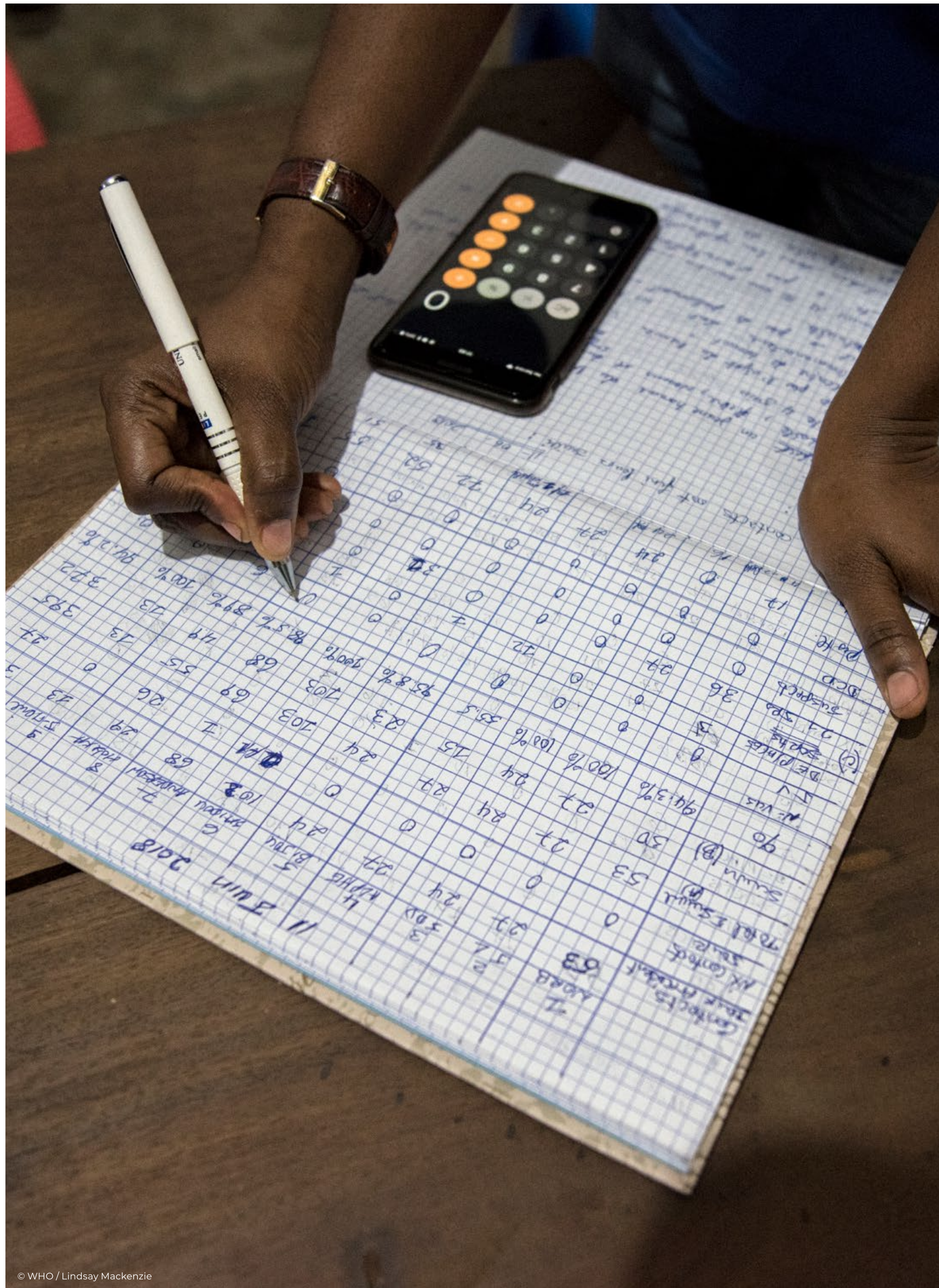
First, a well-functioning mixed health system relies on strong governance. Governments must correct market failures to ensure the appropriate health services are delivered. They have three tools at their disposal (financing tools, regulatory tools, and information tools) that would usually be used in combination to influence different aspects simultaneously.

Second, effective private sector engagement approaches are defined by "problems" and not "solutions". The article underlines a common failure of private sector engagement activities: they are often composed of pre-designed solutions; instead, the starting point should be the problems that the country is facing.

Third, successful governance of the private sector requires data. Sound policies that can harness private sector capacity to advance UHC objectives cannot be developed without adequate data. Countries have several options to gather those data:

- sector analysis;
- health market analysis;
- provider research; and
- consumer research.

Fourth, the private sector needs to be engaged in a meaningful dialogue. Increasingly, development partners, governments, and the private health sector alike agree that sustainable development requires all key players to work together for change. The study highlights six attributes of successful public-private dialogue.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1

Private Sector Utilization: Insights from Standard Survey Data

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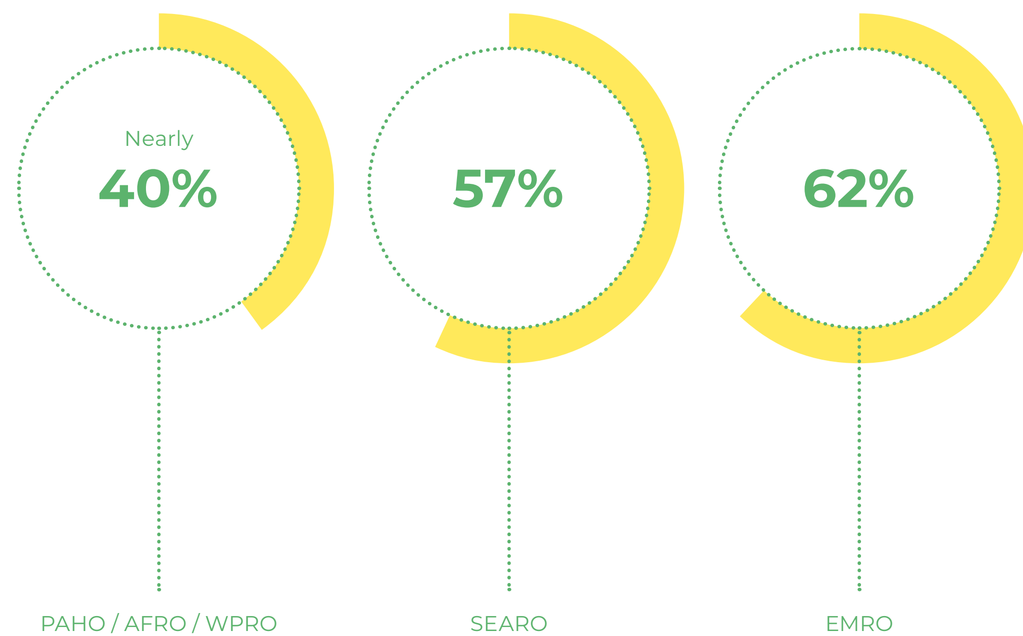


Executive Summary

Universal Health Coverage in Low- and Middle-Income Countries is increasingly expanding through incorporation of private clinics, pharmacies, and hospitals into an overall health system funded in whole or part through government managed health insurance mechanisms. This has highlighted the importance of regulations and policies on health provision which apply across the whole delivery system regardless of ownership status. To advance the understanding of the importance of private-sector policies, and to facilitate the sharing of lessons across countries with similar public-private distributions, we have analyzed data on the source of inpatient and outpatient care from 65 countries. While past studies have conducted similar analysis, ours advances the field in two ways. First, we limit our analysis to data sets from 2010 through 2019, making our study more up-to-date than past studies, while changing health seeking patterns for maternal health since 2010 means that our data set is more representative of overall inpatient care. Second, while past multi-country analysis of public-private ownership have been based on the Demographic Health Surveys, we have added to this data from the Multiple Indicator Cluster Surveys, significantly increasing the countries in our analysis.

Our findings underscore the importance of WHO developing guidance and supporting countries to assure that formal private care providers are integrated into overall health systems.

We have aggregated our analysis by WHO's regions.

Outside of the EURO region, where the private sector delivers just 4% of all healthcare services, the private sector remains significant, and in many countries represents more than half of all care. The private sector provides nearly 40% of all healthcare in PAHO, AFRO, and WPRO regions, 57% in SEARO, and 62% in EMRO. While specific countries with two recent surveys show variation in the scale of both inpatient and outpatient private provision, we did not find regional or global trends towards or away from private care within LMICs. The private sector for inpatient care is more important for the wealthy in many countries; wealth variations are less important in determining public vs. private source of care for outpatient services.

Findings

Our findings underscore the importance of WHO developing guidance and supporting countries to assure that formal private care providers are integrated into overall health systems. Existing literature highlights the need for guidance to national vertical programs on private sector integration (immunization, family planning, malaria control, tuberculosis, etc). More generally, advances to UHC will, in many countries, necessitate private sector inclusion in the dissemination and adherence to standards of practice for quality and access, transparency of pricing, reporting of care practices and illness presentation, and the integration of private providers into referral systems across many areas of care.

Introduction

This study sets out to summarize the importance of private provision of inpatient and outpatient care within health systems of 65 countries in Latin America, Africa, Europe, and Asia. We expand on and update prior studies which have used similar data, and create regional summaries. The reason to undertake this analysis is the change in delivery patterns around the world which makes our data set of inpatient source of care a better proxy for overall inpatient care than was true in the past, and the expansion in recent years of both the system level goal of Universal Health Coverage (UHC) and of the use of Social Health Insurance (SHI) as a vehicle to advance it(*1*). SHI initiatives are increasingly engaging the private sector as a necessary way to achieve UHC in countries where a large part of the existing service provision infrastructure, providers, and care-seeking, is private.

The push towards UHC has thus underscored the need to assure common standards of care are applied to both public and private sector facilities and providers, and that all sources of healthcare are coordinated regardless of ownership status. Referrals between public and private providers, pharmacies, laboratories, blood-banks, and hospitals must be seamless and efficient if care for patients is to take precedence over monopolies driven either by profit or ideology. Sharing of data, diagnosis, medicines, and information is often critical for public health. The experiences of tuberculosis and vaccines have shown the world that integration of care between public and private is possible, and that when done well it can greatly advance health goals(*2*). Advancing both integration and common standards requires adjustments, often significant adjustments, to regulatory systems designed to address only the public sector. These changes include policy, programmatic, and implementation challenges(*3*). Addressing them requires the awareness and attention of policy makers, and of global institutions which can provide guidance and examples of relevant best practices. The work of this study is intended to inform both of these constituencies, as well as providing information on where lessons applicable to any one country may best be drawn.

Measuring the private sector

For nearly 20 years nationally representative surveys have been used to identify variations in access to health services by country and region as well as across wealth and geographic regions within countries. Using Demographic and Health Surveys (DHS) researchers have been able to inform policy and program decision-making with information on care-seeking for families with pediatric illnesses, maternity services, and family planning. This survey data can inform country comparisons. It matters, for example, for national governments, international agencies, and donors to know that 80% of pediatric care in Pakistan is sourced exclusively from the private sector, while in Ethiopia the percent of all pediatric care that is private is only 24%(*4*).

Payment data has the potential to offer an alternative measure of public-private health mix in many countries, however there are challenges. With some variation depending on the source data used, there is consistency in findings that 95% or more of all private expenditure on health is out-of-pocket (OOP) payment for care directly to providers, and that OOP payments are surprisingly stable, hovering around two percent of GDP. An important implication of this is that OOP decreases as a percent of total healthcare expenditures as countries become wealthier and government expenditures towards health increase(*5*). Private payments make up approximately 40% of total health expenditure in Sub-Saharan Africa, 60-80% in South Asia, and 20-80% of all health expenditures in the rest of the world(*6,7,8,9,19*). While private voluntary insurance and social health insurance expansion is changing this slowly, the effects of both are relatively small in LMICs(*1,11*).

Expenditures are a strong measure of the risks of household impoverishment and of access challenges, but show poor correlation to source of care: payments are made to both public and private providers. As such, OOP payments are not a good measure of the importance of the private sector relative to overall healthcare service provision (*5,12,13*). Utilization of care, measured through mostly-standardized questions on large-scale household surveys around the world, provides a more stable and comparable – across times and countries – estimate of the private sector's importance overall. This in turn can inform the need for policy attention to focus specifically on privately owned pharmacies, clinics, and hospitals within the context of overall health systems regulation and guidance.

> **The importance of policy decisions specific to private healthcare provision has been underscored by recent analysis.** (McPake and Hanson, 2016)

The importance of policy decisions specific to private healthcare provision has been underscored by recent analysis(*13*), and by the growing recognition that private healthcare, in many Low- and Middle-Income Countries, is external to both the regulatory and financing systems which are expanding to assure Universal Health Coverage(*3,14*). Where regulatory and subsidy systems have included private providers, the results have been overall improvements in access and quality; better than when these same providers act externally to the national overall health regulatory structure(*15*). Evidence on the importance of private provision within overall national contexts is therefore important as policy makers consider how much attention to give to this issue. Informing this is knowledge of what other countries might have provider sectors of roughly equivalent scale and so provide models worth examining to inform national policies(*16,17,18,19*).

Past efforts to provide this evidence have relied primarily on the DHS as the sole source of nationally representative data on source of care (*20,21,22,23*). We have both updated the DHS data used from prior studies, and nearly doubled our data points by added in surveys from UNICEF's Multiple Indicator Cluster Surveys(*24*).

Our analysis examines 65 countries using DHS and MICS surveys, including more countries than previous studies by Campbell and Footman(*25,26,27*). Our work also utilizes data sets from 2010-2019, updating previous work that used data from time points between 1990 and 2014(*25,26,21,28, 29*). We have used a specific definition of the private sector to include private hospitals, NGO or faith-based hospitals, private clinic/doctor, private pharmacy, and other NGO or faith-based operations such as clinics, outreach services, or community health workers. Our specificity of the definition of the private sector, examination of changes over time, and use of recent data sources are novel.

Addendum

- the data used in this study did not allow for a full analysis of private sector utilization in European countries.
- a further study was commissioned in 2020 using different data to analyze private sector utilization in Europe.

Methods

Using freely available standardized, nationally representative survey data, we estimate the relative use of the public and private sectors across a diverse set of Low-and Middle-Income Countries. After reviewing available data sources, only the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS) provided comparable and comprehensive information on source of care for inpatient and outpatient conditions.

Data

Parameters for inclusion were that a country has a nationally representative MICS or DHS survey between 2014-2019. A second survey, if present, needed to have been conducted between 2010 to within 3 years of the first survey, with preference given for the shortest time period within this if there are more than a single survey meeting these criteria. Surveys spanning two years (such as 2014-2015) are defined as having been conducted in the earlier year, which has implications for inclusion criteria in some instances. 112 surveys met these criteria, however one survey was excluded because the data did not match the other datafiles (Guinea-Bissau MICS 2010). The total number of countries included in the analysis is 65.

The analysis uses information on care seeking for delivery as a proxy for inpatient care. Similarly, care seeking for childhood illnesses is a proxy for outpatient care. The analysis investigates proportion of care sought within the public versus private sector. Surveys conducted between 2010 and 2019 cover DHS rounds 6 and 7, and MICS rounds 4-6. The surveys differ across rounds, in definition of illness, and populations for whom data is collected. For example, in DHS surveys, the analysis obtains information on the place of birth, for a woman's most recent birth in the past 5 years, while in MICS surveys, this may be in the past 2 or 3 years. For childhood illnesses, the analysis categorizes the place of care sought, for an illness in the prior 2 weeks for the youngest child under age 5 in the household. Illnesses included in the study are diarrhea, or Acute Respiratory Infection (ARI)/Fever. Care seeking for ARI (suspected pneumonia) and fever are reported together in all of the surveys for which children with fever are asked about place of care sought.

Definitions

The definition of ARI used is consistent with that used for each source survey, and the definitions differ across source surveys (DHS 6, DHS 7, MICS6, MICS 4 and 5).

Definitions of ARI

- **DHS 6:** Cough accompanied by short rapid breathing. Children with cough who do not meet definition of ARI were still asked about care-seeking. We have removed them from the denominator and only conducted analyses on those who meet definition of fever or ARI (suspected pneumonia) as defined by the survey.

- **DHS 7:** Short rapid breathing which was chest-related, and/or difficult breathing which was chest related. Children with rapid breathing that is not chest related do not meet the definition of ARI, but were still asked about care-seeking. We have removed them from the denominator and only conducted analyses on those who meet definition of fever or ARI (suspected pneumonia) as defined by the survey.

- **MICS (4-6):** Definition of ARI is illness with a cough, accompanied by a rapid or difficult breathing and whose symptoms were due to a problem in the chest, or both a problem in the chest and a blocked nose. Children with rapid breathing that is not chest related do not meet the definition of ARI, but were still asked about care-seeking. We have removed them from the denominator and only conducted analyses on those who meet definition of fever or ARI (suspected pneumonia) as defined by the survey. In some MICS5 surveys, the question on whether the problem was in the chest is not asked. In MICS4 surveys, place of care-seeking for fever or diarrhea is not asked. Finally, surveys from Columbia 2015, Serbia and Kazakhstan did not ask about childhood illness.

For each household with an included reason for care, the analytic dataset captures the country, year, household weight, household wealth quintile, reason for needed care (recent birth, diarrhea, fever or ARI) and source(s) of care for the illness. Additionally, we include the WHO region and sub-region, and country population for the year of the survey from the UN Population Division. For childhood illnesses, more than one source of care for an episode was possible. Source of care was manually recategorized into one of 9 mutually exclusive categories. Each country's data extraction and log files were rechecked by a second analyst for quality control.

For each household with an included reason for care, the analytic dataset captures the country, year, household weight, household wealth quintile, reason for needed care (recent birth, diarrhea, fever or ARI) and source(s) of care for the illness.

If it was not clear what sector a source of care belongs to, then it is classified as 'other'. As a result, some care that is counted as informal may actually be provided by a trained health worker. An example of this is a code of 'fieldworker', without any specification as to what sector the fieldworker belongs to. Surveys from Cuba and Qatar did not include any wealth quintiles. In some analyses, private sector care is sub-categorized into a) Private hospitals, clinics, doctors and pharmacies; b) NGO and FBO facilities; c) Informal facilities.

Regional analyses

For the most recent survey for countries within each WHO region, data were weighted by country population size for the year of the survey. Wealth quintiles were kept as in the original country data, so the regional analyses by wealth represent the behavior of households in the same relative wealth groups.

Assumptions and limitations

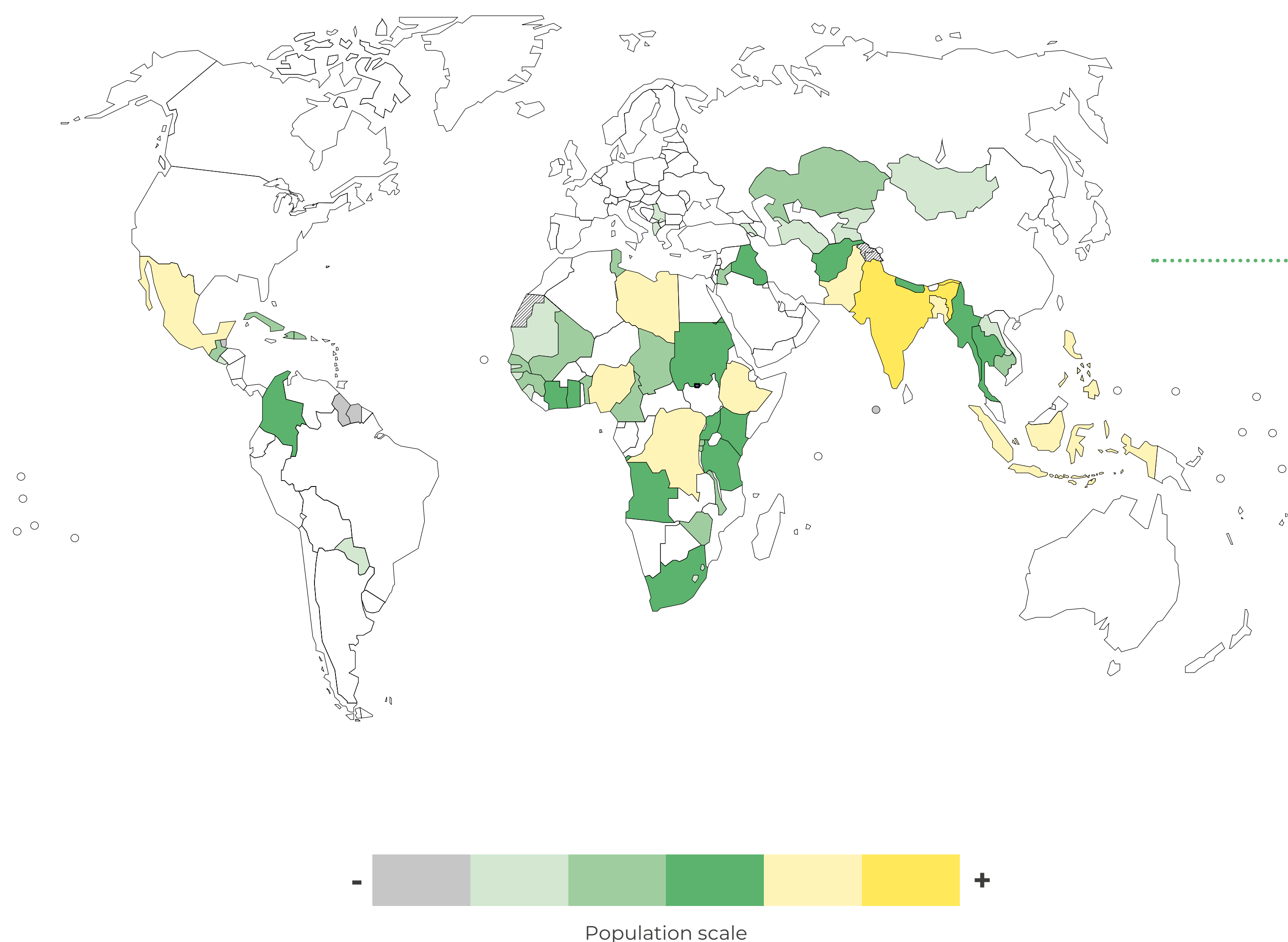
We make a number of assumptions in summarizing and analyzing this data, and in particular in drawing conclusions about all inpatient, outpatient, and overall health system usage based on sources for only a few care-seeking practices. We do so primary because these data provide more information with which to make system-level inferences than other sources. We use them not for their accuracy, but because they are less inaccurate than other options.

Specifically, in our analysis we assume that care seeking patterns for childbirth represent inpatient care seeking patterns. We assume that care seeking for routine childhood illnesses (ARI, Fever and Diarrhea) represent outpatient care seeking patterns. We recognize that these assumptions are weak, and that they are simply a result of lack of available data across countries for care sought for other reasons. Additionally, the data on childhood illness is with regard to illnesses in the two weeks prior to the survey, while for birth, the recall period ranges from 2-5 years, depending on the survey. No attempt was made to reconcile the time periods, when describing care-seeking patterns as the focus of this analysis is on ratios of care-seeking, not quantity of care-seeking. WHO analysis(*30*) shows that of all spending on health within 46 LMIC for which there is data, 25% is spent on inpatient and day curative care, and 28% is spent on outpatient and home-based curative care. Using this ratio, we weight the data on source of care by reason, in order to derive an estimate of overall care-seeking patterns.

Results

Of the 65 countries for which we have data, the majority are in the WHO African region(27), followed by the region of the Americas (11) (Figure 1). There were 49 countries with MICS surveys meeting inclusion criteria, and 62 countries with DHS surveys. (See Table 1 for list)

Figure 1: Countries included in survey



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data source: www.dhsprogram.com; www.mics.unicef.org; https://data.un.org/Data.aspx?d=PopDiv&f=variableID%3a12%3btimeID%3a83%2c84%3bvarID%3a2&c=2,4,6,7&s=_crEngNameOrderBy:asc,_timeEngNameOrderBy:desc,_varEngNameOrderBy:asc&v=1. World Health Organization © WHO 2014. All rights reserved.

Table 1: Country and data sources included

Country	Survey Type	
	MICS	DHS
Afghanistan	1	1
Albania		1
Angola		1
Armenia		2
Bangladesh		2
Belize	2	
Benin	1	1
Burundi		2
Cambodia		2
Cameroon	1	1
Chad	1	1
Colombia		2
Congo	1	1
Cote d'Ivoire	1	1
Cuba	2	
Dominican Republic	1	
Egypt		1
El Salvador	1	
Eswatini	2	
Ethiopia		2
Gambia	1	1
Ghana	1	1
Guatemala		1
Guinea		2
Guinea-Bissau	1	
Guyana	1	
Haiti		2
India		1
Indonesia		2
Iraq	2	
Jordan		2
Kazakhstan	2	
Kenya		1
Kyrgyzstan	2	
Lao People's Democratic Republic	2	
Lesotho		1
Malawi		2
Maldives		1
Mali	1	1
Mauritania	2	
Mexico	1	
Mongolia	2	
Myanmar		1
Nepal		2
Nigeria	1	1
Pakistan		2
Paraguay	1	
Philippines		2
Rwanda		2
Sao Tome and Principe	1	
Senegal (Senegal uses a continuous DHS survey)		2
Serbia	2	
Sierra Leone	1	1
South Africa		1
State of Palestine	2	
Sudan	2	
Suriname	2	
Tajikistan		2
Tanzania		2
Thailand	2	
Timor-Leste		1
Tunisia	2	
Turkmenistan	1	
Uganda		2
Zimbabwe		2
TOTAL	**49**	**62**

The region with the greatest reliance on the private sector is the Eastern Mediterranean region; weighted regional results indicate that 53% of inpatient and 66% of outpatient care takes place in the for-profit private sector (Figure 2). This data is heavily influenced by Egypt and Pakistan. Conversely, citizens in the WHO European region are the most reliant upon public sector services, as seen within the eastern European and Central Asian countries for which we have data (96% of care sought in public sector).

For outpatient care in Africa, 35% of those who seek care go to the for-profit private sector, while 17% seek care at shops, faith healers and other informal providers (Figure 3). Overall, 26% of care seeking is done in the private sector, with an additional 10% with informal providers. The greatest proportion of private sector care seeking occurs in Nigeria (52%), while in Cameroon, Uganda and Benin, greater than 40% of care is sought in the private sector. All figures are for those who choose to seek care for the conditions studied in this analysis.

Figure 2: Public and Private Distribution: EMRO

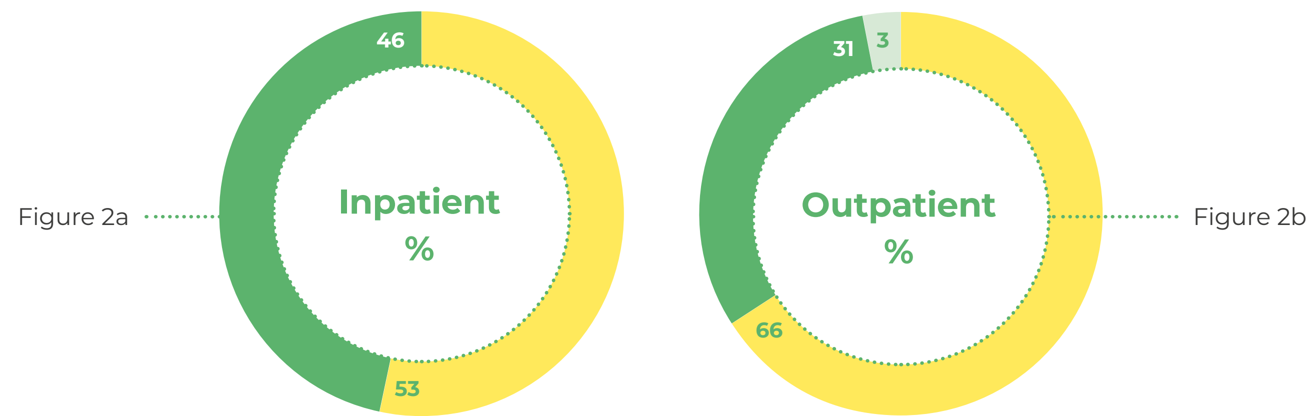


Figure 3: Public and Private Distribution: AFRO

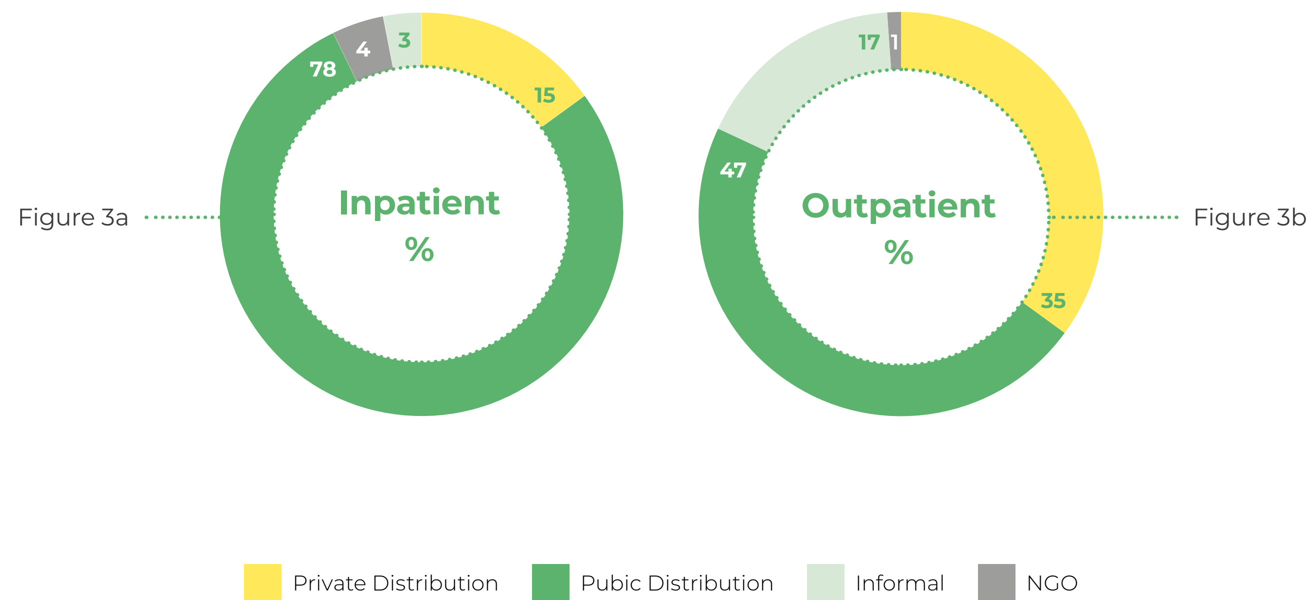


Table 2 lists the top three most privatized countries in each WHO region, and the overall, inpatient and outpatient proportion of care sought in for-profit private sector (excluding NGO or Informal).

Table 3 gives ownership proportions for each WHO region. For those countries with more than one data set we have examined the changes in percent of care sourced from private providers (Figures 4 and 5). While variations are clearly smaller for inpatient services than outpatient (reflecting perhaps the stability inherent to high-infrastructure investment costs), there are no clear global or regional trends toward overall increase or decrease of private care.

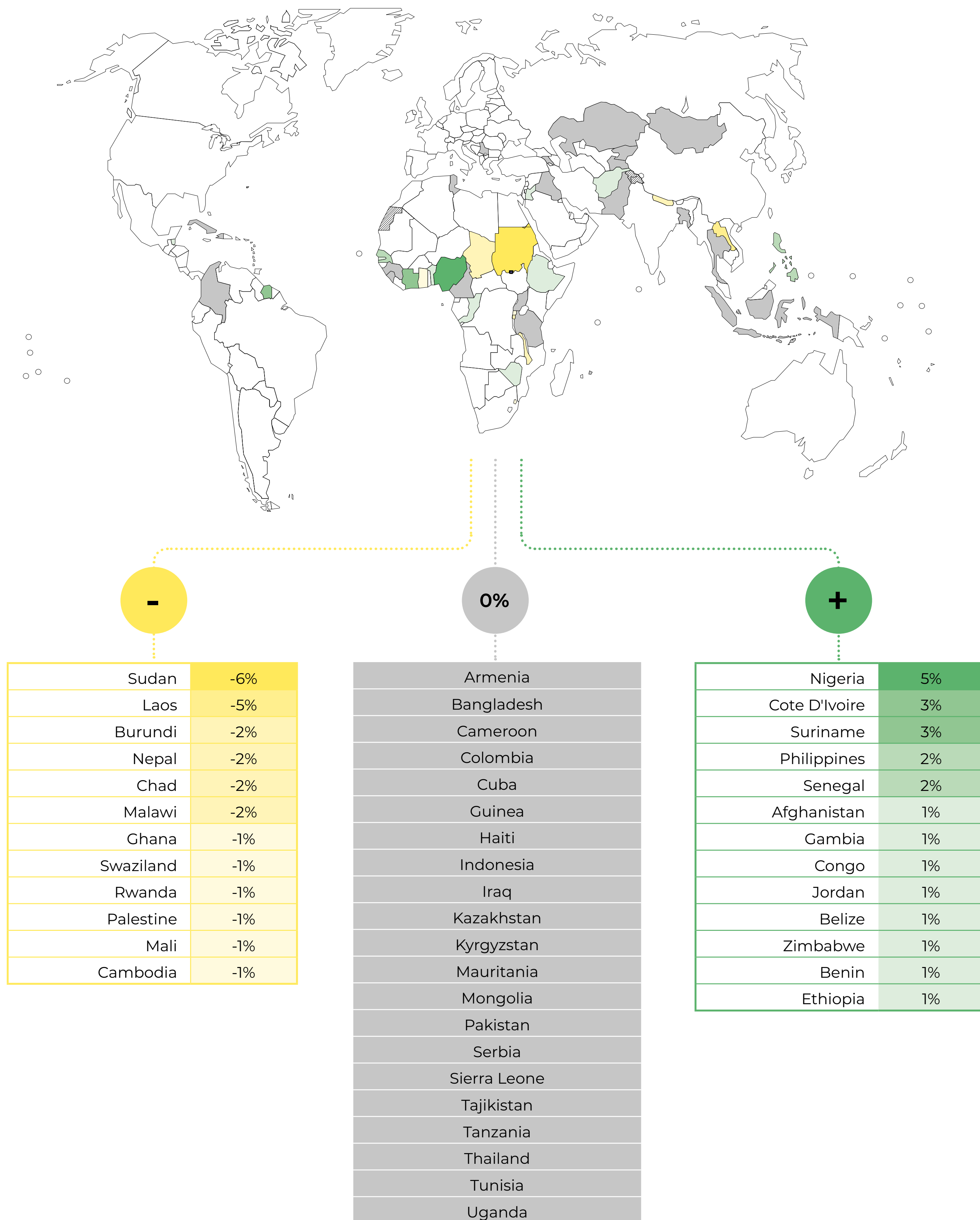
Table 2: Top countries in each region, by overall use of private medical providers

Region	Country	Inpatient	Outpatient	Total
African	Uganda	21.4	56.9	**40.2**
	Nigeria	33	40.2	**36.8**
	Swaziland	31.6	26.7	**29**
Americas	Mexico	15.8	48.3	**33**
	Suriname	29.9	27.4	**28.6**
	Dominican Republic	29.7	27.1	**28.3**
Eastern Med	Egypt	71.2	78.8	**75.2**
	Pakistan	65.5	81.2	**73.8**
	Jordan	33.9	54.6	**44.9**
European	Albania	3.4	11.8	**7.8**
	Kyrgyzstan	1.5	12.1	**7.1**
	Armenia	3.8	5.4	**4.5**
South-East Asia	Indonesia	61	59.1	**60**
	Bangladesh	59.5	55.2	**57.2**
	India	34.3	68.8	**52.6**
Western Pacific	Cambodia	17.6	46.7	**33**
	Philippines	29.1	34.9	**32.2**
	Laos	2.5	25.3	**14.6**

Table 3: Ownership ratio by WHO region Weighted by country population from year of most recent DHS or MICS survey.

Region		Inpatient	Outpatient
PAHO	Informal	1%	9%
	NGO	0%	0%
	Private	31%	37%
	Public	68%	54%
AFRO	Informal	3%	17%
	NGO	4%	1%
	Private	15%	35%
	Public	78%	47%
EMRO	Informal	0%	3%
	NGO	0%	0%
	Private	53%	66%
	Public	46%	31%
EURO	Informal	0%	1%
	NGO	0%	0%
	Private	1%	7%
	Public	99%	93%
SEARO	Informal	0%	7%
	NGO	1%	0%
	Private	35%	68%
	Public	64%	24%
WPRO	Informal	3%	12%
	NGO	0.1%	0%
	Private	27%	36%
	Public	70%	51%

Figure 4: Inpatient change for countries having at least two surveys since 2010



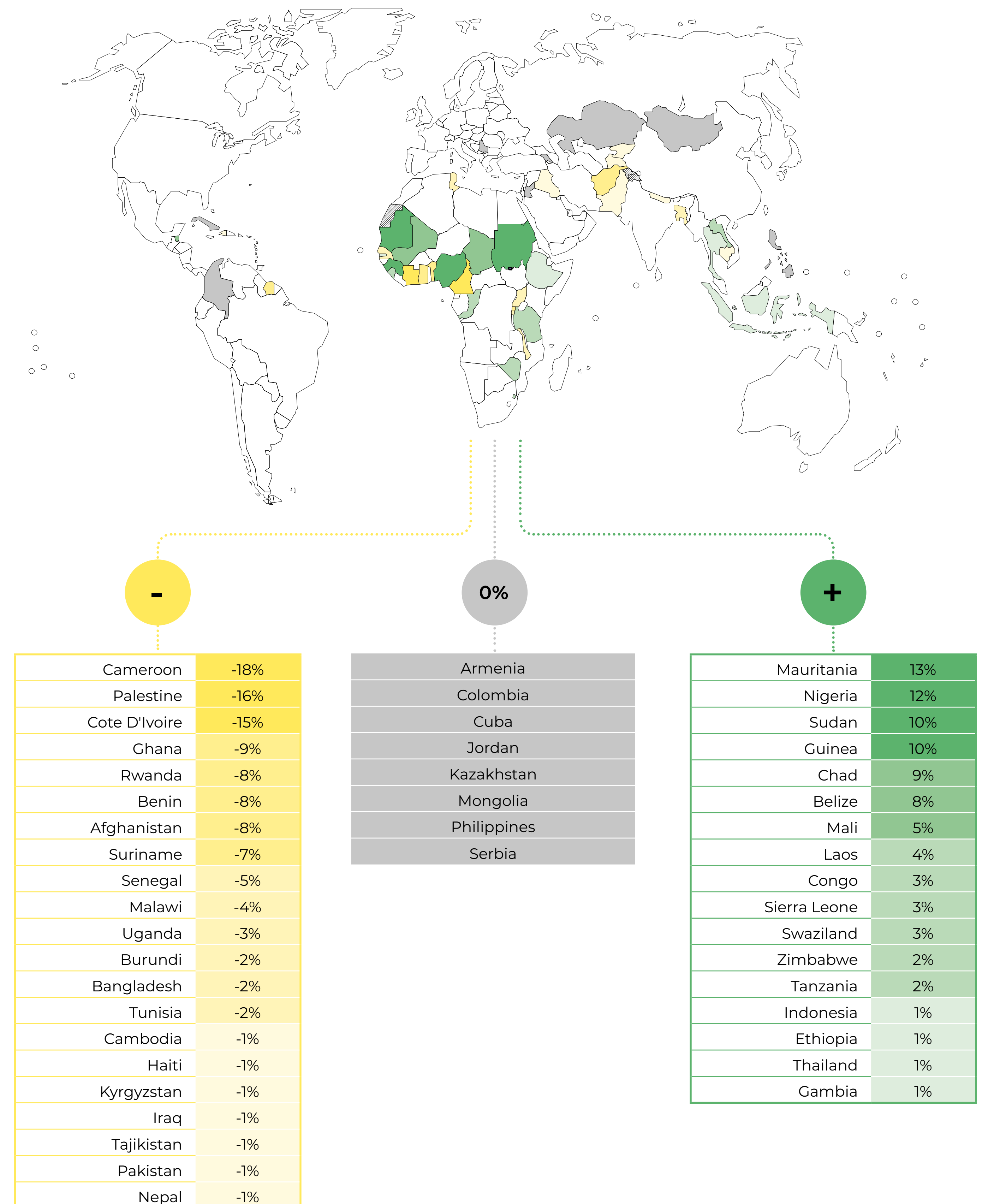
-	
Sudan	-6%
Laos	-5%
Burundi	-2%
Nepal	-2%
Chad	-2%
Malawi	-2%
Ghana	-1%
Swaziland	-1%
Rwanda	-1%
Palestine	-1%
Mali	-1%
Cambodia	-1%

0%
Armenia
Bangladesh
Cameroon
Colombia
Cuba
Guinea
Haiti
Indonesia
Iraq
Kazakhstan
Kyrgyzstan
Mauritania
Mongolia
Pakistan
Serbia
Sierra Leone
Tajikistan
Tanzania
Thailand
Tunisia
Uganda

+	
Nigeria	5%
Cote D'Ivoire	3%
Suriname	3%
Philippines	2%
Senegal	2%
Afghanistan	1%
Gambia	1%
Congo	1%
Jordan	1%
Belize	1%
Zimbabwe	1%
Benin	1%
Ethiopia	1%

Data source: www.dhsprogram.com; www.mics.unicef.org. World Health Organization © WHO 2014. All rights reserved.

Figure 5: Outpatient change for countries having at least two surveys since 2010



-	
Cameroon	-18%
Palestine	-16%
Cote D'Ivoire	-15%
Ghana	-9%
Rwanda	-8%
Benin	-8%
Afghanistan	-8%
Suriname	-7%
Senegal	-5%
Malawi	-4%
Uganda	-3%
Burundi	-2%
Bangladesh	-2%
Tunisia	-2%
Cambodia	-1%
Haiti	-1%
Kyrgyzstan	-1%
Iraq	-1%
Tajikistan	-1%
Pakistan	-1%
Nepal	-1%

0%
Armenia
Colombia
Cuba
Jordan
Kazakhstan
Mongolia
Philippines
Serbia

+	
Mauritania	13%
Nigeria	12%
Sudan	10%
Guinea	10%
Chad	9%
Belize	8%
Mali	5%
Laos	4%
Congo	3%
Sierra Leone	3%
Swaziland	3%
Zimbabwe	2%
Tanzania	2%
Indonesia	1%
Ethiopia	1%
Thailand	1%
Gambia	1%

Data source: www.dhsprogram.com; www.mics.unicef.org. World Health Organization © WHO 2014. All rights reserved.

Discussion

We are making inferences regarding overall public/private healthcare which have significant implications for policy attention to private providers, based upon a limited set of data. This is due to what data is available, rather than what data would be ideal, but we have no reason to believe there is a systematic bias to the conclusions we draw.

We are making inferences regarding overall public/private healthcare which have significant implications for policy attention to private providers, based upon a limited set of data, but we have no reason to believe there is a systematic bias to the conclusions we draw.

Drawing conclusions from imperfect data

Perhaps most notably, we use self-reported information on delivery location as a proxy for overall public-private inpatient care ratios between public and private sectors. This raises a number of questions: do delivery decisions for care seeking differ from other inpatient care seeking, both in whether or not to seek care and where to go if care is sought; do differences in rates of bed turnover mean we should adjust reported deliveries differently for public vs private facilities; how do delivery rates compare to staffing, costs, and health outcomes?

These questions are all largely beyond the scope of this analysis. A comparison of OECD reported data and DHS data from Mexico shows that all-bed ratios and patient reported delivery site ratios are broadly aligned; 26% private for all-beds, vs. 16% private for deliveries(*31*). Data from Kenya suggests that private bed turnover ratios (the number of deliveries/bed) are roughly half that of public facilities, meaning that for every 10 women who report delivering in a private facility 20 will have delivered in a public facility of the same size(*32*). A study from Nepal suggests that bed occupancy rates in Maternity wards is not very different from overall hospital bed occupancy rates (91% vs 74%) and, importantly for our study, that more than two fifths of all inpatients (41.86%) were admitted in the maternity ward(*33*). Facility deliveries have increased significantly in the past decade(*28*). With the exception of only the poorest quintiles in the AFRO region, the majority of the respondents include in our analysis delivered their last child in a healthcare facility. Based on all of this we believe that in the absence of better data it is appropriate to use place-of-delivery data as an unbiased proxy for overall inpatient care in LMICs around the world. A similar argument justifies the use of our pediatric data as a proxy for outpatient care sources.

Conclusions

Our findings confirm earlier studies showing that the private sector remains dominant for outpatient care in many countries, particularly in AFRO, EMRO, and SEARO regions, and significant in inpatient care across the same parts of the world. Comparing our findings to earlier studies, and across repeated surveys within our timeframe, we do not find any clear trend to increasing or decreasing private provision as a component of LMIC health systems. Our findings show that mixed healthcare systems remain the norm in LMIC countries, across regions, and across wealth levels within countries.

The implications of this for UHC are important for regulation and policy, and the national planning bodies responsible for governance together with the global agencies that advise and support them: the management of mixed public and private healthcare systems will determine the success or failure of achieving UHC for many countries. Our analysis should provide countries with a path to identify nations with similar levels of public-private mix, with which to study and share experiences on quality assurance, reporting, referral integration, financing systems, and the many other aspects critical to good management in a complex delivery context.

Further work and examination of lessons specific to countries and regions will be needed to inform better policies in the future.

Given the scale of private provision increased work is needed to identify effective models of governance and integration into overall health system goals.

Given the scale of private provision in all parts of the world except EURO, increased work is needed to identify effective models of governance and integration into overall health system goals. Examples from successfully integrated vertical programs (TB, Malaria, Vaccines) should be documented and shared, while overall systems guidance for reporting, quality regulation, and referral systems need to be better studied, assessed, and experiences shared. Leadership is required to assure that best-practices for the governance of the private sector – which represents 1/3 or more of most care outside of the EURO region – is developed and shared.

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The Provision of Private Healthcare Services in European Countries

Acknowledgements

Dominic Montagu (Metrics for Management)

Background

There is a global movement to make healthcare accessible for those in needs, assuring Universal Health Coverage in all countries by 2030. While pursuing this, many Low- and Middle-Income Countries (LMICs) continue to struggle with how and how much to integrate private providers into the formal government regulated and funded health system; something that is needed because private providers deliver a large percentage of care in most LMICs and the majority of care in many LMICs(*1–3*). Healthcare services in Europe are both effective and appreciated by their citizens and delivered with many different models, and degrees, of private involvement(*4,5*). In the push for UHC, Europe can provide insights into differing experiences with private provision in the context of nationally managed systems. This study provides an up-to-date review of private provision across different sectors in countries across Europe.

This study must be read in conjunction with the previous study "Private Sector Utilization: Insights from Standard Survey Data".

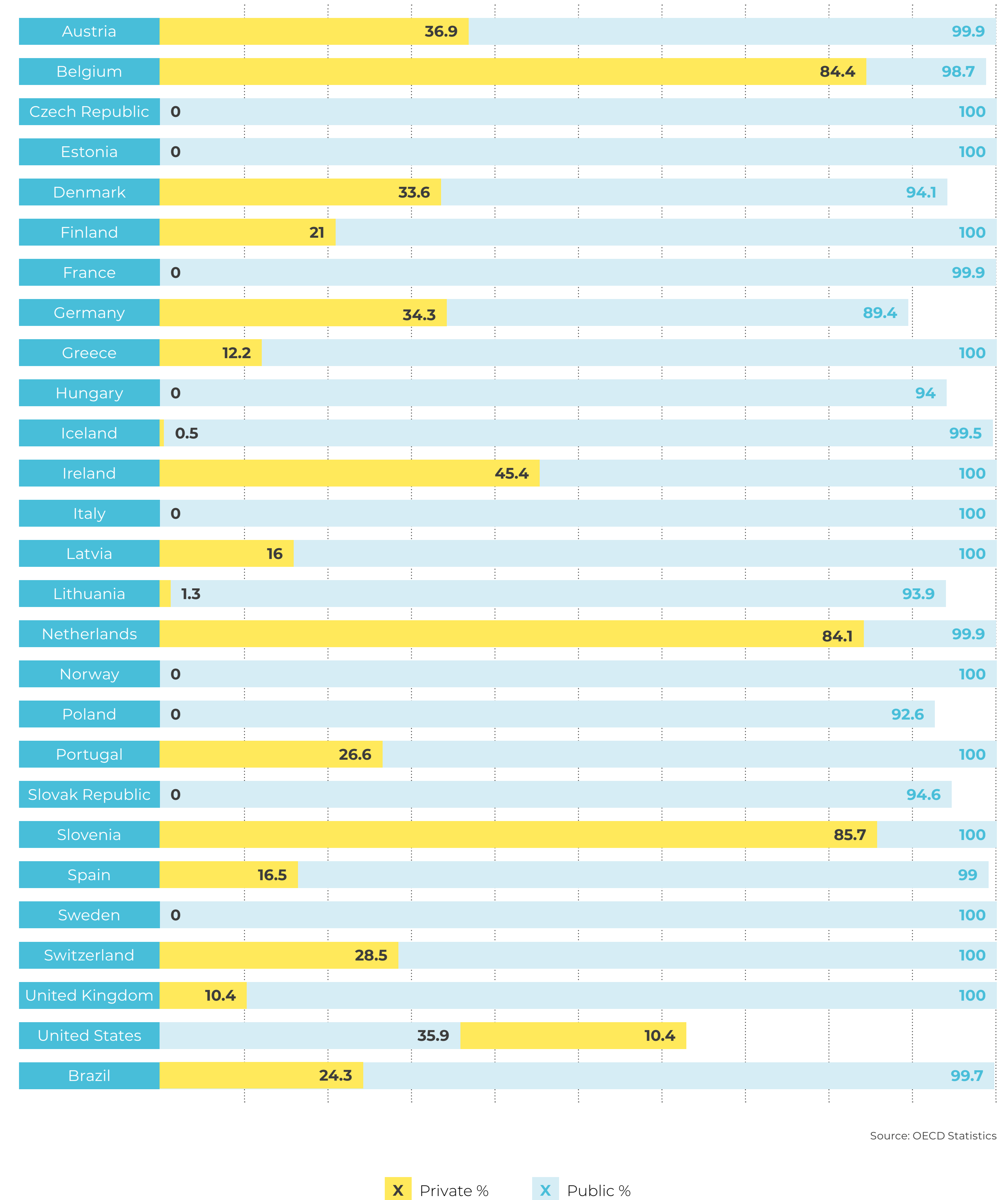
This study must be read in conjunction with the previous study "Private Sector Utilization: Insights from Standard Survey Data". This first study had a limitation: the type of data used meant that European countries were poorly represented in its results. So, it was decided to proceed with a second study, using different data, to complete an analysis of private health care in Europe.

Financing Context

Provision of healthcare functions independently of financing and there is more competition, more variance, and more change within the ownership, incentives, and regulation of care provision than is the case with financing. Nevertheless, financing sets the context for ownership, together with policy and regulatory guidance, directly or indirectly determining what ownership mix can develop.

Universal Health Coverage (UHC) exists in all of the European countries we studied. Unlike LMICs, healthcare financing in Europe is almost universally government managed, either directly through taxation revenue (as in the UK) or semi-directly through mandated, managed, and government subsidized Social Health Insurance (as in Germany). Across Europe, government and social health insurance provide a healthcare safety net for nearly all citizens as shown by data from the OECD health system survey (Figure 1, blue bars). While the form of insurance varies between countries, and supplemental private insurance (yellow bars) is common in some (Belgium, Holland, Slovenia) but not others (France, Norway), the most important implication for service provision, is that where they exist, private providers in most countries are paid either by national health insurance systems or by tightly regulated social health insurance schemes that coordinate purchasing(*4–6*). Out of pocket payments for healthcare are consistently low across all European countries surveyed, totaling less than 0.5% of spending on preventative care and less than 20% of Total Health Expenditure in 2018(*7*). The lesson for other countries is that government purchasing and regulation are neither a guarantee of, nor a barrier to a large private market for healthcare provision.

Figure 1: Social Healthcare Safety Net Coverage, 2018.



Methods

Scope and Focus

We restricted our analysis to European countries which are members of the OECD. We excluded EU members which were not also OECD members, and OECD countries outside of Europe. Turkey is an OECD country and partially on the European continent, however 97% of the landmass is in Asia and we made a decision to exclude it from this analysis for that reason. In this paper, for the sake of simplicity, we refer to the selected countries as “Europe”.

We restricted our analysis to European countries which are members of the OECD.

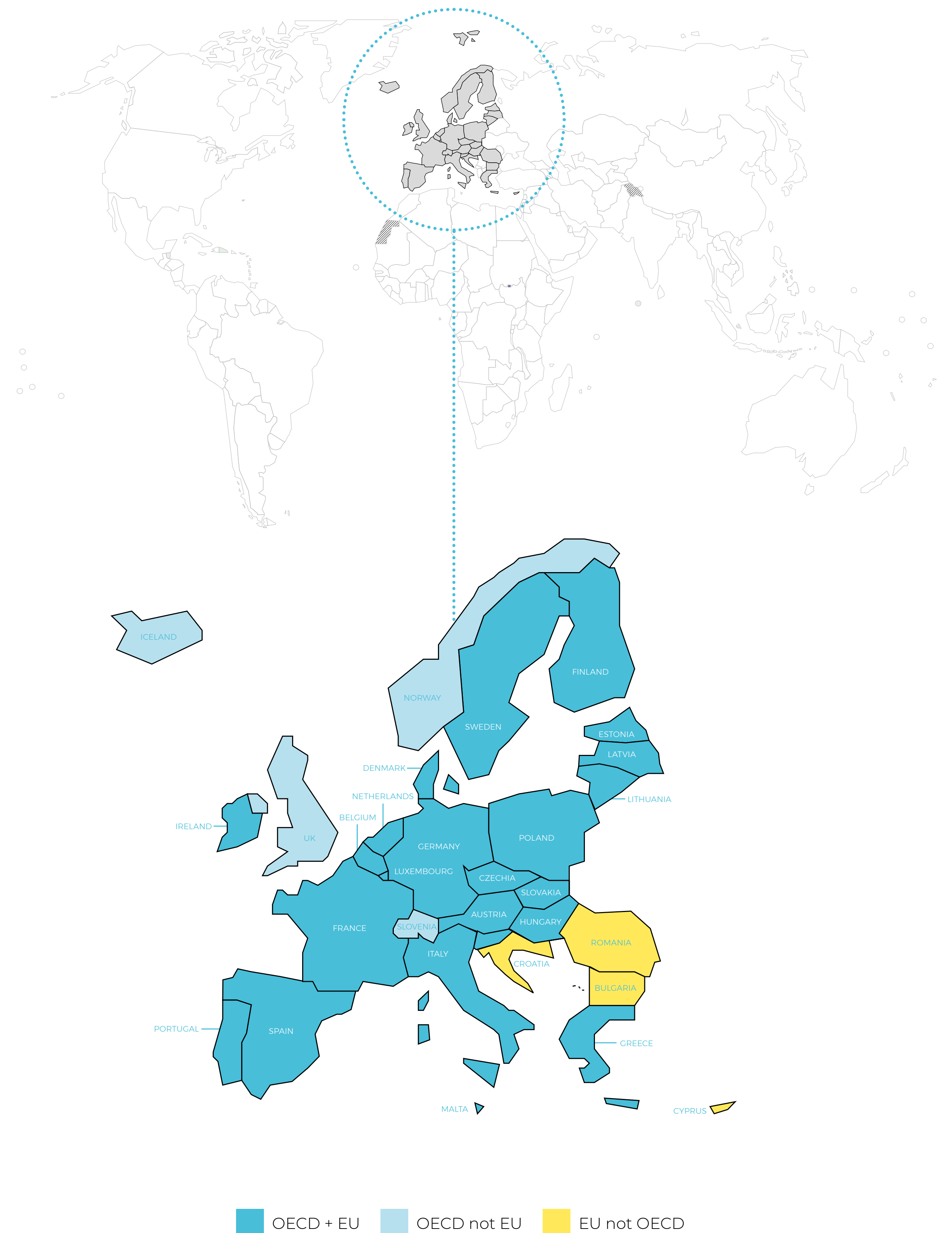
Data Sources

We reviewed all publications on the included countries’ health systems from the OECD and WHO European websites. For each country we also searched for journal publications in English through PubMed and Google Scholar, and where data was contradictory or lacking we conducted subject specific Google Scholar searches by country (eg. “dentist Luxembourg”) for additional sources from white papers. Where all of these sources failed, we contacted experts within WHO and personal connections within academic institutions in the countries with information gaps for supplemental sources in other languages.

When calculating the scale of the private sector role within each country (figure 4, tables 1 and 2) we relied heavily on the Health System in Transition (HSiT) national reports from the European Observatory on Health Systems and Policies. These ranged in date-produced from 2003 (Iceland) to 2019 (Latvia) (*8,9*). If country-specific reports use pre-2008 data, regardless of when they were published, we set them aside, and instead used data from the 2008/9 OECD health system survey(*5*). When journal publications or national reports had credible national data which was more recent than either the 2008/9 Survey or the national HSiT report, we used that source.

We applied the healthcare service categories used by the OECD to look separately at inpatient services, specialist services, primary care, and pharmacies(*5,10*). We use hospitals as a proxy for inpatient services, this reflecting the majority of providers, care delivered, and incomes in hospitals across all countries surveyed(*11*). Outpatient Specialist services and dentistry are treated together. Primary Care could be either general practitioners (UK) or primary care centers (Sweden). And pharmacies here refer only to community pharmacies and so exclude hospital-based pharmacies.

Figure (1–3): Included Countries



Data source: https://www.oecd.org/about/members-and-partners/. World Health Organization © WHO 2014. All rights reserved.

Findings

Health Care Provision in Europe

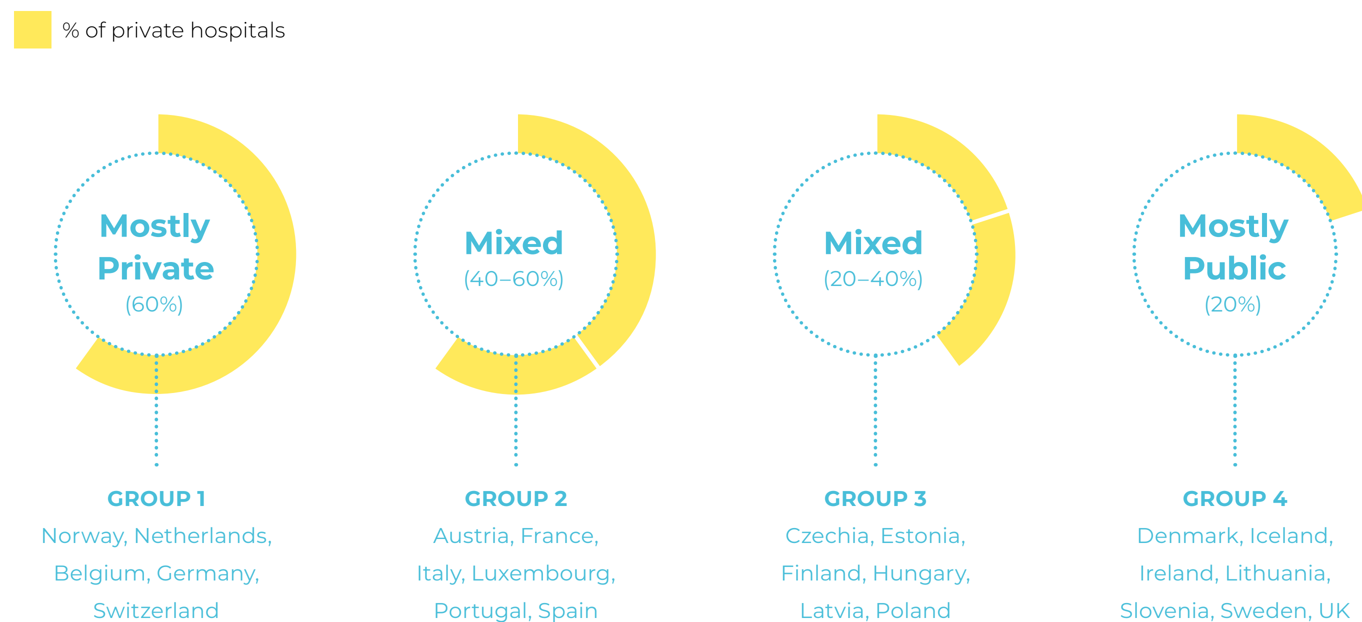
We evaluated each country on hospital ownership data and then reviewed for consistency against other aspects of care provision. From this we grouped the health systems in Europe into four types (Figure 3), based on how reliant the overall system is on private provision. This grouping was informed by analyses of the interaction between regulatory and purchasing agencies of government and privately owned providers of care across health service domains(*12–14*). Health systems are highly path-dependent(*15,16*) and the four types, or Groups, reflect the continued influence of the financing and ownership models which created current structures. In Germany, the influence of the Bismarkian model of social insurance and privately contracted delivery remains evident(*17*). In the UK, the influence of Beveridge's vision for the National Health System continues to resonate in current days (*18*). Nevertheless, the distinctions between European health systems are becoming less important as financing models align(*19*).

Hospitals

Hospitals are in transition across Europe as outpatient services shift outside of medical facilities and most countries push for increased efficiency as measured by shorter average stays and higher bed usage rates(*14,15*). Our findings from countries with more recent data showed little change from the ownership status summarized in a 2008/2009 survey among OECD countries(*5*). Across all European countries the role, and importance, of private hospitals within the larger health system fall into four distinct categories (Figure 3).

We grouped the health systems into four types based on how reliant the system is on private provision.

Figure 3: National Private-Healthcare Typologies in Europe, by Hospital Ownership



The behavior of private hospitals differs between the four groups, as can be seen in how private hospitals contribute to available inpatient bed within each group (Figure 4).

In Group 1, the private hospitals beds roughly match the private hospital numbers: this is where most inpatient care of all kinds is offered. Where public and private hospitals exist in parallel, as in Germany, the differences in services offered, bed numbers, bed-stay duration, and patient experiences between public and private hospitals are minimal: to the consumer and the social health insurance payer, public and private facilities are functionally equivalent. These countries' health systems are based on Bismarck's model care and financing.

In Group 2, this equivalence exists for some services, or in some regions, but is not universal. In these countries private facilities increasingly have taken on profit-making outpatient services, often surgeries that have few co-morbidities and predictable management but also including delivery services and (among non-profits) some cancer management. The result of this can be seen in the average facility size: private hospitals in Group 2 have fewer beds than government facilities, and higher bed turnover reflecting their emphasis on outpatient and clearly defined, lower risk, care(*21*). These countries' health systems are heavily influenced by the Bismarckian model.

In Group 3 this same leaning away from comprehensive inpatient services and towards a narrower set of short-stay areas of care continues. Facilities are smaller and more specialized; non-profits are less predominant within the overall mix of facilities. While private hospitals exist, they offer fewer inpatient stay opportunities and take on fewer inpatient, chronic, or emergency services. Health systems in Group 3 countries have, largely, derived from the Semashko model which influenced much of Eastern European social services during the 20th century(*22*).

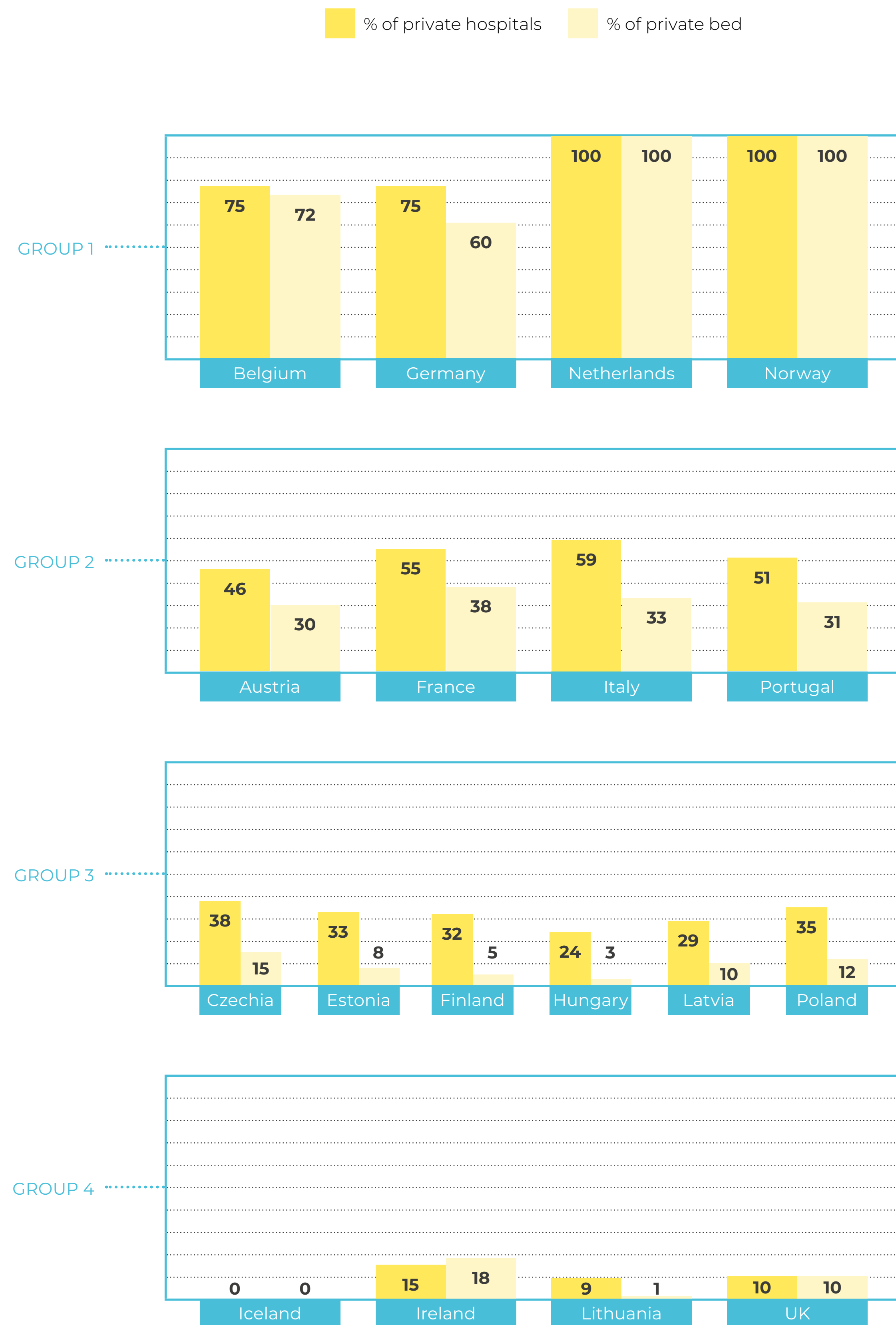
Countries in Transition: Group 3 Hospitals

A decade ago, the countries in Group 3 would have been called "economies in transition" from planned economies, organized around government provision of social services, including health, to market economies. It may be, then, that Group 3 will shift, or has already shifted, in ways not reflected in our data from four or five years ago, towards or away from Group 2.

The Group 4 countries are all countries with a strong national emphasis on social services. This group also includes many of Europe's small and isolated countries. For these, centralized management of a limited number of facilities is practical and competition unlikely to be an effective complement to government purchasing. In all Group 4 countries private hospitals either don't exist at all (Iceland), or exist as a small minority of facilities, principally serving only private patients for services not covered by national insurance (eg: cosmetic surgery) or outpatient services for patients who are willing to pay to avoid the wait times for government care. Health systems based upon Beveridge.

The differing role of private hospitals can be seen in the different ratio of beds-per-hospital shown in Figure 4, using the most recent data from each country. Ireland appears to be an anomaly; the only country where the private sector has more beds/facility than the public, although as elsewhere these beds are primarily for short-term services(*23,24*). The very low percentage of private beds in all Group 3 countries indicates that in all of these countries private hospitals exist, but largely to provide outpatient surgeries and consultations.

Figure 4: Private Hospitals and Beds as a percentage of all Hospital and Beds



Dentists

Nearly all dentists in Europe work privately either in solo or group practices. In France 91% of the country's dentists are self-employed private practitioners(*21*). In Czechia the rate is 95%, in Austria 80%. Other than a few within hospitals, nearly 100% of dentists are private practitioners in Iceland, Italy, Lithuania, Luxembourg, Netherlands, Portugal, Greece, Germany, Spain and the UK(*7,8,25,26,26,27,27–32*). The exceptions are few. In Finland private practitioners represent just more than half of all dentists and provide approximately one half of all dental care(*33,34*). While there is some concern within the dental profession regarding how the growth in third-party payments will effect practices, most dental services across Europe continue to be funded by a mix of direct patient payment and government subsidy(*35*). Dental services for children up to 18 are government funded in all European countries(*36*). In Italy and Greece, dental services are nominally free within the government sector, but long wait times leads many patients to seek care from private offices(*36*). In the UK, dental care has been included in National Health Service (NHS) funding since 1948, however as in other countries, since 1951 adults have a co-payment required for non-acute services(*36*).

Nearly all dentists in Europe work privately either in solo or group practices.

Specialist Services

Data on specialist services (Table 1) comes from the OECD health systems survey(5). It found that in more than half of surveyed European countries specialists operate in private practice, either as solo practitioners (9/22 countries) or in groups(3/22). The countries where government specialist services dominate are all either in Group 2 (Italy, Spain, Portugal), Group 3 (Czechia, Finland, Hungary, Poland) or Group 4 (Ireland, Sweden, UK).

Table 1: Principal Mode of Specialist Care Provision

GROUP 1	
Belgium	Private Solo Practice
Germany	Private Solo Practice
Netherlands	Private Group Practice
Norway	Private Solo Practice
Switzerland	Private Solo Practice
GROUP 2	
Austria	Private Solo Practice
France	Private Solo Practice
Italy	Public Hospital
Luxembourg	Private Solo Practice
Portugal	Public Hospital
Spain	Public Center
GROUP 3	
Czechia	Public Hospital
Finland	Public Hospital
Hungary	Public Centres
Poland	Public Centres
GROUP 3	
Denmark	Private Solo Practice
Iceland	Private Group Practice
Ireland	Public Hospital
Sweden	Public Hospital
United Kingdom	Public Hospital

Primary Care

The 2008/9 OECD health systems survey found that primary care services were predominantly provided in private settings in 15 of the 22 European countries, including almost all countries with social health insurance systems and five countries with national health systems: Denmark, Ireland, Norway, France, and the United Kingdom. In Finland, Iceland, Italy, Poland, Portugal, Spain, and Sweden primary care is mostly public (Table 2).

The 2008/9 OECD health systems survey found that primary care services were predominantly provided in private settings in 15 of the 22 European countries.

In Sweden, primary care is provided by health centers, comprised of a multidisciplinary workforce including general practitioners, nurses, specialist nurses with expertise in diabetes or other chronic illnesses, and often occupational therapists and psychologists. In 2019, 56.2% of Sweden's 496 primary care centers are public. The remaining 43.8% are private, operating under contracts with a region(*37*).

Table 2: Principal Mode of Primary Care Provision

GROUP 1	
Belgium	Private Solo Practice
Germany	Private Solo Practice
Netherlands	Private Group Practice
Norway	Private Solo Practice
Switzerland	Private Solo Practice
GROUP 2	
Austria	Private Solo Practice
France	Private Solo Practice
Italy	Public Center
Luxembourg	Private Solo Practice
Portugal	Public Center
Spain	Public Center
GROUP 3	
Czechia	Private Solo Practice
Finland	Public Center
Hungary	Private Solo Practice
Poland	Public Center
GROUP 3	
Denmark	Private Group Practice
Iceland	Public Center
Ireland	Private Solo Practice
Sweden	Public Center
United Kingdom	Private Group Practice

Pharmacy

Outside of hospitals, community pharmacies across Europe are all privately owned and operated. There remain country variations in ownership restrictions, with Spain, France, and other countries restricting ownership by corporate chains and franchise arrangements as a way to protect and encourage local ownership(*38*). Eighty-five percent of the 145, 143 pharmacies in Europe are private. Of these private pharmacies, one in three are affiliated with a franchise or other shared brand and one in eight are part of a chain(*39,40*). The retail pharmaceutical component of the health system is sometimes inefficient, inequitable, unevenly distributed, and expensive. But it mostly works, and despite some shortcomings pharmacies function much like groceries, bakeries, or other commodity retailers. As a result most countries in Europe regulate pharmacies as a traditional, privately owned, market (*41*). The case study of Estonia, which liberalized its pharmacy market between 1993 and 1995 after gaining independence from the USSR, showed private ownership resulted in greater use, lower cost to the consumer, and greater client satisfaction(*42*). However, by 2014 regulation was needed to correct for market failures. Specifically, rural communities unserved by pharmacies were able to apply to the State which then mandated pharmacy chains meet certain size criteria to open a pharmacy in those regions(*43*).

In Sweden, a similar transition occurred. Until 2009 all pharmacies were government owned as part of the National Corporation of Swedish Pharmacies. From 2009, half of the government pharmacies were sold, and new private pharmacies were permitted. The total number of pharmacies increased by 20% in the following year and by 2011 there were 13 pharmacy operators in the country(*44*). The trend towards greater free-market structuring of pharmacies, and adaptive regulation to correct for market failings, has occurred across most countries of Europe, albeit at differing rates.

The trend towards greater free-market structuring of pharmacies, and adaptive regulation to correct for market failings, has occurred across most countries of Europe, albeit at differing rates.

Conclusion

The delivery of healthcare in Europe, from hospitals to primary care to specialty services to pharmacies, demonstrates that while there have been and remain significant variations in how the private sector is engaged to provide healthcare within the larger health system, the variety can be taken to show that there are many ways to effectively deliver care. The private sector is neither necessary for the provision of national health care, nor is private sector service an impediment to a strong and effective national healthcare system. That can be said about hospitals, where the distinctions between ownership models are most stark and most clearly determined by national policy differences and changes. It can also be said for the provision of primary and specialty care, where the degree of private provision has historic roots, but both public and private models appear to deliver effective equity, access, and care(*17*).

At the same time, there is a near-universal accord within European health systems that the provision of community pharmacy and dental services are best served by private markets. The narrow set of services in these areas of care offer insights into why they operate, and are regulated, this way(*45*). One insight from Europe which has lessons for LMIC countries now striving for Universal Health Coverage is that, outside of pharmacy and dental services, there is neither a need for large scale privately provided medical services to achieve UHC, nor any negative consequences from having some or all services provided privately. As in Europe, for any country now pursuing UHC, historical experiences and path dependency may dictate whether the private sector is an important provider of care. The varied models, and success, of Europe show that any extant delivery mix can be managed. Well planned national policies and financing can assure effective universal coverage regardless of any inherited delivery structure.

The private sector is neither necessary for the provision of national health care, nor is private sector service an impediment to a strong and effective national healthcare system.

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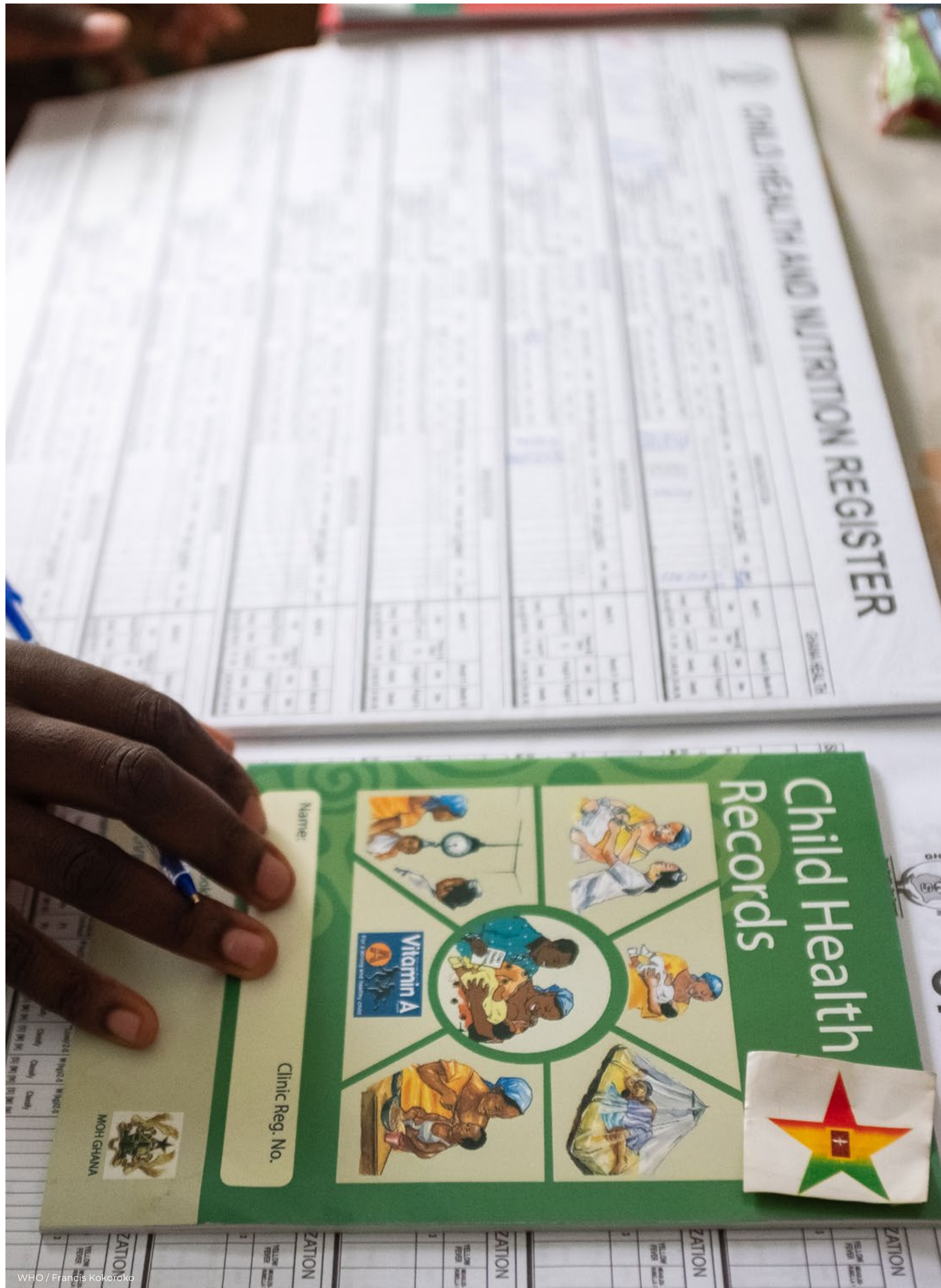

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3

Measuring the Size of the Private Sector: Metrics and Recommendations

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Nirali Chakraborty (Insight Metrics)
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Executive Summary

As our global community seeks to advance universal health coverage (UHC), we must acknowledge that the private health sector is an important and growing source of care worldwide. To reach UHC, we must effectively engage the heterogeneous private sector. Governments need to be able to regulate care provision, and ensure proper stewardship of resources. To do so, we must understand the size and scope of the private sector and be able to measure its contribution toward universal health coverage on a routine basis.

We must understand the size and scope of the private sector and be able to measure its contribution toward universal health coverage on a routine basis.

A limited number of metrics have already been suggested to measure the private sector's role in UHC. However, the underlying data sources are often infrequent or incomplete, and thus do not meet the need to provide a routine source of information on the private sector. For a metric to be more immediately useful, the ability to calculate it from existing and more frequent data sources would be beneficial.

After having examined the possibilities of administrative data, financial data, nationally representative surveys, and social media data we suggest 12 metrics to measure the private sector's role in UHC and explore the feasibility of these metrics in a set of four case studies. Through the case studies we demonstrate that while each country may face different challenges in measuring UHC, there is still an important need to define standardized metrics. Starting with a small set of priority metrics, the World Health Organization can support countries to bolster their data through selection of key data and encouragement to report, research that advances the knowledge of promising existing data sources, and guidelines on standard data collection on the health workforce and service delivery points.

The keys to understanding the private sector's contribution to universal health coverage are to build the best available picture using existing data, while simultaneously investing in multi-sectoral improvements to standard data availability. We must also address data gaps with high quality and timely research. Through these actions, we will be able to provide new insights to help countries achieve UHC.

The keys to understanding the private sector's contribution to universal health coverage are to build the best available picture using existing data.

Introduction

The private sector is an important and growing source of care worldwide(*1,2*); we cannot expect to achieve universal health coverage (UHC) without it. We see increasing use of private sector actors for health care provision, as well as to provide financing(*3*). We need to better understand the private sector for regulation, governance, and accountability, yet there are questions about how to monitor progress(*4*). Governments need to be able to enact and enforce appropriate legal restrictions and regulatory controls in order to ensure care meets minimum quality standards and is delivered by qualified providers(*5,6*). We also need to ensure that governments have appropriate stewardship over public finance initiatives to support health services, that public resources are not misspent by private providers, and that there is financial protection so that patients are not overburdened with health expenditures or charged excessively(*1*). Further-more, there is a moral imperative to ensure that the private sector is accountable to both patients and the overall health system. When accountability is lax, treatments or tests may be overused to maximize profit, or private sector clinics may rely on staff trained in the public sector(*7*). The private sector should be a contributor to UHC, but without understanding the size or scope of this important sector, governments and global actors or initiatives are unable to capitalize on private sector health service provision.

While the precise level of private sector health services is not well defined, there are estimates that between 50 to 70% of all health expenditures are within the private sector(*8*). For reproductive, maternal and child health services, private providers are a primary source of care. For example, more than half of all treatments for childhood illnesses in low- and middle-income countries are through private providers(*9*). And recent estimates show that the private sector, including informal providers in this definition, administer more than half of health care services in Africa(*7*).

This report assesses opportunities for improved routine measurement of the size of the private health care sector across countries. Framed within the context of achieving UHC, we review current approaches to assessing the size of the private health sector and available data sources. We suggest measures which could be used to under-stand different dimensions of the private health sector, as well as an agenda for future research.

This report assesses opportunities for improved routine measurement of the size of the private health care sector across countries.

Framed Within UHC

To achieve UHC, we must take a systems approach and be able to address the challenge of stewarding a mixed public and private health system(*1,10*). Our interventions and management approaches must recognize the links between the public and private sector(*11*) in order to capitalize on private sector contributions that can help to ensure the availability of safe, good quality services that are both geographically and financially accessible(*1,7*). While more attention has been focused on the public sector's role in UHC, we must also be able to measure and manage private sector actors in order to strengthen the entire health system(*1).* This will require a new way of thinking about health-care stewardship in order to effectively engage the private sector toward realizing UHC goals.

Over the past decade, the UHC cube diagram(*12*) has emerged as the major organizing framework and graphical depiction of the factors requiring attention in order to achieve universal health coverage. The cube focuses on coverage under pooled funds, and shows national averages. However, the cube does not offer an easy way to understand the private sector's contribution, or potential, for a country to achieve UHC. Studies and surveys are designed to understand the values making up the interior and exterior cubes, and may be inadvertently leading to data deficits.

Limitations in understanding the private sector's role in health coverage are seen on each of the cube's three axes. Costs covered focus on those covered by pooled funds, indicating that all of the empty space represents out of pocket costs. However not all out of pocket expenditure is incurred in the private sector. For services covered, the implied denominator is all services required to meet the health needs of the population. In reality, whether services are available in the health system at all, or available in proportion to need, may not be well understood. Individuals seeking care informally, forgoing care for lack of funds, or unable to receive specialized care due to medication, equipment or provider deficiencies exist outside the boundaries of the cube. Whether the solution to extend coverage to the whole population lies in focusing on the public or private sector continues to be a matter of debate, yet most of the focus of UHC to date has been on the public sector(*14*).

Without understanding the relative and actual size of the private health sector, it is difficult to advocate for expanding or harnessing its potential. The private sector is heterogeneous and made of a complex range of actors, making it difficult to not only clearly define the private sector's involvement in health care, but to measure its role(*3,11*). It encompasses all non-state actors involved in health service delivery, including for-profit and not-for profit entities, providers in the formal and informal sectors, and domestic and international actors(*14*). As a result, it is often poorly regulated or has limited governmental oversight.

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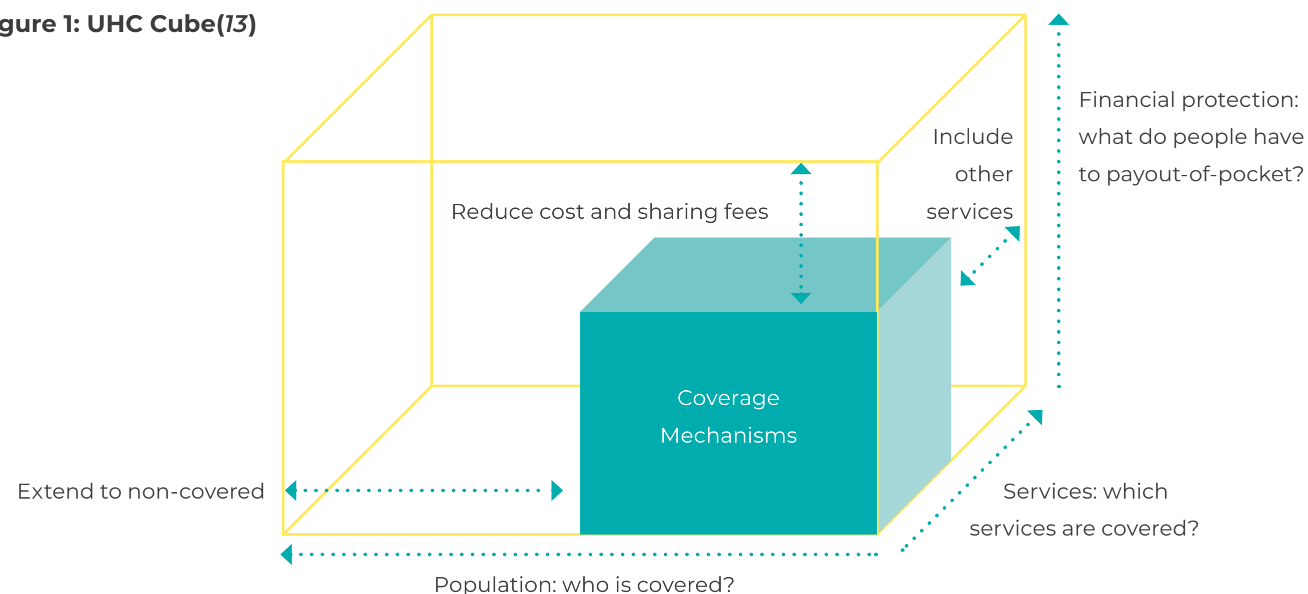
Figure 1: UHC Cube(*13*)



Existing Metrics

In reviewing the current landscape of metrics, the private health sector has been assessed in terms of financial size and potential, physical size, and reach or coverage within the population. Measures have been developed for the purposes of assessing investments, comparative research, or tracking global goals.

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A limited number of metrics have been suggested for the private sector's role in UHC. Mackintosh and colleagues proposed a set of metrics based on existing data to describe the private sector(*5*). They propose three metrics around:

- demand side private finance patterns;
- supply side scale of private sector health enterprises, and
- public sector reliance on fees for service.

The first metric includes out-of-pocket (OOP) spending and pre-paid insurance plan expenditures, calculated using the World Health Organization (WHO) global health expenditure database. Expenditures are used as a proxy to describe the characteristics of private sector supply, but do not capture the total proportion of private services. Furthermore, OOP spending is not limited to spending in the private sector, and includes both public services fees and the purchase of medicines. As a result, private sector contributions to total health expenditure does not correlate with the limited data available on total number of private hospital beds, private sector share of primary facilities, or contribution of private provider consultations to the total number of medical consultations(*5*).

The second metric, which examines private sector share, acknowledges that no comparable cross-country data exist for capacity levels or activity rates and that surveys, and frequency of surveys, vary by country. Thus, they suggest using country-level surveys, household data, and facility surveys. However, different countries and different surveys classify private facilities and sources of treatment in varied ways, and not all surveys capture small-scale or unregistered facilities or dispensaries. While the Demographic and Health Survey (DHS) offers the most comparable data, it covers a limited set of health services.

Different countries and different surveys classify private facilities and sources of treatment in varied ways, and not all surveys capture small-scale or unregistered facilities or dispensaries.

The third metric posits that public sector fees influence who the private sector serves, the quality of those services, and the price for clients. Using National Health Accounts, they measure the public sector's proportionate reliance on fees for services, with similar caveats on OOP spending discussed earlier.

Wadge developed a framework, "Evaluating the Impact of Private Provider on Health and Health Systems" to assess private providers' impact on patients and the health system for UHC(15). It suggests indicators or evidence that "assessors might want to explore when applying the framework" and includes impact areas such as quality of services, access, the care ecosystem, and stewardship, among others. The framework was designed to better understand the financial investments of a development group, and thus application of these indicators to a wider landscape is limited.

The Global Impact Investing Network (GIIN) has created indicators to measure impact in the healthcare sector. Like the Wadge framework, the purpose of the indicators is to assess the effectiveness of impact investments. The indicators examine access to healthcare, job creation, use of medical facilities, healthcare quality improvements, preventive care, healthcare affordability, and access to finance. Healthcare investors select which metrics to track, and use of metrics is not standardized or universal(*16*). While the indicators could be applied to the private sector and UHC, they were not designed to measure the private sectors' role in advancing UHC.

While the indicators could be applied to the private sector and UHC, they were not designed to measure the private sectors' role in advancing UHC.

Two major metrics are used to assess UHC, but also have limited use to capture private sector contribution or potential. The service coverage index, combining data from 16 tracer indicators, can indicate how a country, overall, is able to provide essential health services for the population. Of these, 12 rely upon household survey data for information, and data is incomplete. For example, while 183 countries have recent estimates for child immunization, only 29 have recent estimates for malaria prevention, and 6 for management of diabetes(*17*). The index is reliant upon statistical modeling to fill in gaps, and uses data sources which are not frequently updated. Of the underlying data sources used, only the DHS and Multiple Indicator Cluster Surveys (MICS), offering information on reproductive, maternal and child health indicators, routinely ask about source of care. In the case of service coverage, a lack of data to assess coverage does not necessarily mean that the population does not have access to health services. In particular, for noncommunicable diseases (NCDs), global data on prevalence and treatment coverage for diabetes and hypertension is not available, yet these are two areas where significant private sector investment in pharmaceuticals has taken place.

The second common UHC metric offers insight into health expenditure by detailing catastrophic expenditure incurred by households. As mentioned in some critiques of the measure, the underlying data and survey instruments used to calculate out-of- pocket health expenditure, and total household expenditure, are inconsistent and infrequent(*18*). This measure only captures costs paid to the health system, and not associated expenses or opportunity costs, and does not capture households who could not afford the health service due to cost. Additionally, the underlying survey data may not disaggregate between costs paid to the public or private sector, and some countries do use OOP payments as a significant source of public sector expenditure(*5,19*).

The metrics and research described above do not suffice in providing a routine source of information on the private health sector's size and market importance, however they do make the case for the need for such measures.

Current Data Availability

For measures to be more immediately useful, being drawn or calculated from existing data sources is a benefit. Potential sources of data include administrative data, financial data, nationally representative surveys, and social media ("big") data. We explore and describe the opportunities and limitations of these various types of data in defining the size of the private health sector.

Potential sources of data include administrative, financial and social media data.

Administrative Data

Insurance claims data or reimbursement data are a particularly important type of administrative data that could be used to track the tracer indicators for UHC provided by the public sector and private sector by selecting the relevant ICD-9/ICD-10/ ICD-11 codes or Diagnosis Related Group (DRG)/ DRG-equivalent code for each tracer indicator. However, as of 2016, only 58 countries were using at least one of 20 variant DRG-based systems for reimbursement of hospital services(*20*), leaving a big gap in terms of countries covered. Additionally, DRG-based systems mainly deal with hospital services.

Pharmaceutical sales databases provide another interesting source of administrative data. One such example is the MIDAS Database curated by IQVIA, which collates the total manufacturer sales by therapy area and channel of distribution from over 90 countries. Data are captured in a standardized way and updated quarterly. These data can be used to conduct sales analysis to understand private and public sector case load and indications of consumption. As with other data sources, the total number of countries covered is limited and in some countries the coverage or ability to differentiate total sales from private sector sales is also limited. The database is proprietary, and thus there are costs associated with accessing the data.

Among the administrative data systems explored was the DHIS2 system, currently in use in over 100 countries by governments, as well as organizations such as WHO, PEPFAR and PSI. DHIS2 is an open source software solution that is fully customized to the user, leading to variation in the type, architecture, and availability of data collected. Instances are uniquely owned and data is rarely publicly available. In most DHIS2 country-level implementations, the software is used to track public sector data only. Where countries make an attempt to also capture private sector data, with the exception of Kenya, reporting in is woefully low. Country-by-country requests for high level access to view data, in order to complement any private sector information found on case load or facilities, would be required to leverage this data source.

Another administrative source of information at the country level is a database of licensed and registered physicians.

Another administrative source of information at the country level is a database of licensed and registered physicians. Each country requires physicians to be licensed and registered in at least one government database, and physicians are often also participants in local and regional professional organizations, representing specialties. Examples include the Health Professions Council of South Africa, a licensing and regulatory authority with an online but not up to date register of practitioners, and FOGSI (Federation of Obstetric and Gynaecological Societies of India). Using such databases to understand the size of the private sector is impractical due to the need to access information at each country or state level, as well as differing levels of data completeness. Complete public sector data could help to 'back-calculate' the size of the private sector based upon total number of providers.

Financial Data

Government revenue service (Tax) and customs authorities (Duties) maintain records of the taxes levied on business entities and pharmaceutical imports. These records exist and are able to be obtained at aggregate level for research and analysis purposes in many countries, however the process and challenges of doing so is similar to DHIS2. Such records could be used to understand revenues in the private health sector, and the stated value of pharmaceutical imports.

National Health Accounts (NHA) can provide a wealth of information, including on financial flows to the private sector, and out of pocket expenditure in public sector facilities. The process of collecting the information required to produce health accounts, necessitates data from private providers, NGOs, households and various government line ministries to understand budgetary allocations. Although the input data exist, once produced, the classification systems for provision, consumption or payment do not differentiate between public and private health care service providers. Furthermore, NHA are not routinely produced, with only 42 countries reporting consistent production every 1-3 years.

Nationally Representative Surveys

Data from nationally representative surveys of health facilities, such as the WHO's Service Availability and Readiness Assessment (SARA) or Measure DHS Service Provision Assessment (SPA) surveys, were also explored, however these surveys have low geographic coverage. Since 2010, only 11 countries have conducted a SARA survey and 8 countries have conducted a SPA survey. Data from the DHS and MICS household surveys ask about source of care for reproductive, maternal, and child health (RMCH) conditions only. A study looking at DHS data from 1990-2013 across 70 countries finds use of the private sector to range from 30% to 67%, depending on the health condition(*9*). An analysis of DHS and MICS surveys from 65 countries between 2014-2019 finds that 26% of overall care-seeking in sub-Saharan Africa is done in the formal private sector, with an additional 10% in the informal sector. The most privatized region is the Eastern Mediterranean region, with 66% of outpatient care taking place in the formal private sector. Unfortunately, DHS and MICS data are limited to RMCH conditions, and a re infrequently conducted in countries.

Social Media

Finally, in markets with strong mobile and internet penetration, including high-income markets, analyses have been done on web and social media text and search terms, to map the spread of diseases, and topical knowledge(*21,22*). We explored the feasibility of similar strategies to understand the size of the private health sector, but discounted it at this time for a number of reasons. First, mobile and internet penetration varies by country, as does how people use the internet (searching for doctors online may not be a common strategy). Second, the platform most used from country to country, or between demographics, varies, and will change over time, making the analyses less replicable. Lastly, the most comprehensive analyses would require collaboration with the research arms of large data gathering companies, such as Amazon Web Services, or Google, and universities.

At present, relevant data is available uniquely (country-by-country) and type, quantity, quality, and source varies. Access to information such as the caseload or financial size within the health sector, relevant to investors, is often obtained by observation, personal appeal, and not systematically. As described in more detail in the case study (see page 10), comprehensive country reports are possible when one is willing to use a variety of data sources and methods. Examples include the USAID funded private sector assessments from Madagascar and Cote d'Ivoire, which interviewed nearly 100 people each, and conducted several weeks of in-country data collection, or the government mandated competition commission inquiry in South Africa on the functioning of private healthcare markets as a precursor to UHC(*23-25*). As a result of variable and inconsistent data availability, the data strategy, and resulting summary metrics, would differ by country. Over time, however, some data sources may become more widely available. These include data from for-profit aggregators such as IQVIA, which currently has no demand for market data in much of sub-Saharan Africa and thus has not entered these markets strongly, or insurance claims databases, as proportion of the population insured increases.

Suggested Metrics

To direct resources, advocate for improved private sector collaboration, or conduct multi-country comparisons, it is important to have a short list of standard, easy to understand, measures. These measures should be relevant to policymakers, and the data manipulation required should be minimized to promote uptake. We use the UHC cube as an organizing framework for metrics which could offer, in varying degrees, an understanding of the size and market importance of the private health sector. Several possibilities are described, due to the differing data needs of each, as well as difficulty in data coverage. Each measure described as a count within the private sector would be more instructive if reframed as a proportion. To do so, one would need the same information within the public sector. Our research has demonstrated that full public sector information may be incomplete, or difficult to acquire without manual data extraction. Where the information is readily available, we have included proportions of an indicator as a metric.

Population Coverage Axis

Understanding the total number of private sector hospitals, or proportion of hospital beds in the private sector, is a useful measure of the scale and potential of the private health sector in a country. It provides a target for the number of private sector entities qualified to participate in a large-scale insurance program, or to accept other payment mechanisms designed to reduce household burden. These data may be available via regional or national administrative records for licensing, registration, or tax purposes; a baseline could be obtained via a health facility survey.

Figure 2: Proposed Metrics for Understanding Market Size and Importance of Private Health Sector

UHC cube axis	Select metrics	Indicators
Population coverage	Private sector outlets	• # of private hospitals • # of private pharmacies or drug sellers
	Private sector capacity	• # of private sector hospital beds • # of private sector hospital beds/10,000 population
Cost coverage	Revenue	• Total revenue of private sector outlets, by outlet type
	Expenditure	• Total household expenditure in the private sector • Domestic private health expenditure per capita (USD)
Service coverage	Private sector providers	• # of registered or licensed doctors/midwives in the private sector • # of doctors by specialty in the private sector
	Private sector utilization	• Proportion of care sought in the private sector, by disease condition • Proportion of inpatient care sought in the private sector • Proportion of outpatient care sought in the private sector

Cost Coverage Axis

In complementary ways, information on revenue for the private health sector, and expenditure within the private health sector, shed light on market size and importance within the economy, for investors, and as an advocacy tool. Revenue information may be estimated via tax records or from NHA, while in more mature markets, market research and investment studies likely exist. Some detailed household expenditure surveys include information on health expenditure by sector, and the WHO Global Health Expenditure Database (GHED) information can be used to calculate private sector real and proportional expenditure. In countries where public sector services are free or nominal, total household expenditure in the private sector can be approximated by total out of pocket health expenditure. Combined with NHA data on proportion of OOP expenditure used in public sector, the total and relative household expenditure in the private sector can be more accurately calculated.

Service Coverage Axis

For accountability to health care users, understanding how many providers are present in the private sector, by specialty, cadre or level of the health system, can help to inform training and quality assurance strategies. As described, these data are likely available but currently difficult to obtain systematically. Finally, we would consider the gold standard measure for assessing the size of the private sector to be the proportion of care sought in the private sector, by reason for care-seeking or disease condition. These data may be obtained via specialized household surveys which go beyond RMCH conditions, or estimated using claims/reimbursement data for the top 10 burden of disease conditions in countries with sufficient insurance penetration. As noted above, current data availability using either of these two methods is low.

We would consider the gold standard measure for assessing the size of the private sector to be the proportion of care sought in the private sector, by reason for care-seeking or disease condition.

Case Study

In order to understand the feasibility of the metrics proposed earlier, we selected four countries for exploratory analysis, based upon geographic and cultural diversity, representation of several WHO regions, and data availability in English, French or Spanish:

- India - WHO SEARO
- South Africa - WHO AFRO
- Mexico - WHO PAHO
- Indonesia - WHO SEARO

The four countries have similar profiles regarding major sources of burden of disease within the population, with between 3 to 5 chronic diseases in the top 10 sources of morbidity and mortality (Table 1). These countries differ with regard to public sector contribution to the health system.

In all four countries selected, health expenditure in the private sector is a significant proportion of all health expenditure. In India and Indonesia, the private sector accounts for three times and two times, respectively, the amount that the public sector contributes to health expenditure. In Mexico and South Africa, the private and public sectors account for almost the same amount of health expenditure. Spending on pharmaceuticals accounts for ¼ of total health expenditure in Indonesia, ⅙ in India and Mexico, and ⅛ in South Africa (Table 2). Therefore, these countries provide an interesting sample to examine how to assess private sector contribution to UHC.

Table 1: Top 10 Burdens of Disease(*26*)

Rank	India	Indonesia	Mexico	South africa
1	Ischemic heart disease	Stroke	Ischemic heart disease	HIV/AIDS
2	COPD	Ischemic heart disease	Chronic kidney disease	Ischemic heart disease
3	Stroke	Diabetes	Diabetes	Lower respiratory infection
4	Diarrheal diseases	Tuberculosis	Interpersonal violence	Stroke
5	Lower respiratory infection	Cirrhosis	Cirrhosis	Diabetes
6	Tuberculosis	Diarrheal diseases	Stroke	Tuberculosis
7	Neonatal disorders	COPD	Alzheimer's disease	Interpersonal violence
8	Asthma	Alzheimer's dis-ease	COPD	Road injuries
9	Diabetes	Lower respiratory infection	Lower respiratory infection	Diarrheal diseases
10	Chronic kidney disease	Neonatal disorders	Road injuries	COPD

Table 2. Health expenditure profiles

Country	Current health Expenditure (CHE) as % of gross domestic product (GDP) 2015(27)	Domestic private Health expenditure (PVT-D) as % current health expenditure (CHE) 2015(27)	Total Pharmaceutical Sales as % of Healthcare Expenditure 2014(28)	Oop as % of CHE (2015)(27)	% OOP spent on Drugs
India	3.9%	74%	16%	65%	45%
Indonesia	3.3%	59%	24%	48%	70%
Mexico	5.9%	47%	16%	41%	-
South Africa	8.2%	44%	12%	8%	-

We searched for available data to define each of the recommended metrics and have presented the data in a summary table (Table 3). Data were limited, and outside of data reported in the WHO GHED, data sources were inconsistent across countries. We describe different data approaches in the case studies section below.

To fully populate the table of metrics for each country will require leveraging administrative data, which is often required to be collected by statute for the registration of private health facilities and licensing of health workers and should not add additional burdens of data collection. These data are not easily available publicly or electronically. For some countries and metrics, estimates will be required. For example, taxation data may only capture the formal sector, so either the measure acknowledges this limitation, or ancillary information on informal health markets are used to improve the estimate. These calculations were outside of the scope of this report.

As demonstrated in Table 3, some of the metrics proposed can be readily obtained. But there are notable gaps where additional research will be needed to identify or generate the data.

India

The private health sector in India is at least a $56 billion market. It accounts for 3 times the amount spent by the public sector on health. The total spend on pharmaceuticals is ⅙ of current health expenditure. A major portion of overall out of pocket health spending has been estimated to be for medicines for NCDs; as high as 64% and 58% for cases of hypertension and diabetes(*36*), respectively the number 1 and 9 disease conditions in India (Table 1). In the case of tuberculosis (TB), the 6th leading cause of morbidity and mortality in India, Arinaminpathy et al. estimated that the private sector treated twice the number of cases treated by the public sector utilizing a commercially available dataset on the sales of pharmaceuticals used to treat TB(*37*). With an estimated 70% of outpatient care provided by the private sector (Table 3 Private Sector Metrics), the private sector is the major provider of care for NCDs, such as diabetes and hypertension in India and even infectious diseases such as TB, which are traditionally managed through public sector driven programs. Additionally, more than 80% of reimbursements from all the health insurance schemes in India were made to the private sector(*38*), further reinforcing the importance of private sector health delivery in India. An annual Government of India publication provided information on number of doctors and hospitals, while a periodic household survey provided information on the proportion of healthcare provided by the private sector(*30.31*).

The private health sector in India is at least a $56 billion market.

Table 2. Health expenditure profiles(a)

UHC CUBE AXIS	METRIC	INDIA	INDONESIA	MEXICO	SOUTH AFRICA
Population Coverage	# private hospitals	80,265	1,767	3,070	409
	# of private pharmacies		42,409	26,000	3,250
	# private hospital beds		128,499	44,514	34,572
	# of private hospital		5.0	3.6	6.2
Cost Coverage	Total Revenue of Private Sector Outlets				
	THHE in Private Health Sector				
	Total annual OOP exp in USD	$ 49,744,051,240	$ 10,584,646,633	$ 26,562,990,239	$ 1,990,484,100
	PVT-D per capita in USD	43	59	247	207
Service Coverage	# Registered/Licensed	114,969		227,567	17,493
	# Registered/Licensed	926,426			14,255
	Total # Registered/ Licensed doctors	1,041,395	159,960	238,949	31,748
	Proportion of registered/ licensed doctors in the private sector	89%			45%
	# Registered/licensed midwives in private sector				
	# Doctors by specialty in private sector				6,726(*b*)
	Proportion of outpatient care	71%	63%	39%	30%
	Proportion of inpatient care	58%	42%		19%

Indonesia

In Indonesia, 60% of current health expenditure is private, amounting to a $15 billion market annually. Pharmaceutical expenditure accounts for ¼ of current health expenditure. The private sector dominates pharmaceutical sales accounting for 75% of the market(*33*) and up to 70% of OOP expenditures are spent on medications(*39*). In 2012, the private sector accounted for 63% of outpatient care and 42% of inpatient care(*33*). The introduction of Jaminan Kesehatan Nasional (JKN) in 2014 - the single payer health insurance scheme implemented by the social security agency Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS) - and its subsequent expansion which currently covers 221 million Indonesians, approximately 87% of the population, and 27,211 facilities, has reconfigured healthcare in Indonesia.

Fifty one percent of the providers are private and 60% of the hospitals registered are private(*40*). A 2013 study found that 65.6% and 81.2% of income of surgeons and obstetricians, respectively, were from the private sector(*41*) while 80% of all general practitioners (GPs) were estimated to have private practices(*42,43*). The domestically produced annual report, Indonesia Health Profile 2017, provided information on the number of private hospitals and hospital bed(*32*).

In Indonesia, 60% of current health expenditure is private, amounting to a $15 billion market annually.

(a) Sources of Data: All four countries row 4 calculated by dividing row 3 by 2015 population estimate for country multiplied by 10,000, rows 7 & 827, row 12 calculated by dividing row 10 by row 11; India rows 1,15 & 1630, rows 9,10 & 1131; Indonesia rows 1, 2, 3 & 1132 rows 15 & 16 calculated from table 7.3 p 227 in The Republic of Indonesia Health System Review33; Mexico rows 1,3,9,11 &1534, row 235 ; South Africa row 125 , rows 2,3,1029, row 9 calculated from information in Econex report29, row 11 sum of rows 9 & 10. THHE=total household health expenditure, OOP= out-of-pocket, PVT-D=Private Sector Domestic Health Expenditure

(b) Disaggregation by specialty available from 2013 Econex Report.

Mexico

Private sector and public sector spend in Mexico are nearly even with spending in the public sector slightly more than that in the private sector. Furthermore, 85% of private expenditure is directly OOP. With a population half the size of Indonesia, Mexico's per capita private health expenditure is four times larger, yielding $31 billion in annual private sector health expenditure.

Private sector and public sector spend in Mexico are nearly even with spending in the public sector slightly more than that in the private sector.

Data from a 2017 WHO Primary Health Care Systems Case Study provided the bulk of the information for Mexico, while the number of private pharmacies was estimated from other research(*34,35*). For other suggested metrics, we found that the information for Mexico is theoretically, but not practically available. Specifically, Mexico's form PEC-6-20-A collects information on hospital location, services, human resources, material resources, and morbidities. It includes private sector service provision in the registration, and is conducted annually. The online database did not work. Another government regulation stipulates that all hospitals that are members of the National Health System are required to provide reports to the Red Hospitalaria de Vigilancia Epidemiológica (Hospital Epidemiological Surveillance Network). The most recent report includes 2015 data. Other databases for physicians or hospital registration were also found to be incomplete or difficult to access.

South Africa

Similar to Mexico, the private sector and public sector account for similar percentages of current health expenditure (CHE) although public sector spend in South Africa is slightly a bigger percentage of CHE than in Mexico. Unlike India and Indonesia, where the private sector treats more patients, the private sector in South Africa only accounts for 30% of outpatient care and 19% of inpatient care. Access to the private sector is highly inequitable, with the public sector largely serving the 83% of the population who are uninsured. Out of pocket expenditure is very low (8% of CHE), with most of the $11 billion annual private sector market covered through pre-payment and pooling mechanisms. Three private hospital groups dominate the market, with a combined 83% of market share based upon beds(*25*). As in Indonesia and India, South African medical doctors have the liberty to work for both the public and private sectors.

The private sector in South Africa only accounts for 30% of outpatient care and 19% of inpatient care.

In 2013, it was estimated that 37% of GPs (7,529) and 59% of specialists (6,726) work in the private sector(*29*). For South Africa, significant information on the private sector was obtained from a one-time government commissioned study of competitiveness in the private sector, released in 2019(*25*). The report stated that no national or provisional verified databases exist which provide information on current facilities and numbers of beds, and that the facility licensing process is neither transparent nor well regulated.

Recommendations

While the metrics we have proposed provide an interesting starting point to capture the private sector's contribution to UHC, the results do not present a universal approach to measurement. As described, each metric and data source explored have limitations in our current environment. While each country may face different challenges or choose to focus on different areas in measuring progress toward UHC, there is value in defining standardized metrics(*44*) that allow us to understand countries present progress toward UHC, while also demonstrating what is needed to achieve UHC(*4*). Therefore, in order to embrace a new way of governing in mixed health systems, we need to dive deeper and initiate new research to meet the measurement gaps.

We need to dive deeper and initiate new research.

To understand the size and importance of the private sector, we presented a series of potential metrics. As discussed, the gold standard measure would be the proportion of care obtained in the private sector, by reason for care-seeking or disease condition. However, this measure is not currently feasible to achieve routinely, to be replicated, and to be collected globally.

Therefore, we recommend that WHO selects a limited number of priority metrics from those proposed, and focuses on how to support countries to collect and report on that data in order to measure progress toward UHC.

As WHO considers where to focus its efforts in private sector UHC measurement, we offer recommendations for how the underlying administrative data for the suggested metrics can be improved, and suggest what needs to be done to strengthen those data. We have focused our recommendations on administrative data as the most amenable to improvement through WHO efforts.

Many of the metrics suggested would be stronger if expressed as a proportion.

First, many of the metrics suggested would be stronger if expressed as a proportion, rather than a number. However, in order to do so, the relevant information in the public sector must be complete and accessible. The data gaps we experience in not understanding the full size of the private sector are not limited to a lack of data about the private sector. An estimate of private sector provision would be easier with:

- master facility list, inclusive of all public and private sector inpatient facilities;
- health workforce roster, which, at minimum, should include all physicians by specialty, and place of employment if in the public sector. Additional information on other cadres (clinical officer, physician assistant, nurse-midwife, etc.) would be beneficial;
- revenue collected within the public sector, through out-of-pocket expenditures. These data are likely available within the process of creating national health accounts, or within government budget documents, however they are not easily accessible;
- disaggregation of national health accounts data by health sector, for the classification of health care providers.

WHO can suggest countries collect data to create a master facility list and health workforce roster, to assess revenue collected within the public sector, and to disaggregate national health accounts by sector. In addition, WHO can encourage countries to report one or more of the above data sources.

Second, current coverage of pharmaceutical sales data in low- and middle-income countries (LMIC) is very limited, but opportunities to improve it exist. IQVIA has data on only 34 LMIC, with private sector sales information in less than 50% of them. Other large data intelligence firms did not respond to our requests for information. WHO may commission select studies in LMIC to improve current knowledge of pharmaceutical sales, as well as demonstrate to the commercial data firms the strategic and public relations value of working with international agencies in pursuit of global development goals. Data is not currently available because no one has wanted to purchase it.

Current coverage of pharmaceutical sales data in low- and middle-income countries (LMIC) is very limited, but opportunities to improve it exist.

Third, we recommend that if the standards are not already present, WHO is well positioned to provide international recommendations on the type of information to be collected during licensing and renewal processes for medical providers. These data will be useful beyond understanding private sector size. They may, in fact, be able to spur market investment in health facilities on a wider scale because the data deficits on the size and market penetration of the private sector which faces WHO is the same as that which investors in low- and middle-income health care markets face. These investors (social, impact or traditional) leverage individual relationships and commissioned research to study potential investments, limiting the potential for wider health sector growth and improvement. Specifically, we recommend standard data to be collected during health workforce licensing and renewal processes, which includes employment information, and standard data to be collected from private sector in-patient facilities during accreditation and renewal processes, which include bed capacity and provider coverage.

Research

As international agencies and country regulatory authorities work to improve the consistency and completeness of relevant data described before, supported and guided by WHO, new research can provide additional information to fill the gaps, and make models more robust.

We recommend new research that will complement data strengthening activities.

Widespread changes to the collection and accessibility of routine administrative data take time, and once the door is opened to making potential changes in a system, many stakeholders will have requests. Yet, the presence of international agency representatives (WHO, World Bank, etc.) worldwide offers an opportunity to collect necessary information which exists outside of searchable online databases. In addition to improvements in routine administrative data, information obtainable through one or several discrete research studies can also advance the field.

New research can provide additional information to fill the gaps, and make models more robust. We recommend new research that will complement data strengthening activities.

Two of the data sources currently available to understand health care utilization by sector are household income and expenditure surveys (HIES), and DHS (or MICS). These nationally representative population-based surveys may be conducted every 5 years, with differing frequency by country, and are often externally funded. In addition, pharmaceutical data exists, but is proprietary. Given our understanding of these data, three areas of inquiry could have tremendous potential:

- how can information on household health expenditure, and total household expenditure, be obtained in a way that is acceptable and reliable, but does not necessitate a comprehensive HIES?
- how much do household care-seeking patterns (specifically choice of health care provider/facility) differ for different members of the household, or for different health conditions? To what extent are the DHS and related surveys, which focus on place of care for reproductive and child health needs, a sound proxy for overall care-seeking?
- how can commercially available pharmaceutical data inform health spending in both the public and private sectors?

Significant research regarding the reliability and validity of various ways to assess expenditure has been conducted, concluding, broadly, that asking detailed expenditure questions yields higher expenditures than when a household is asked about aggregates(*45*). Surveys focusing on health tend to yield higher health expenditures than those where health is only one item(*18*). The major surveys in use today to assess health expenditure differ in recall period, survey length, question specificity and frequency of administration, resulting in the need to model health expenditure. Reliance upon models is sufficient for reporting UHC indicator 3.8, but is not practical when assessing the impact of an intervention on out of pocket expenditures. The comprehensive set of questions, while more valid, is not practical for inclusion in more general surveys due to its length. A research and consensus building process to develop a 'good enough' measure of health and total expenditure, for use in routine data collection, would facilitate metric use for both programmatic and national reporting.

The second question is important to understand the extent to which DHS-type surveys can be a proxy for overall care-seeking, as there is limited to no evidence that outpatient care-seeking decisions for childhood infectious diseases are similar to those for non-communicable diseases among adults. Yet, in many LMIC, non-communicable diseases are top contributors to overall burden of disease, making it critical to understand care-seeking behaviors. In a select set of 'exemplar' markets, primary or secondary research on care-seeking and expenditure for the top burden of disease conditions would support or refute the reliance upon DHS data to understand private health sector use.

Finally, it is clear from national health accounts studies that by volume, the major source of private expenditure is pharmacies. Even in countries where public sector utilization is high, drugs are often procured in the private sector. We have described the current geographic availability of some pharmaceutical market data, but without purchasing a sample of the data, the possibilities for higher order market size estimates are unknown.

We recommend that a deep-dive into the possibilities of currently available commercial pharmaceutical sales data be conducted.

It is clear from national health accounts studies that by volume, the major source of private expenditure is pharmacies.

Conclusion

The last decade has devoted considerable attention to studying and improving upon public sector functions in order to achieve UHC. However, as is becoming increasingly clear, we must also be able to measure, manage and engage the private health sector in order to strengthen the health system, and ensure health care is accessible by all. This report has focused on measurement of the private sector – an important step for advocacy and accountability nationally, and for generating investment and partnership globally. We have outlined the current data available, and where it is insufficient. In an evolving arena, it is necessary to move away from expensive, infrequent household surveys reliant upon donor funds. Yet, we cannot move away from these sources of data without an alternative. They exist, and can be improved, by doing the following:

Build the best picture available today, using data that current exists.

Of the six major metrics described earlier many countries will likely have information available to construct at least one of them, even if that information is not available through online searches, or in English. A disparate picture is better than no picture at all. Encouraging initial measurements will help WHO spur improvements in other administrative data sources that will, eventually, lead to consistent measurement approaches across countries.

Being able to measure private sector size and spending will significantly improve country progress toward UHC.

Invest in multi-sectoral solutions.

Information to understand the health sector overall, and the private sector in particular, is not only the domain of the ministry of health. We have proposed opportunities to improve administrative data, but improvements in the records for taxation, customs, and regulatory agencies can also help define the number, physical and financial size of the private sector. Combining hospital revenue data with physician registries, or looking at imported and indigenous production of medications alongside data from central and regional medical stores can provide a robust cross-sector lens that better defines the private health sector's role.

Use what investors use, and address the gaps with research.

Investors seek to understand the risk and return of their investment, and need to characterize health needs and ability to pay. For UHC, the same information can be used to advocate for comprehensive strategies to address population health, an expansion of who, what and where pooled funds cover, and partnerships. We can improve our ability to estimate and model the size of the private sector based upon administrative and regulatory data, coupled with data already collected for and valued by the private health care sector (pharmaceutical sales, equipment sales, manufacturing and use projections, etc.). To do so, we need well designed research studies that will seed model assumptions, particularly for non-communicable disease care-seeking.

While it is still challenging, there are important opportunities to measure the private sector using currently available data and to strengthen that measurement through timely research. Being able to measure private sector size and spending will significantly improve country progress toward UHC.

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4

Private health sector engagement in the journey towards Universal Health Coverage

Landscape Analysis

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Executive summary

Most countries have mixed health systems, in which health-related products and services are provided by the public and private sectors from a wide range of health service providers. In particular, the fragmented mixed health systems in many low- and middle-income countries (LMICs) lack coordination, which poses additional challenges in meeting national health priorities. Private health sector's involvement in health services provision may not be ignored as utilization is common for many key health services across low-income populations, especially as countries aim to progress towards universal health coverage. Previous studies and reports have underlined the importance of engaging the private health sector and developed various strategies and approaches for effective public stewardship of mixed health systems. However, the progress on private health sector engagement across LMICs in different regions remains unclear.

Previous studies and reports have underlined the importance of engaging the private health sector. However, the progress on private health sector engagement across LMICs in different regions remains unclear.

This report assessed the level of private health sector engagement in 18 LMICs with highest overall utilization of private health providers in six WHO regions.

This report assessed the level of private health sector engagement in 18 LMICs with highest overall utilization of private health providers in six WHO regions. Through reviewing official documents, grey literature, and peer-reviewed literature, we conducted a landscape analysis of private health sector engagement in the 18 countries using the domains in the World Bank/International Finance Corporation's private health sector engagement assessment framework. The most recent available documentation and literature were reviewed to provide updated information on the progress and challenges of private health sector engagement in the countries.

Our findings indicated a general recognition of private health sector's role in achieving population health goals, but specific policies on private sector engagement and formal dialogue mechanisms remained uncommon.

Regarding information exchange, a majority of the countries established systems for collecting information from the private health sector with limited information on private pharmacies, although challenges on implementation were commonly described and levels of reporting varied among reporting systems.

In the domain of regulation, all countries have administrative and bureaucratic regulation systems to control the entry of new private health providers to ensure minimal standards and training are met in both medical and pharmaceutical services provision, and some also linked specific requirements with financial mechanisms for cooperation. About a third of the countries also have regulation on pricing of medical services and/or medications. Despite the existence of regulation, enforcement appears to be a challenge in most countries.

As most countries have a public insurance for healthcare, only half provided partial coverage for services provided by private health providers.

The financing domain described mechanisms of strategic purchasing of private health services in leveraging service provision to meet population demands. Contracting was the most common mechanism in financing private health services, while less have experience in voucher scheme financing to reduce financial barriers for disadvantaged populations. As most countries have a public insurance for healthcare, only half provided partial coverage for services provided by private health providers.

Nearly two-thirds of countries reviewed have established one or more national programs in tuberculosis (TB), malaria, and immunization, which commonly engaged the private health sector through public good distribution, ensuring referral and notification mechanisms, as well as providing training for private health providers. Countries may build on these national program successes to address implementation gaps in system-wide approach. As level of private sector engagement varied across domains and countries, more uniform implementation of private sector engagement across the six domains may enhance progress towards universal health coverage.

To support the goal of universal health coverage, clearer norms and guidance are needed across the six domains in the World Bank/International Finance Corporation's private health sector engagement assessment framework to ensure a more system-wide approach for the effective governance of the private sector within mixed health systems.

More uniform implementation of private sector engagement across the six domains may enhance progress towards UHC.

Background

The private health sector has been an important source of health service delivery in low- and middle-income countries (LMICs). Almost all countries have mixed health systems, with service provision from both the public and private sectors. A large proportion of populations across LMICs in different regions obtain services from a wide range of private health sector, including for profit, non-profit, formal, or informal entities of various scales. Although the extent of private service provision and types of services vary by country(*1,2*), studies found private health service utilization is common for a number of key health services, including treatment for childhood illness and reproductive health services(*1,3*).

As countries progress towards universal health coverage (UHC), the private health sector's involvement in provision of health services cannot be overlooked given the significance of private health sector's scale and scope in the health services provision in LMICs. Despite the heterogeneous and complex nature of the private health sector, concerns of the high out-of-pocket payments and the lack of quality control in private health sectors have been major considerations in the goal of universal health coverage(*2,4*). Additionally, access to referral services to ensure efficient patient care pathways in LMICs are challenging, particularly with the diverse private health sector(*5*). The three dimensions of UHC: ensuring coverage, access, and financial protection, are unattainable without effective governance of the private sector(*6,7,8*)

The importance to engage and promote effective partnerships across public and private health sectors has been recognized by policy analysts, governments, and international organizations over the last two decades(*9,10,11,12,13,14,15,16*). Over the years, various strategies and approaches have been developed for effective public stewardship of mixed health systems to work with the private health sector, ranging from prohibition to encouragement of the private health sector(*12,17*). While public-private partnerships have been more commonly practiced on specific disease control and vaccine programs(*15,18,19*), the level of formal engagement with private health sector in the provision of general health services remains unclear.

It has become more pressing for countries to engage with private health sector to move forward towards UHC.

As increasing challenges including changing demographics and the increase in non-communicable disease burden have affected many health systems in many LMICs, it has become more pressing for countries to engage with private health sector to move forward towards UHC. Although the need for private health sectors engagement has been generally recognized and various strategies proposed, it is important to identify the pattern and progress of private sector engagement across the health sector in different LMICs across regions. Additionally, it is crucial to understand the current documented level of engagement with the private health sector across different domains to identify important opportunities. Innovations in point of care diagnostics and digital health services also create new types of partnership for innovations in universal health coverage, highlighting the need for understanding the current status of private health sector engagement.

This landscape analysis aims to analyze private sector engagement in health service delivery, with a focus on primary health service delivery, by identifying patterns, gaps and opportunities across different LMICs country contexts and supplement with relatable experiences from HICs through official document review and literature review.

Scope

Scope of the landscape analysis

The scope of this landscape analysis encompasses 18 LMICs across the six WHO regions that have the highest utilization of private health providers. The landscape analysis was conducted through a document review of the 18 countries, focusing on national policies, and national and regional programs related to the provision of health services published by local government, World Health Organization (WHO), the works of WHO regional offices, and the United States Agency for International Development (USAID). Only the most recent official country documents (e.g. national health strategy and policy), country portfolios, and reports that describe national health services provision publicly accessible online were reviewed. In addition to the grey literature and official documents review, the landscape analysis is supplemented with a literature review of peer-reviewed articles published since 2010.

The scope of this landscape analysis encompasses 18 LMICs across the six WHO regions that have the highest utilization of private health providers.

Limitations

This approach has several limitations. Not all official country documents from the 18 countries were available online and some country portfolios and program documents available on the web may not be the most recent version. Although efforts were made to identify the most recent official documents through searching the country's government and Ministry of Health website, we were unable to verify if the latest version of the document was accessible. Additionally, this approach enabled the assessment of only documented private health sector engagement implementation primarily from government and some developmental agencies' perspective, which were public statements of engagement with private sector from the governments' viewpoint. Additionally, these country documents and reports predominantly cover the formally recognized private health sector. As such, informal private health sector functioning outside government's regulatory systems is generally not represented in this landscape analysis.

While the documentation review allows identifying the extent of private health sector engagement in government plans and policies, specific in-country context, degree to which such process have been successful in improving access to appropriate services, and programmatic challenges of private health sector engagement in practice is beyond the scope of this document.

Defining key terms

This landscape analysis focuses on assessing private health sector engagement in the 18 countries. A few of the key terms are defined below.

Private health sector

Private health sector is defined as all non-state providers of health services, which includes for-profit (both formal and informal) and not-for-profit (NGOs, faith-based organizations, community-based organizations), domestic or international entities(*7*). As such, the private health sector is heterogeneous and can include providers who are unqualified or underqualified(*20*).

Private health sector is defined as all non-state providers of health services, which includes for-profit and not-for-profit, domestic or international entities.

Service delivery

Service delivery involves provision of effective, safe, good quality personal and non-personal health care. These services may include primary, secondary, or tertiary care. Service delivery may involve physical interaction between a patient/client and a health care provider, and also includes 'virtual' health services such as digital health and telemedicine(*21*).

This document focuses specifically on health service providers who directly interact with service users and supply them with health care services or medicines.

Health service providers

Health service providers may be trained (pharmacists, doctors, nurses, and midwives) or informally trained; may work on their own or in institutions and may provide health care or other health products such as drugs and contraceptive supplies. This document focuses specifically on health service providers who directly interact with service users and supply them with health care services or medicines. Two additional groups of actors have important roles but are not considered here as part of the private health sector: intermediaries or third-party organizations, such as insurance authorities, or civil society organizations; and donors, who play an important role in financing health programs and influencing health policy indirectly(*15*).

Governance

Governance is defined as "how societies make and implement collective decisions"(*22*). While governance is a broad concept, the governance function generally "characterizes a set of processes (customs, policies or laws) that are formally or informally applied to distribute responsibility or accountability among actors of a given [health] system"(*23*). Good governance is also described as involving subfunctions that ensures "that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability"(*24*).

Private sector engagement

Private sector engagement (PSE) refers to "a partnership between the public and private sectors to achieve a specific goal"(25), direct interaction between the state actors and the private sector, as well as private to private collaborations that are properly regulated. In general, there are three broad categories of private sector engagement: including private actors in developing public health policy; development of ownership and contractual arrangement; and influencing behavior of private sector actors.

Public Private Partnerships

Public Private Partnerships (PPPs) are "a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance"(*26*). PPPs encompass a wide variety of arrangements and vary in the scope of services covered in the health care sector. A critical element of PPPs is the sharing of risk between the private party and the government, which depends upon the level of capital committed by the private party, length of partnership, provision for renegotiation, and the structure of payment mechanisms(*27*).

Public Private Partnerships (PPPs) are "a long-term contract between a private party and a government entity".

Public-Private Mix

Public-Private Mix (PPM) "encompasses diverse collaborative strategies such as public-private (between national disease programmes and the private sector), public-public (between national disease programmes and other public sector care providers such as general hospitals, prison or military health services and social security organizations), and private-private (between an NGO or a private hospital and the neighborhood private providers) collaboration" (*28*). PPM is commonly used for some disease areas such as tuberculosis.

Public-Private Mix is commonly used for some disease areas such as tuberculosis.

Methodology

This landscape analysis focuses on top three countries with highest overall utilization of private health providers in each of the six regions of WHO (a total of 18 countries). These countries were identified based on findings from Montagu and Chakraborty (Table 1)(*29*). Data on health system characteristics were obtained by online search of official databases: The World Bank, WHO and regional offices websites, International Health Metrics Evaluation. Additional searches were conducted to identify private sector representative bodies by searching the grey literature using keywords: "healthcare federation", "health association", "private health association", or "private medical association". Peer-reviewed literature search was also conducted to supplement the official documents and grey literature search.

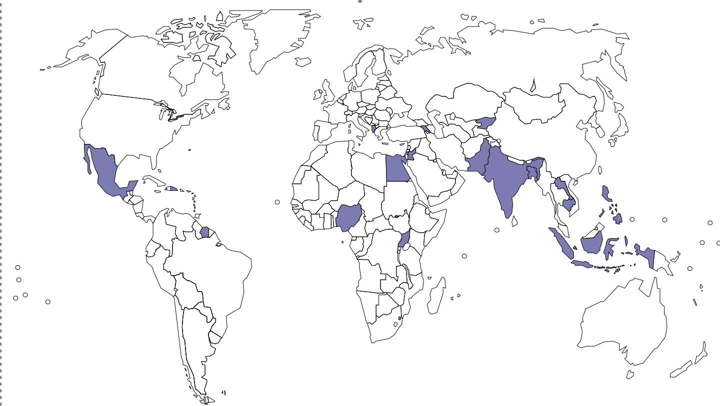
To assess the most recent status of private health sector engagement in each country, three types of documents were specifically searched using WHO and regional offices database, government, and Ministry of Health (MOH) websites:

- national policies, national health strategy, or national health plan;
- specific health program strategies, plans, or guidelines (e.g. immunization, malaria control and treatment) published by the government;
- health system reviews and private sector assessments of each country conducted by WHO or USAID. A peer-reviewed literature search was conducted using Medline database to identify relevant studies conducted between 2010 and 2020. Only articles available in English were reviewed and the most recent documents were used for the analysis.

We used the World Bank/International Finance Corporation's private health sector engagement assessment framework to analyse the patterns and extent of private health sector engagement across five domains: policy and dialogue, information exchange, regulation, financing, and public production (modified as engagement in vertical services provision)(15). The overall assessment framework and the indicators are listed in Appendix 1. When applicable, relevant examples from high-income countries (HIC) are described in the corresponding section. Information from HICs were obtained from health system reviews, similar to the methods described for LMICs.

Table 1 List of countries included in the landscape analysis

WHO region	Countries included
AFRO	Uganda, Nigeria, Eswatini (formerly known as Swaziland)
EMRO	Egypt, Pakistan, Jordan
EURO	Albania, Kyrgyzstan, Armenia
PAHO	Mexico, Suriname, Dominican Republic
SEARO	Indonesia, Bangladesh, India
WPRO	Cambodia, Philippines, Lao People's Democratic Republic



Policy and Dialogue

The policy and dialogue domain provides an overview of any plan or existing formal engagement between the public and private health sectors. Active involvement of private health sector in national health strategic plans and establishment of formal dialogue mechanisms create an enabling environment and a foundation for other domains of engagement, as they provide the platform that private health providers can use to contribute to national health goals.

Most countries in the analysis have identified the importance of involving the private health sector in their national health plans or policies.

Most countries in the analysis have identified the importance of involving the private health sector in their national health plans or policies. While the extent of private health sector being mentioned differed by the countries, almost all of the 18 countries (2 countries could not be determined) included private health sector in specific objectives in their national health plans. Almost half of the countries also engaged the private health sector in the development of such objectives and outlined the role of private health sector in achieving their national health goals. However, only a few countries have further established a formal partnership framework in the health sector to facilitate sector-wide implementation.

Of the 18 countries, only Uganda, Nigeria, and Philippines have a designated policy to public-private partnership in the health sector (not including specific disease-focused program). Among the three countries, Uganda has the longest history of interest in public-private partnerships (PPP) in health since 1995 and established a PPP working group which operated under the Health Policy Advisory Committee to implement and monitor the national strategic plans(*30*). Besides the country's non-sector specific PPP Act, in 2012, Uganda's Ministry of Health has established a health-sector specific PPP policy that modified and adapted the PPP Act to the health sector and described the areas that the Ministry of Health would work with the private sector(*31*). Nigeria's PPP policy in health articulated various aspects of PPP, including financing for different forms of PPP for health, provision of care in PPP, as well as crafted the regulatory framework, but the challenge of forming effective partnership remains(*32*). Although the PPP policy in health provided the general framework, implementation of forming effective partnerships requires continual strong coordination of different stakeholders in the health sector and has not been documented in most countries.

Of the 18 countries, only Uganda, Nigeria, and Philippines have a designated policy to public-private partnership in the health sector.

Table 2: Overview of policy and dialogue of private sector engagement in health in the 18 countries

	Strategic Vision			Policy	Dialogue
	'Private health sector' or 'private sector' mentioned in national health strategic plan/ national health policy	Consultation with private sector while drafting the national health strategic plan/ national health policy	Specific Objective for private sector engagement	National policy for engaging the private health sector	Formal Dialogue Mechanism with the private health sector
Uganda	■	■	■	■	■
Nigeria	■	■	■	■	•
Eswatini	■	■	■	•	•
Egypt	■	•	■	•	•
Pakistan	■	•	■	•	•
Jordan	■	■	■	•	•
Albania	■	•	■	•	•
Kyrgyzstan	■	•	■	•	•
Armenia				•	•
Mexico	■	•	■	•	•
Suriname	■	■	■	•	•
Dominican Republic	■	•	■	•	•
India	■	•	■	•	•
Indonesia	■	•	■	•	•
Bangladesh	■	•	■	•	•
Cambodia	■	■	■	•	•
Lao PDR	■	■	■	•	•
Philippines	■	■	■	■	•

■ Documentation/policy exists • No relevant information found ☐ No document found to obtain the information

Example from Uganda

In 2012, the government of Uganda formulated a formal policy for Public Private Partnership in Health (PPPH Policy) that describes the goals for the partnership and outlines institutional arrangement for implementation. The policy acknowledges the role of the private sector in achieving universal health coverage, improving equity, increasing access, strengthening efficiency, and creating mixed health system that complements each other. It also details the strategic priorities for the partnership.

The PPPH policy demonstrated a major progress in public-private partnership in health. However, the implementation is hindered by several barriers below:

- lack of awareness about the policy outside the Kampala district among both public and private sector
- health officers are unwilling to implement as it conflicts with other development partners' regulations.
- despite its large mandate, the PPPH node lacks resources to carry out all the activities outlined.
- lack of common understanding of PPPH. Several private not-for profit organization have a historical relationship in supporting the public sector that is informal or ad-hoc and not necessarily according to the PPPH Policy.
- development partners have varying degrees of commitment to work with the private health sector.

Source: O'Hanlon et al. 2016 Uganda Private Sector Assessment in Health. 2017

Information Exchange

Information exchange between the government and private health sector is critical especially in mixed health systems, where private sector is often the first source of healthcare services. For purposes ranging from disease surveillance, health resource planning and allocation, to better coordination of health services delivery, the inclusion of private health sector in existing information system and mandate to reporting remains essential. On the other hand, the private sector needs to stay informed on government's health strategy and disease surveillance. Inclusion of private health sector on the health information channels can play an important role in facilitating engagement.

Information exchange between the government and private health sector is critical especially in mixed health systems.

Despite the recognition of the importance to engage private health sector in national health plans and policies, countries varied in their level of information exchange with private health sector. About two-thirds of the countries have national health information systems that collect routine information from both public and private health providers and countries mandate private health providers to report health information. However, there was a wide range of level and completion of reporting from private health providers among these countries. To improve compliance and the ability to regulate reporting, some countries linked submission of facility reports with license renewal for private health facilities and required submission of missing reports prior to renewal of the health facility license. However, incentives for compliance from the private sector is uncommon, unlike some high-income countries such as the example from New Zealand(*33,34*).

Health Information Service in New Zealand

Following the first ministerial strategy for health information in 1991, the New Zealand Health Information service was established in 1992. The information service included three major components:

- National Health Index (NHI) – a unique patient identifier;
- National Minimum Data Set (NMDS) – national data on public and private hospital discharges;
- national Statistics.

The well-developed information technology systems, the highly computerized General Practitioner (GP) practices and the widespread use of electronic medical records are all in favor of the success of the information system. In an effort to support the GPs in purchasing computers and complying to the electronic claiming procedures, the government offered NZ$ 5000 to the GPs in 1998. This increased the utilization of computerized billing and appointment systems and had reached 100% by 2008.

Source: Cumming J et al. New Zealand: Health System Review. Health

Despite the recognition of the importance to engage private health sector in national health plans and policies, countries varied in their level of information exchange with private health sector.

Level of reporting also differed between types of information systems. For instance, the private sector in Jordan reported only to notifiable disease of epidemic prone nature, but not to other communicable and noncommunicable diseases(*35*), while majority of private providers in Swaziland reported to the health management information systems and less reported to the immediate disease notification system(*36*). Furthermore, systems and regulations for routine private sector reporting remained lacking in a few countries(*37,38,39*), resulting in informal and unsystematic data sharing, as well as a lack of integration in the public health information system(*38*). In Suriname, the national health sector plan in 2011-2018 described the objective "to strengthen the national health information system to generate, analyze, and utilize reliable information from public and private sources"(*40*). While it was unclear if the plan has been fully implemented, national surveillance of reported diseases acquired cooperation of private clinics and specific services such as vaccination coverage was reported by private clinics.

While majority of the 18 countries required private health providers to report on specified diseases and services, the inclusion of private pharmacies in health information exchange was generally uncommon.

While majority of the 18 countries required private health providers to report on specified diseases and services, the inclusion of private pharmacies in health information exchange was generally uncommon. Only Uganda and the Philippines had information system that covered private pharmacies and no description were found among other countries.

It is important to recognize that countries may have multiple disease specific surveillance and monitoring systems besides national health information system and notifiable disease reporting, such as TB, malaria, and HIV. Some of these parallel disease-specific monitoring platforms may result in fragmentation due to differences in reporting forms and systems. Common barriers of private health providers reporting to national health information systems include being cumbersome process, lack of incentives, and lack of training provided to private sector staff in the reporting systems(*41,42,43*). While efforts have been made to reform health information systems towards web-based platform and collection of individual-level data to facilitate data integration across many LMICs, a comprehensive review of progress and compliance to the information standards across different health information systems by private sector should be explored.

HMIS in Cambodia

- The Ministry of Health of Cambodia launched a web-based reporting and access, Health Management Information System (HMIS) in 2010. Providers from the public and the private sector who had internet access were able to enter data directly, whereas those without internet connections submitted returns on paper.

- the attributes of HMIS that contributed to a reporting rate close to 100% were:
  - single system for all routine health data
  - standardization of the set of forms across all levels
  - retaining the design from the past
  - reliability in completeness and timeliness of data
  - computerization for most health facilities

- the validity and reliability on the HMIS data are both high and is reported to be within 5% of the results of household surveys.

- the data from HMIS is used for routine reviews, provincial planning and budgeting.

Source : Annear PL et al. The Kingdom of Cambodia: Health System Review. Health Systems in Transition. 2015. 5 (2) 1-178.

Table 3: Summary of information exchange with private health providers in the 18 countries

	Policy	Dialogue
	National Health Information System that includes private providers	National Health Information system that includes private pharmacies
Uganda	■	■
Nigeria	■	
Eswatini	■	
Egypt	■	•
Pakistan	×	•
Jordan	■	•
Albania	×	•
Kyrgyzstan	■	•
Armenia	■	•
Mexico	■	•
Suriname	■	•
Dominican Republic	■	•
India	×	•
Indonesia	■	•
Bangladesh	■	•
Cambodia	■	×
Lao PDR	×	•
Philippines	■	■

■ Documentation / policy exists × No regulation / system exists

• No relevant information found ☐ No document found to obtain the information

Regulation

The domain of regulation focuses on a government's ability to design and implement rules and approaches to ensure a minimal standard and availability of health services. Across the 18 countries, all countries have a standardized registration and regulation process of private health providers (except Eswatini – no relevant documentation was found) and pharmacies (except Mexico – no mention of pharmacy regulation) to control market entry. The responsibilities of health providers regulation are generally carried out by the national or provincial Ministry of Health or Ministry of Trade in each country. Such responsibilities generally include ensuring the licensing and registration of the private health sector. Despite the perceived importance of the regulatory domain and the intended function, the level of regulation and enforcement varied widely across countries and major challenges have been reported particularly in lower-income countries with higher rural populations. Medicines in Jordan are highly regulated, in terms of quality assurance, registration, import and export, as well as pricing. On the other hand, unlicensed drug stores remained highly prevalent and often operated near to public health facilities in rural Uganda. A mapping study reported 76% of the private drug shops were unlicensed in more than 200 surveyed villages in eastern rural Uganda, and the barriers to licensing reported being the cost of license and lack of qualifications to apply(*41*).

In several countries, accreditation of private health facilities is also included as a regulatory process by the government to ensure quality of care (Indonesia) or served as a requirement for engaging in a contract with the public sector or with the national insurance body (Nigeria, Mexico, the Philippines). Other countries do not mandate accreditation process, which is often implemented by local or international non-governmental organizations serving as independent regulators.

Regulation of private health facilities in Jordan

The private primary health facilities in Jordan are regulated by the Ministry of Health (MoH) through the Directorate of Licensing Health Professionals and Health Institutions. The facilities are required to fulfill a minimum requirement on location, infrastructure, equipment, and human resources and can be penalized in case of non-adherence or violations.

Until 2018, health providers were not required to renew their license as it was valid for lifetime. A new bylaw was endorsed in 2018 by the government that requires all health professionals to renew their licenses once in five years. The renewal initiative is designed to develop the workforce by encouraging participation in professional educational activities.

The Jordan Medical Association works along with the MoH to set the professional fees according to a minimum and maximum scale for private providers.

Source: Ajlouni MT. Jordan Private Health Sector Profile. Final Draft. Regional Office of Eastern and Mediterranean Region. WHO. April 2019.

While licensing and registration are commonly applied regulatory approach, price regulation can also be applied to attain better health coverage, service quality, as well as financial protection and health outcomes through the creation of economic signals and incentives to influence behavior(*44*). However, economic regulation of the private health sector has not been usually practiced across the countries: less than a third of the countries reviewed has laws or policies to set maximum fees for health services provided by the private sector. Most of these countries that regulate pricing of private health services also have regulations on drug pricing, although different regulation body and mechanisms are applied for medicines. Additionally, Pakistan has developed its first ever drug price policy in 2015 to improve the availability and affordability of medicines(*45*), while the Philippines government has recently sought public consultation on updating a tentative list of Maximum Retail Price for drugs and medicines(*46*). However, despite the legal mechanism on drug price control, there was report of illegitimate price hikes of five times increase by pharmaceutical companies in Pakistan over 3 months in 2016 and companies used various tactics to avoid regulatory authorities(*47*), underlining the challenging situations in enforcing regulations.

Besides the administrative and bureaucratic controls by government that have traditionally been perceived as the main regulatory strategy, regulatory strategies in health markets are diverse and may not be solely enforced by the state. Other regulatory strategies include market supply-oriented approaches, consumer/citizen-oriented approaches, and collaboration-oriented approaches(*48*).

The authors suggested that multi-pronged approach would be required amid the increasingly complex health products and services markets in LMICs and may not be addressed by governments alone(*48*). However, limited evaluations have provided strong evidence for different approaches of government regulation, training, and coordination of private for-profit providers in LMIC, as suggested by a recent systematic review(*49*). Despite the limited studies, the review found training providers for improving quality of care demonstrated moderate evidence. However, management improvement was rarely described as an approach in the review of private health sector regulation in these 18 countries and other regulatory approaches beyond administrative and bureaucratic functions may be further explored, including the use of price regulation in health care and pharmaceuticals.

Table 4. Summary of regulation and enforcement in the 18 countries

	Standardized registration and regulation of private providers	Standardized registration and regulation of private pharmacies	Regulation on service pricing	Regulation on drug pricing	Enforcement of regulation
Uganda	Documentation / policy exists	Documentation / policy exists	×	×	Weak evidence
Nigeria	Documentation / policy exists	Documentation / policy exists	•	×	Weak evidence
Eswatini		Weak evidence			
Egypt	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	×	Weak evidence
Pakistan	Documentation / policy exists	Documentation / policy exists	×	Documentation / policy exists	Weak evidence
Jordan	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Weak evidence
Albania	Documentation / policy exists	Documentation / policy exists	•	•	Weak evidence
Kyrgyzstan	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	•
Armenia	Documentation / policy exists	Documentation / policy exists	×	×	Weak evidence
Mexico	Documentation / policy exists	•	•	•	Weak evidence
Suriname	Documentation / policy exists	Documentation / policy exists	•	×	Weak evidence
Dominican Republic	Documentation / policy exists	Documentation / policy exists	•	×	•
India	Documentation / policy exists	Documentation / policy exists	•	Documentation / policy exists	Weak evidence
Indonesia	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Weak evidence
Bangladesh	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Weak evidence
Cambodia	Documentation / policy exists	Documentation / policy exists	•	×	Weak evidence
Lao PDR	Documentation / policy exists	Documentation / policy exists	×	×	Weak evidence
Philippines	Documentation / policy exists	Documentation / policy exists	×	Documentation / policy exists	Weak evidence

Documentation / policy exists — Weak evidence — × No regulation / system exists

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Financing

The financing domain describes the potential revenues available to the private sector from the government and the mechanisms that allow government's influence of these funds. As the private sector in LMICs are often financed out-of-pocket, the lack of financial risk protection has been one of the major concerns and impediment towards universal health coverage in countries with high use of private health sector. While public funding traditionally supports and subsidizes public sector health services in LMICs, strategic purchasing of private health services can leverage health service provision especially when the population's health care needs are not met by the public sector.

The lack of financial risk protection has been one of the major concerns and impediment toward UHC.

One of the mechanisms to improve the effectiveness of public funds is the use of contracts to pay private health care providers. Most of the 18 countries have experience in service contracting with private health sector in certain regions or in providing services in specific health conditions. Countries use contracting with private health providers for a variety of purposes. In Pakistan, the management of basic health units was contracted out to non-governmental organizations under the People's Primary Healthcare initiative to improve health services provision and increase of primary health care utilization(*50*); while in Mexico and Suriname, the public sector contracts with private providers for specific high-demand interventions, or to provide services in remote locations(*51*). The time-limited contracting mechanism also allows governments to negotiate and specify pre-conditions for private providers to engage in a contract, such as the requirement to obtain accreditation to ensure service quality. Such mechanism can enhance regulatory function described in the previous section.

Philhealth coverage in Philippines

- the government of Philippines introduced a social health insurance programme called Philhealth in 1995 with the aim to provide financial risk protection for the Filipino people.
- Philhealth covers 92% of the country's population and reimburses both government and private health facilities.
- a board of directors, chaired by the Secretary of health, oversee the regulation of Philhealth. The health facilities that are accredited by Department of Health (DOH) are automatically accredited by Philhealth.
- the government plans to actively engage the private sector including nongovernmental organization and other professional organizations to in planning supply side investments in Philhealth and expanding Philhealth accreditation for all benefit packages.

Source: Dayrit MM, Lagrada LP, Picazo OF, Pons MC, Villaverde MC. The Philippines Health System Review. Vol. 8 No. 2. New Delhi: World Health Organization, Regional Office for South- East Asia; 2018.

One of the mechanisms to improve the effectiveness of public funds is the use of contracts to pay private health care providers.

Although contracting can assert influence on private health providers, the supply side approach may not improve service use among the underserved populations. Voucher schemes can incentivize providers to improve their service quality and access by disadvantaged populations. The demand side approach is often used to improve equity for specific type of services such as reproductive health program and maternal and child health programs(*52,53*), with the assumption that affordability being the barrier to access the service. Recently, voucher scheme has also be applied to the treatment of chronic health conditions such as diabetes mellitus and hypertension (the Philippines)(*54*). A third of the countries reviewed have experience with the Ministry of Health engaged in one or more voucher programs. A recent evaluation of the voucher program in Pakistan found the program helped expand contraceptive access and choice among the populations in need(*55*).

Wide-scale financial risk protection cannot be achieved without high population coverage for a core set of health services.

Wide-scale financial risk protection cannot be achieved without high population coverage for a core set of health services by pooled financing. Despite 15 out of the 18 countries reviewed have established public health insurance schemes, nearly two-thirds of them have limited population coverage (<50%), some of which only covered specific sectors or groups of the population. However, a few other countries have rapidly expanded their population coverage in recent years: Indonesia introduced the national insurance program (JKN) in 2014, and enrolled 75% of the Indonesian population by 2018(*56*); Lao People's Democratic Republic Ministry of Health launched a tax-based national health insurance in 2016 and rolled out to cover over 90% of the population by the end of 2017(*57*); the Philippines expanded population coverage to more than 90% since 2013 through subsidizing premiums for senior citizens and the poorest population(*58*).

Universal Medical Care in Canada

- in 1966, the federal government introduced the Medical Care act to cost share single payer universal medical care insurance with provincial governments. According to this act, all residents of Canada are covered through a universal health insurance program that is administered by the provinces and territories.
- the primary health services are provided mainly through family physicians who have a private practice and receive remuneration majorly based on fee-for service schedules that is funded by provincial ministries.
- some provinces have introduced activity-based and incentive-based funding models as alternative payments to promote healthy behaviour among physicians.
- as a result of the universal coverage of the insurance program, only 14.7% of the total health expenditure is out of pocket payments while informal payments are almost non-existent and have not been observed in any provinces or territories.

Source: Gregory P. Marchildon. Canada: Health system review. Health Systems in Transition, 2013; 15(1): 1 – 179.

Majority of the publicly financed health insurance cover the use of public sector health services only, with eight countries also cover some private health care facilities. Many of these national health insurances that reimburses private facility include primary health care services (75%). However, unlike the national health insurance in some high-income countries where the full cost of services is covered (e.g. Canada and a number of European countries), the coverage of private health services is often partial and patients have to cover the co-payment out-of-pocket. Five countries' national health insurance provide coverage for pharmaceuticals to provide some financial protection on medicines, although growth in medicine prices can be a major driver of increasing co-payments(*59*). Most of the countries have limited information on offering financial incentives to providers.

Table 5: Summary of financing in the 18 countries

	Experience in service contracting of private health sector (regional or specific disease)	Experience in voucher scheme (regional or specific disease)	Publicly Financed Health care for citizens	Coverage of private providers through public insurance	Coverage of private providers for primary care through public insurance	Coverage of pharmaceuticals through public insurance	Duty exemptions/ Tax exemptions for private providers
Uganda	Documentation / policy exists	Documentation / policy exists	×	×	•	•	•
Nigeria	Documentation / policy exists	•	Weak evidence	Documentation / policy exists	•	•	×
Eswatini		•	×				
Egypt	Documentation / policy exists	•	Weak evidence	Documentation / policy exists	Documentation / policy exists	•	×
Pakistan	Documentation / policy exists	Documentation / policy exists	Weak evidence	×	•	•	•
Jordan	Documentation / policy exists	•	Weak evidence	×	•	•	•
Albania	Documentation / policy exists	•	Documentation / policy exists	×	×	Documentation / policy exists	•
Kyrgyzstan	Documentation / policy exists		Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Weak evidence
Armenia	Documentation / policy exists	•	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	•
Mexico	•	•	Weak evidence	×	•	•	•
Suriname	Documentation / policy exists	•	Weak evidence	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	•
Dominican Republic	•	•	Weak evidence	Documentation / policy exists	•	•	•
India	•	Documentation / policy exists	Weak evidence	×	×	•	•
Indonesia	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	×
Bangladesh	Documentation / policy exists	Documentation / policy exists	×	×	×	•	•
Cambodia	Documentation / policy exists	Documentation / policy exists	Weak evidence	×	•	•	•
Lao PDR	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	×	×	•	•
Philippines	Documentation / policy exists	•	Documentation / policy exists	Documentation / policy exists	Documentation / policy exists	×	Documentation / policy exists

Documentation / policy exists — Weak evidence — × N o regulation / system exists

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Engagement in Vertical Services Provision

Public-private engagement in vertical services provision symbolizes a collaborative effort between the sectors in working towards specific public health goals. As many LMICs established disease specific programs for diseases of national importance, a number of these programs engaged with private health providers as they are often the first point of contact for these diseases or prevention service. Such engagement requires functioning supporting systems in place to make progress towards disease control targets. To assess the level of public-private engagement in these programs, four sub-domains were assessed:

- functioning referral system - the requirement of private providers to notify patients to a common information system;
- distribution of public goods – utilization of private providers to distribute government funded goods that are free for care seekers;
- training of private providers – efforts taken by the vertical programs to strengthen the capacity of private providers;
- established Partnership – a formal arrangement between the public and the private sector.

Nearly two-thirds of the countries reviewed have established one or more national programs in tuberculosis (TB), malaria, and immunization. Most of them have set up referral and notification system from private health providers to the public sector. Of the three vertical programs, national TB control programs were the most common to establish formal partnership with the private sector. Training of private health providers was more common between TB and malaria control programs. While private health providers in many countries didn't have established engagement model, they were actively involved in national immunization programs and provided with vaccines to facilitate provision of services and reporting. These program specific engagement with the private health sector may provide experience and can facilitate more system-level engagement.

Public-private engagement in vertical services provision symbolizes a collaborative effort between the sectors in working towards specific public health goals.

Table 6: Summary of Vertical Services Provision in the 18 countries

	Engagement by TB program				Engagement by Malaria program				Engagement by Immunization program			
	Functioning Referral System	Distribution of public goods	Training of Private Providers	Established Partnership	Functioning Referral System	Distribution of public goods	Training of Private Providers	Established Partnership	Functioning Referral System	Distribution of public goods	Training of Providers	Established Partnership
Uganda	Doc	Doc	Doc	Doc	Weak	Weak	Weak	Weak	•	•	•	Doc
Nigeria	Doc	Doc	Doc	Doc	Doc	Weak	Weak	•	Doc	Doc	Doc	Doc
Eswatini												
Egypt												
Pakistan	Doc	Doc	Doc	Doc	Doc	Weak	•	•	Weak	•	•	•
Jordan												
Albania												
Kyrgyzstan	•	•	•	Doc								
Armenia												
Mexico												
Suriname					•	Doc	Doc	Doc				
Dominican Republic												
India	Doc	Doc	Doc	Doc	Weak	•	Weak	•	Doc	Doc	•	•
Indonesia	Doc	•	•	Doc	Weak	•	•	•	Doc	•	•	•
Bangladesh	•	•	•	Doc					Doc	Doc	Doc	•
Cambodia	Doc	Doc	Doc	Doc					Doc		•	•
Lao PDR	•	•	•	•	Doc	Doc	Doc	Doc	Doc		•	•
Philippines	Doc	•	Doc	Doc	Doc	×	Doc	•				

Documentation / policy exists (Doc)   Weak evidence (Weak)   × No regulation / system exists   • No relevant information found   (empty) No document found to obtain the information

Trends and private health sector engagement towards universal health coverage

This report provides an updated overview of private sector engagement across 18 LMICs that have high private health sector utilization. Using the assessment framework from the World Bank/ International Finance Corporation's report in 2011, we reviewed level of private sector engagement across the domains of policy and dialogue, information exchange, regulation, financing, and vertical services provision. This documentation review provides a peripheral summary of engagement with private health sector.

This documentation review provides a peripheral summary of engagement with private health sector.

For governments in LMICs to provide governance across the mixed health systems, including both the public and private sectors, challenges remain in bridging the gap between the strategic visions and the development of specific health policy and formal platforms for private-sector engagement in the health sector. All countries reviewed acknowledged the importance to engage private health sectors in achieving their national health goals, although few established polices in the health sector for public-private collaboration or formal mechanisms of dialogue. While contexts facilitating and challenging policy development can differ widely among countries, Uganda's emergent experience in the development and implementation of the national health policy in public-private partnership may provide useful lessons for other LMICs.

The need to gather information from private health sector was realized but many countries documented challenges in information exchange between the public and private sectors.

The need to gather information from private health sector was realized but many countries documented challenges in information exchange between the public and private sectors. Despite the mandate for private sector to report health information to specific government body using designated systems, level of implementation differed widely not only between countries and specific private health sectors, but also among different reporting systems and types of health information within a country. These discrepancies in reporting weaken the ability to build accountability and understanding to foster engagement with private health sectors. Furthermore, limited access to accurate information about private health service utilization can limit other domains of private sector engagement, particularly in regulation and financing mechanisms. As pricing and payment systems rely on accurate information on service utilization and costs, information systems can be an important barrier to implementing payment mechanisms to providers(*44*). Important lessons to improve information exchange between the public and private sectors may be shared across programs, countries, and regions, a process which can be guided and facilitated by WHO.

The role of regulation has predominantly focused on the administrative and bureaucratic process of registration and licensing in LMICs. Besides having legal mandates to control the entry of private health service providers and setting minimal standards for such providers to operate, other mechanisms may be applied to enhance enforcement and improve compliance of maintaining quality of services. For instance, a number of countries linked their financing mechanisms with some regulatory functions, such as the requirement to obtain accreditation in ensuring minimal service quality to have the ability for contracting with the government, and the incentive to improve their services to attract consumers through a voucher scheme mechanism. In addition to formal private health providers, informal private providers are an important source of health care in a number of LMICs, which act outside the regulatory framework. In recent years, governments began to recognize the importance of informal private providers and the need to organize training and formal registration for these providers (*60,61*). Connecting regulation and financing enables extending the regulatory role beyond the traditional administrative function to market supply-oriented approaches and collaboration-oriented approaches, and co-production of service and regulations across key stakeholders. WHO may collate countries' experience and development of best practice, and create knowledge sharing on different mechanisms and pathways to connect regulation and financing domains by LMICs to strengthen governance.

In recent years, governments began to recognize the importance of informal private providers.

The implementation of regulation along with financing mechanisms may also facilitate regulatory mechanisms to improve performance. In Philippines, the focus of including the private health sector with the Primary Care Benefits was used to incentivize the delivery and utilization of services at primary level, encouraging primary care providers and drug outlets to participate once accredited(54). It is important to note that implementation of these multi-faceted regulations requires institutional collaboration across Ministry of health, service regulatory agency and national insurance agency. Effective governance of mixed health systems requires not only cooperation and collaboration between the public and private sectors, but also among different health and financing agencies. As the public financing coverage rapidly expanded, ensuring the quality of services by both public and private providers and the extent of service coverage are important aspects in the governance of health service provision.

In addition to financing, regulation functions are fundamentally linked to policy and dialogue, as well as information exchange. Effective implementation of regulation requires the foundation of specific policies, while open dialogue with the private sector can enhance regular information exchange between the private and public sectors. These interrelated types of engagement between the public and private sectors have been facilitated in some vertical disease control programs, with tuberculosis control programs commonly incorporated public-private partnership. Countries may build on these platforms, as well as their successes and lessons learned to address implementation gaps in a more system-wide approach.

To support countries as they strive towards the goal of universal health coverage, norms and guidance are needed for more system-wide approach to the effective governance of the private sector within mixed health systems. As engagement with private health sector varies widely between countries, there are important lessons to learn across countries and regions. While such efforts are driven and led by individuals and organizations in country, WHO can facilitate the dynamic processes of learning and adaptation through working with country and regional institutions to improve public stewardship of all health system players.

Table 7: Country overviews

								Primary Care Provider ownership			
								Clinical		Retail (Pharmacies)	
	Economic status	WHO Region	Current Health Expenditure (CHE) as % (GDP)	Out-of-pocket expenditure (% of current health expenditure) (2016)	Developmental Assistance for Health in millions of 2018 USD	Private sector Representative bodies	Proportion of utilization of private sector medical providers	Public sector	Private sector	Public sector	Private sector
Uganda	LIC	AFRO	6.27	40.32	851.68	Uganda Healthcare Federation (UHF)	40.2	3001 (48.45%)	3192 (51.54%)	1002 (12.71%)	6885 (87.29%)
Nigeria	LMIC	AFRO	3.76	75.21	1351.54	Healthcare Federation of Nigeria (HFN)	36.8	28540 (81.98%)	6275 (18.02%)	NA	NA
Swaziland/ Eswatini	LMIC	AFRO	6.93	9.9	117.66	-	29	167 (98.23%)	3 (1.76%)	NA	NA
Egypt	LMIC	EMRO	5.29	61.99	96.07	-	75.2	4 937 (22%)	51 484 (78%)	1 852 (3%)	67 511 (97%)
Pakistan	LMIC	EMRO	2.90	65.23	NA	No distinct partnerships/association but initiatives have been taken by private actors like Aga Khan	73.8	5 941 (8%)	73 650 (92%)	15000 (27%)	40 000 (73%)
Jordan	UMIC	EMRO	8.12	27.98	36.24	Private Hospitals Associations	44.9	1 119 (22%)	4 000 (78%)	1 111 (35%)	2 622 (65%)
Albania	UMIC	EURO	NA	57.98	5.28	-	7.8	415	NA	NA	750
Kyrgyzstan	LMIC	EURO	6.19	57.59	68.26	-	7.1	948	NA	NA	NA
Armenia	UMIC	EURO	10.36	80.65	16.65	-	4.5	254	NA	NA	NA
Mexico	UMIC	PAHO	5.52	40.38	1.16	-	33	27739 (98%)	627 (2%)	NA	NA
Suriname	UMIC	PAHO	6.23	21.82	5.83	-	28.6	104 (41.6%)	146 (58.4%)	NA	NA
Dominican Republic	UMIC	PAHO	6.14	44.62	61.66	-	28.3	NA	NA	51	3717
India	LMIC	SEARO	3.53	64.58	292.94	NATHEALTH. Healthcare Federation of India	52.6	197023	NA	NA	800000
Indonesia	LMIC	SEARO	2.99	37.34	7.25	PERSI (Indonesia Hospital Association)	60	31711	NA	NA	30643
Bangladesh	LMIC	SEARO	2.27	71.89	490.29	Bangladesh Private Medical Practitioners Association (BPMPA)	57.2	NA	NA	NA	123800
Cambodia	LMIC	WPRO	5.92	58.56	161.68	-	33	NA	8488	NA	2156
Lao PDR	LMIC	WPRO	2.53	46.44	NA	-	14.6	894	222	NA	2132
Philippines	LMIC	WPRO	4.45	53.94	244.02	-	32.20	NA	NA	NA	NA

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International Organisations and the Engagement of Private Healthcare Providers

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Introduction

In most low- and middle-income countries (LMICs), key health-related products and services are delivered by a mix of public and private sector organisations. Large segments of the population, including the poor, receive the healthcare they need in the private sector, from a range of for-profit, not-for-profit, formal or informal entities(*1*). As Figure 1 shows, a majority of services for children with fever or diarrhoea are undertaken in such facilities in low- and lower-middle income countries.

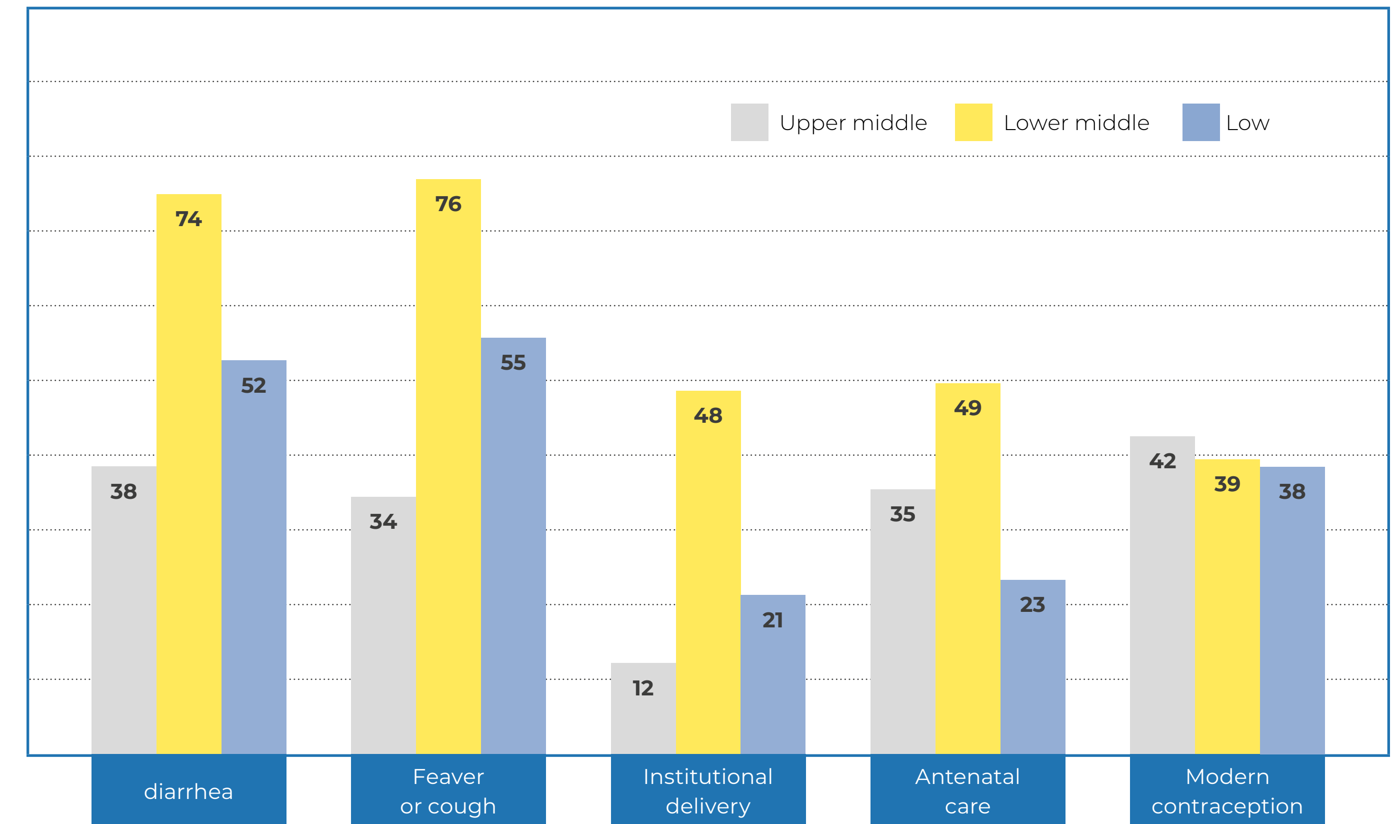
In recent years, researchers have examined the main factors underlying the expansion of the private sector.

In recent years, researchers have examined the main factors underlying the expansion of the private sector. On the demand side, these include: a perception that the public sector offers low quality care compared to the private sector(*2*); a shortfall of public health facilities in some rural and semi-rural locations; and large-scale urban migration and the public sector's inability to respond to changing demographics. On the supply side, and especially in countries where dual practice is common, the private sector represents a key source of income for many doctors and other health workers(*3*).

As a result, a large private sector exists across many service areas, including primary care, hospitals, diagnostics, specialist therapeutic and curative services, and pharmaceutical supply chains, and several international agencies have adopted strategies to engage this sector in pursuit of their programmatic goals. These agencies include the World Health Organisation (WHO) itself, which has sought to ensure that national treatment programmes relating to TB and malaria have engaged sections of the local private health sector involved in delivering programme-related services and products. However, in the context of the 2030 Agenda for Sustainable Development, there is now a pressing need, as well as a promising opportunity, for the international community in general, and WHO-HGF in particular, to drive forward an agenda for strategically engaging the private sector to achieve health system strengthening objectives, including Universal Health Coverage (UHC) and the health-related SDGs. Therefore, our aim in this report is to assist the WHO's Advisory Group on the Governance of the Private Sector for Universal Health Coverage by analysing the nature and extent of current global health practice in this domain. We focus on three objectives in particular:

- to map the current private sector engagement activities of key global health actors, with a focus on the goals, geographical foci, and programmatic approaches, of such activities;
- to assess the strengths and limitations of these activities from the perspective of UHC; and
- to analyse how WHO-HGF, as a new player in this area of activity, can deploy its distinctive strengths in order to accelerate progress towards UHC.

Figure 1. Treatment in the private sector as a percentage of total treatment in 70 low- and middle-income countries - by income group and service category



Source: Grepin, K Private Sector An Important But Not Dominant Provider Of Key Health Services in Low- And Middle-Income Countries Health Affairs 35, no.7 (2016):1214-1221

Method

We conducted an initial web search to identify the international actors that have been most active in private health sector engagement in LMICs (including bilateral and multilateral aid agencies, global health initiatives, UN agencies, and charitable foundations), and the evolution of their activities over time.

We identify the international actors that have been most active in private health sector engagement in LMICs.

We conducted an initial document analysis, and a set of key informant interviews with key individuals with direct experience of private sector engagement in LMICs (see the acknowledgements), to describe the nature and extent of current programmes being undertaken by international actors. Based on this analysis, we sought to identify the set of actors that have substantial and direct involvement (e.g. through direct financing or policy support) in private sector engagement. We then analysed relevant documents produced by these organisations, and conducted further key informant interviews with senior staff members in these organisations to define for each of these:

- its main goals in relation to the private health sector;
- the key countries/regions and products/ services targeted; and
- its clients, operating frameworks, modes of engagement, and programmatic approaches. (These data are presented in tables 3, 4 and 5.)

Drawing on our findings, we analysed the strengths, limitations and key gaps of current engagement approaches from the perspective of UHC – which we define here as a level of coverage in which everyone can access the health services they need, of sufficient quality to be effective, without incurring financial hardship. Accordingly, three broad themes were used to guide our interview questions and analyse our data, as follows:

- the extent to which existing activities represent a strategic approach to private sector engagement for health systems strengthening;
- the extent to which the goals and mechanisms of existing activities are consistent with the core UHC dimensions of equity in service use and financial protection; and
- the ways in which WHO-HGF can optimise its contribution to this set of activities, given its leadership role in the health systems strengthening for UHC agenda.

Drawing on our findings, we analysed the strengths, limitations and key gaps of current engagement approaches from the perspective of UHC.

A Brief History

Here we present a brief history of private sector engagement activities in global health. Our account highlights the origins of engagement in the large disease-specific 'vertical programmes', and the evolution of engagement into broader-based private sector development strategies and (some) 'horizontal' approaches. The account provides context for the analysis of international agencies' current activities, and the outline of recommendations for WHO-HGF.

First wave – the Social Marketing Experience

Social marketing (SM) is one of the first approaches to PSE in the health area. During the 1950s and 60s, several US government agencies successfully employed SM techniques to influence health-seeking behaviours. Key examples included the use of seat belts, breast cancer screening, and tobacco cessation. The first ever nation-wide SM programme in an LMIC was launched in the 1960s by the government of India. Policymakers realised that consumer access to low-cost condoms through public health facilities was inadequate. In response, they launched the Nirodh condom project for family planning (FP) and sexually transmitted infections (STIs). This project developed working relationships with mass-consumer goods companies to distribute subsidised condoms through commercial actors in the retail sector(4).

The success of the India SM experience led to the development of global SM programmes, managed by international organisations and domestic entities with financial support from a select number of bilateral development partners. The three primary development partners supporting SM have been:

- **USAID:** In the 1970s, USAID funded the newly formed Population Services International (PSI) to expand the India experience throughout South Asia. In the 1980s USAID launched the SOMARC projects, managed by the Futures Group. USAID continues to support global and country-level SM projects that promote a wide variety of health products in FP/RH, HIV/AIDs, MCH and malaria.
- **KfW/BMW:** Although KfW SM programmes have not had a specific geographic focus, they have concentrated mostly on family planning/reproductive health products (FP/RH), oral rehydration salts (ORS) and insecticide-treated bed nets (ITNs).
- **DfID:** The UK's experience in SM programmes dates to 1989 and a project in India managed by Marie Stopes. DfID's SM programmes accelerated in the 1990s; and by the beginning of the 2000s, DfID had supported more than 30 country SM programmes. Today, DfID remains an active player – it's SM projects concentrate on products for FP, STIs, and communicable diseases, especially malaria.

Rationale for SM programmes

- public sector provision is often inefficient and ineffective.
- guaranteeing access for particular 'segments' of consumers (e.g. unmarried youths in need of family planning products or services) is difficult to achieve through the public sector alone.
- access through local shops is easier when compared to public health facilities.
- subsidized prices reduce economic barriers.
- purchases lead to a greater sense of "value", more consistent use and appropriate use.

DfID. Review of DFID Approach to Social Marketing. Annex 2: Overview of Social Marketing. September 2003.

As other development partners – like UNICEF, UNAIDS and the World Bank – noticed the positive impact of SM programmes, they began to adopt SM approaches in their health programmes. As a result, the list of BCC and health products has continued to grow.

Table 1 provides a brief overview of the breadth and scope of SM programmes in LMICs. There is strong evidence of SM's effectiveness and health impact. Multiple studies have demonstrated the effectiveness of SM across a range of health areas – including HIV/AIDS, maternal and child health, and FP/RH. For malaria, research has linked behaviour change resulting from SM interventions to changes in health status(5), as a result of which SM is considered a "high impact practice" in family planning.

The success of SM programmes had a major influence on donor thinking towards the private health sector. The first few clinical social franchising programs (i.e. networks of private sector facilities that are contracted by an NGO to provide standard services under a common brand) were created in south and southeast Asia in the 1990s. By 2015, more than 90 such programmes existed in 40 low-income and middle-income countries. Most of these are in India and Kenya. Major donors - USAID, DfID, the Bill & Melinda Gates Foundation (BMGF), and the Norwegian Agency for Development Cooperation (NORAD)—have invested millions of dollars in these franchises. Social franchises offer a wide range of services in relation to: FP, SRH (not including FP), safe motherhood, TB, malaria, HIV/AIDS, abortion/PAC, paediatrics, NCDs, vision and dental care. However, FP continues to be the service that is offered by most franchises.

Table 1: Sample of SM BCC Health Topics and SM Health Products

SM	Area	BCC Health Topic or Health Products
BCC	Child health	Immunization campaigns | Growth monitoring
	HIV/AIDS	Voluntary testing | Aids prevention
	MH	Exclusive breastfeeding | Skilled delivery | ANC+ 4
	Sanitation	Handwashing
Products	Child health	ORS | Household water treatment | Zinc | Soap
	Malaria	ITNs | Artemisinin-based combined therapies
	Maternal health	Iron/folic acid | Safe delivery kits | Vitamin A supplements
	FP/RH	Oral contraceptives | Cycle beads | Injectables | Condoms | Emergency contraception
	HIV/AIDS	Condoms

Social Marketing Approaches*(5)*

- NGO (Product) Model: Works with existing NGOs or establishes a new NGO to develop a brand, and sell, distribute and promote the branded product through local infrastructure.
- Behavioural Change Communications (BCC) Model: Extensive use of BCC approaches has been made, often in combination with product distribution programmes.
- Manufacturers Model: In which a commercial manufacturer provides marketing support to enter a new market, maintains control over the brand, and is responsible for sales and distribution.
- Social Franchising Model: A network of private healthcare providers linked through an MoU/agreement to provide socially beneficial health products under a common brand. A "franchisor" brands franchisees: to signal to clients the quality and affordability of products at franchise clinics.
- Total Market Approaches (TMA): In which different consumer segments are assessed to define the comparative advantage of public, SM, and commercial (private) delivery of products or services.

Second Wave – Global Public-Private Partnerships

The latter half of the 1990s witnessed another form of private sector engagement – global public-private partnerships for health development (GPPPs). Global health PPPs involve collaboration between the corporate and public sectors with the purpose of overcoming market ''failures'' in public health(6). In the succeeding decades, this type of partnership has attracted considerable resources into the international public health arena.

Most GPPPs focus on partnerships related to drugs and vaccine development. However, there are also other types of GPPPs (Table 2), i.e.:

- **product based partnerships** consist primarily of drug donation programs but also allow for bulk purchase of products for public sector programs in low-income countries at a reduced price (e.g. female condoms or HIV/AIDS medications).
- **product development partnerships** are designed to address a failure of the market to develop products with significant positive externalities (i.e. high social, but modest financial, returns).
- **system/topic partnerships** seek to harmonize approaches and coordinate public and private actors involved in a single disease as well as raise the profile of the disease's on the global health agenda.

Table 2: Example of GPPPs

Type	Example
Product based partnerships	Mectizan Donation Programme
	Malarone Donation Programme
	Albendazole Donation Programme
	Zithromax Donation Programme
Produce development partnership	BMGF Childhood Vaccine Program (CVP)
	International Aids Vaccine (IAVI)
	Malaria Vaccine Initiative (MVI)
	Medicines for Malaria Venture (MMV)
Systems/issue partnership	Children's Vaccine Initiative (CVI)
	GAVI – Global Vaccine Initiative
	Roll Back Malaria Global Partnership
	Stop TB Initiative

The entrance of BMGF into the global health arena played a catalytic role in the GPPP agenda. As one of its first investments in global health, the BMGF partnered with GAVI in 1998. The BMGF has also invested significant funds to accelerate discovery the new vaccines through its support to multiple product development partnerships (CVP, IAVI, MVI). As an example, BMGF has invested in one GPPP – BMGF Childhood Vaccine Program (CVP) – to develop more than two dozen vaccine projects the cut across 18 different diseases focusing on the world's leading causes of childhood deaths: diarrheal disease, pneumonia, and malaria.

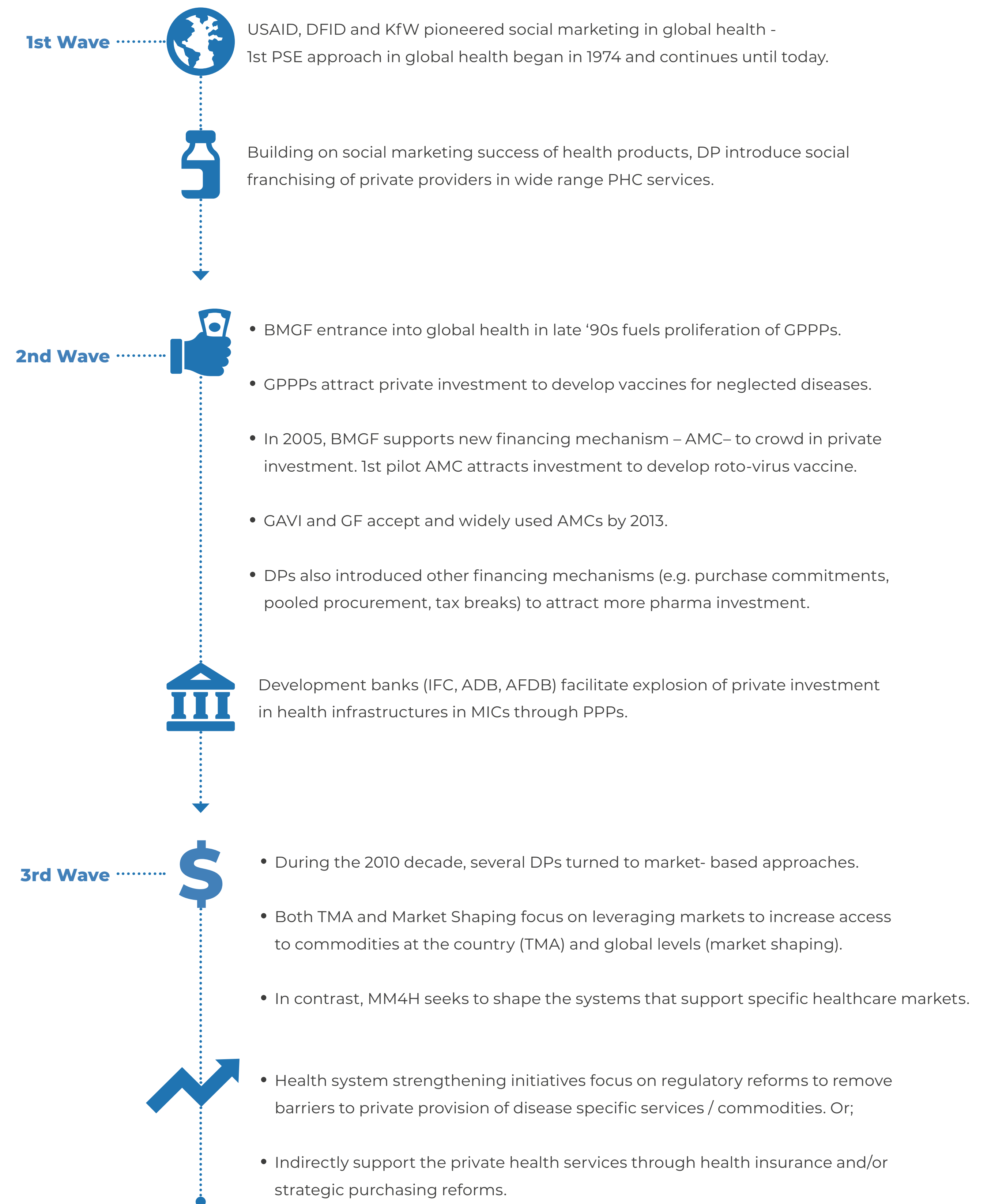
BMGF has also invested in piloting innovative financing mechanisms to crowd in private sector investment – mainly in pharma – as another strategy to develop vaccines and drugs for neglected diseases. For example, the Advance Market Commitment (AMC) pilot started in 2005 and was officially launched in 2007 with a collective US$1.5 billion commitment from BMGF, Canada, Italy, Norway, Russian Federation and the UK. The first AMC deal was for pneumococcal vaccines. The AMC deal succeeded in aaccelerating the development of a new pneumococcal vaccines, introducing the effective pneumococcal vaccines for developing countries, and accelerating vaccine uptake by ensuring predictable vaccine pricing for countries. Subsequently, development partners facilitated other financial incentives in addition to AMC (e.g. tax breaks, purchase guarantees, reputation enhancements, etc.) to crowd in private investment.

In this same period, development banks such as the International Finance Corporation (IFC) began to accelerate direct investment (of both equity and debt finance) in commercial health sector businesses and, at the same time, lobby governments to reduce regulatory barriers to private sector development, and adopt new forms of public-private partnerships (PPPs), e.g. in relation to specific diagnostic and treatment services, and even whole hospital systems(*7*). Until the 1990s, the IFC had not had a strong portfolio in the health sector. This changed dramatically during the first decade of this century. By 2016, the IFC had an active portfolio of $2 billion in private sector healthcare businesses located in LMICs(*8*).

International health was once dominated by the public sector through UN agencies and bilateral organizations with some NGO participation.

International health was once dominated by the public sector through UN agencies and bilateral organizations with some NGO participation. However, with the introduction of GPPPs and the increasing emphasis on private sector development, there is, in global health, a far greater degree of involvement on behalf of private sector and commercial actors - and, in general, greater familiarity with and acceptance of market-based approaches.

Figure 2. Brief History of Global Health Initiatives to Engage the Private Sector



Third Wave – Market Systems in the Health Sector

Although by the early 2000s, social marketing programmes were yielding some positive impacts, development partners began to grow concerned about long-term sustainability of such efforts. Over the last decade in particular, development partners like USAID started to push for greater self-reliance, and to graduate SM programs to local NGOs. In addition, development partners wanted to take to scale some of the private sector initiatives developed in response to HIV/AIDS in the late 1990s, such as contracting of NGOs to deliver key health services (e.g. South Africa's 'down-referral' model)(9) and outsourcing parts of the health system (e.g. in Kenya and Uganda, the contracting to faith-based organisations to many supply chains to get drugs and health supplies to underserved regions).

Development partners turned to two different but complementary approaches.

Development partners turned to two different but complementary approaches – market-based approaches, and engagement of the private sector with a specific focus on health system strengthening.

Market-Based Approaches

USAID pioneered one of the first market-based approaches: the Total Market Approach (TMA). USAID's implementing partners began experimenting with TMA as a strategy to assist SM programmes to become more sustainable. The assumption is, with a TMA approach, the public and private sectors work together to increase the market for and the availability of FP products and services. The claimed advantages of the TMA are that it increases affordability and choice so that different socio-economic groups can utilise services. USAID has invested in standardizing the TMA approach and developed methodologies to conduct market analysis to determine a country's readiness for TMA. USAID's FP programmes widely use TMA, and the UNFPA also supports this approach.

The TMA seeks to leverage the comparative advantages of different market sectors to enhance FP services across market segments with government coordination and support. It is based on an understanding that meeting the diverse needs of different population segments requires increased attention to coordination across sectors.

The assumption is, with a Total Market Approach, the public and private sectors work together to increase the market for and the availability of FP products and services.

USAID has also driven the development of another market-based approach: Market Shaping.

USAID has also driven the development of another market-based approach: Market Shaping. In 2014, the Centre for Innovation and Impact at USAID released the Healthy Markets for Global Health: A Market Shaping Primer(*10*). The primer was developed through a collaboration with several multi-lateral organizations involved in bringing vaccines, drugs and other health products to the global market - USAID, UNITAID, UNICEF, Gates Foundation, DFID, Norad, the Global Fund, and the Government of South Africa. The primer provides an overview of the basics of market shaping, an analytical approach for tracing market shortcomings to their underlying root causes, and guiding principles for designing, implementing, and evaluating interventions. In many ways, the market shaping primer brings together the collective experience in GPPP and presents a systematic approach to diversify "the supply base, increase shipment reliability, and ultimately increase product access for end users". However, it is important to note that market shaping focuses almost exclusively on "life-saving commodities" in the health sector.

During this period, DfID and the World Bank came together to develop a new market systems approach, called Managing Market for Health (MM4H). This builds on the Making Markets Work for the Poor (M4P) approach that seeks to change the way markets (primarily micro-finance and agricultural markets) work so that poor are included in the benefits of growth and economic development. The DfID and World Bank collaboration has sought to apply similar principles and experiences to the health sector. Unlike its predecessors, MM4H centres on the government's role in shaping local health market sectors – e.g. primary care, hospital services, specialist services, product supply chains etc – through the use of a problem-based strategic framework and the use of 'tools of government' through which policymakers influence markets in support of core health policy objectives, such as equity of access, enhanced affordability, and higher quality services.

MM4H centres on the government's role in shaping local health markets– e.g. primary care, hospital services, specialist services, product supply chains etc – through the use of a problem-based strategic framework and the use of 'tools of government' through which policymakers seek to influence markets in support of health policy objectives, with a focus on equity.

In common with these concepts, DfID supported a multi-year project to increase the use of private sector-provided health services by poor people in Kenya, Ghana and Nigeria using an MM4H approach. The project incorporated community engagement to encourage enrolment; advocacy to increase the range of preventative and primary care services in the National Health Insurance (NHI)-covered package; empanelment/ accreditation of franchised providers; and technical assistance to private providers to improve business skills and access to credit. A similar three-year project in Kenya – PSP4H – sought to apply M4P principles in the country's health sector, with the aim of reducing the cost of private health insurance and enhance access to private midwifes, private pharmacy networks, private eye care and surgery.

The brief history provides context for findings concerning the global health community's current approach to private sector engagement. As the trends in private sector engagement reveals, the approaches have been ad hoc and opportunistic, responding to country needs and global health crisis as well as the arrival of new actors into the global health community. However, the recent developments in private sector approaches relating to health systems strengthening and managing market systems are more promising. To consolidate the advances made to date in private sector engagement, it is important to move from ad hoc to strategic approaches embraced across agencies.

Key Findings

We drew on an initial online search to identify a 'long-list' of international organisations – including WHO divisions and regional offices – with a private sector component of their activities. We identified a large number of such entities, in various organisational categories (inter alia bilaterals, multilaterals, development banks, charitable foundations, and WHO departments/regional offices).

We identified a 'long-list' of international organisations – including WHO divisions and regional offices – with a private sector component of their activities.

In particular, we identified a large number of bilateral donors (the aid agencies of the US, the UK, France, Japan, Canada, the Netherlands, Norway and Sweden etc) that indirectly support private sector engagement activities by co-funding international agencies (e.g. UN agencies such as the UNFPA, UNITAID, UNICEF, UNAIDS and WHO) and multi-lateral initiatives (e.g. GAVI, GATFM, Global Funds and the World Bank/GFF.[2] For example, GAVI has become an important player in private sector engagement at the global level - shaping international markets for health products and medicines through its GPPPs. Similarly, GATFM is a major financier of disease-specific programmes, in HIV/AIDS, TB and malaria, that include large-scale attempts to engage the private sector.

However, our primary focus in this report is that subset of organizations which is directly engaged in private sector engagement at the country level. Specifically, we focused our analysis on the 10 entities (see Table 3) that were identified by key informants as global leaders in the private sector engagement agenda on the grounds that:

- they have programmes and projects that directly engage with the private health sector in LMICs; and/or
- they are active "in the trenches" of the private sector engagement agenda, using their expertise and influence to ensure that LMIC policy networks recognise the scale and importance of the private sector and, where possible, adjust their policies accordingly.

We focus on these 10 because, in our view, these are the main organisations that WHO-HGF will need to partner with, and learn from, in building an informed case and momentum behind the more strategic, UHC-focused, approach to private sector engagement that is called for by the 2030 Agenda for Sustainable Development and the WHO's thirteenth general programme of work, 2019–2023.

We focused our analysis on the 10 entities because, in our view, these are the main organisations that WHO-HGF will need to partner with.

2 We also examined the activities of the regional development banks – the European Bank for Reconstruction and Development (EBRD), the Asian Development Bank (ADB) and the African Development Bank (AfDB) – in the health sector. These banks are working with LMIC governments to implement infrastructure-related public-private partnerships (PPPs). However, with the exception of a small number of upper middle-income countries (e.g. Egypt, South Africa, Turkey), these efforts have so far had limited traction in the health sector.

Most agencies' engagement efforts are focused on programme-specific objectives

As this document made clear earlier, in the past, most donor-led private sector engagement approaches have been tied to 'vertical programmes', i.e. programmes that:

- are focused on specific products and services (particularly, those related to certain health/disease areas such as FP/RH, MCH, HIV/AIDS, TB, and malaria);
- engage a distinct set of funders and partners; and
- involve a specific set of activities, priorities and evaluation approaches related exclusively to programme-specific objectives.

Our data shows that this verticalised approach to engagement remains the norm. According to the key informant interviews, the Public-Private Mix for TB Prevention and Care – led by the WHO Global TB Programme – is perceived to be the most mature and sophisticated example of this approach. The PPM approach in TB involves the provision of free/heavily subsidised medicines and health products to clinical and diagnostic facilities in return for an agreement to notify cases and undertake training. In some cases, engagement includes financial incentives under formal contracts. In addition, to inform its programming, the Global TB Programme has been involved in developing and applying new methods of private sector data collection and analysis, including patient pathway analysis, which has helped bring to light the considerable presence of the private sector in TB prevention and treatment(*11*).

Similar approaches have been used to serve programme objectives in other disease areas. For example, between 2013 and 2016, WHO was involved in a programme to support the creation of markets for quality-assured rapid diagnostic tests for malaria (mRDTs) in five LMICs - Kenya, Madagascar, Nigeria, Tanzania and Uganda. Sustaining Health Outcomes through the Private Sector (SHOPS and its sequel, SHOPSPlus) – a USAID funded project – harnessed private sector capacity in multiple countries with the aim of improving health outcomes related to FP, HIV/AIDS, and MCH. Both projects provided financial resources, training and market information to inform suppliers along with technical assistance to reduce regulatory barriers and enable scale up of commercial markets.

Table 3. Key international organisations directly involved in private health sector engagement in LMICs

Type	Example
Bilaterals	Department for International Development (DfID)
	KfW
	United States Agency for International Development (USAID)
Multilaterals	World Bank (Health, Nutrition and Population)
	International Finance Corporation (IFC)
	Global Financing Facility (GFF)
Foundations	Bill & Melinda Gates Foundation (BMGF)
WHO divisions / regional offices	Global TB Programme
	Global Malaria Programme
	Regional Office for the Eastern Mediterranean (EMRO)

In some cases, product-specific strategies have elements of a more 'horizontal' approach. For example, USAID's PSP-ONE, SHOPS, SHOPSPlus and SM programmes support activities to reduce regulatory barriers to private engagement. Examples of such activities include: (i) reforming regulations to allow private providers to diagnose and treat TB, HIV/AIDS and malaria patients; (ii) changing regulations related to the marketing of FP products; and (iii) bringing together public and private actors to dialogue on ways of addressing challenges to programme implementation.

But, even here, the focus is on strengthening health systems so that they are better able to address programme-specific objectives, as opposed comprehensive health system objectives, such as UHC. While the technical work undertaken in these programmes has been valuable, the focus on specific disease-areas, rather than on strengthening health systems more generally, has been limiting in terms of:

- **geographical coverage**. The primary factor determining the locus of engagement is the burden of the targeted disease. There appears to be no relation between the presence of engagement and the need for it – e.g. no evidence that activity is more likely to occur in settings in which there is a large, unregulated private sector relative to the public sector.
- **product/service coverage**. Current activity is concentrated on products (streamlined importation, efficient provision with geographic reach, and retailing and dispensing/testing within pharmacies and drug shops), and there is less emphasis on services (and where services are captured, there is limited consideration of linkages between those targeted and other critical services delivered in hospitals, clinics, etc).
- **the extent of health systems analysis**. In general, the dominant programme-specific focus is unlikely to deliver – and may even undermine - the strategic framework for private sector engagement called for by the WHO thirteenth general programme of work, 2019–2023, and reflected in the Advisory Group's focus on Governance of the Private Sector for UHC.

Indeed, our documents and key informant interviews indicate that only a modest subset of the international agencies – DfID, the World Bank-HNP and the GFF – are routinely supporting/ advising on market-based approaches and private sector purchasing strategies in a systems-focused way (Table 4).

Some agencies' approaches to engagement are not well-aligned with UHC objectives

Bilateral donors support a range of programmes that focus on shaping or expanding specific commercial markets – e.g. markets for voluntary private insurance, or for health products and services. For example, the TMA approach, supported by USAID (see Table 5), seeks to segment the market according to consumer group. A core objective of the TMA is to take financial pressure off the public sector, allowing the public sector to focus its resources on those with the least ability to pay(*12*). The key informant interviews revealed that there is uncertainty about the extent to which this approach is consistent with UHC. The financial impact of out-of-pocket financing implied in TMA may not be consistent with financial protection. In addition, for reasons documented in the World Health Report 2010, neither voluntary nor out-of-pocket financing are conducive to equitable access to care.

Similarly, the IFC has led the development of a number of funds for investment in commercial health businesses in Africa. These include the Africa Health Fund (US$105 million), the Investment Fund for Health in Africa (US$66 million) and the follow-up Investment Fund for Health in Africa II (US$137 million) – all part of the World Bank/IFC's Health in Africa programme, an investment programme initially valued at $1bn, whose objective was to "catalyze sustained improvements in access to quality health-related goods and services in Africa, achieve financial protection against the impoverishing effects of illness... with an emphasis on the underserved."(*13*). However, an independent mid-term review of Health in Africa, conducted by Brad Herbert Associates in 2012(*14*), reported the programme's failure to reach poor people via the private sector, leading to a major re-scoping of the programme.

It is possible that an expansion of such markets will lead to the establishment (or consolidation) of a 'two-tier' health system, one in the market is segmented into "high quality services for the affluent, and poor services for the poor".

However, there is some doubt among our informants as to whether investments focusing on expanding commercial markets in insurance, products and services can play a meaningful role in accelerating progress towards UHC. Where such goods are distributed on the basis of individuals' willingness and ability to pay, there is likely to be inequities in their distribution to the population. It is possible that an expansion of such markets will lead to the establishment (or consolidation) of a 'two-tier' health system, one in the market is segmented into "high quality services for the affluent, and poor services for the poor".

This is a particular concern for programmes that aim to expand insurance markets (or individual insurance companies, or HMOs) as a means of enhancing coverage. While it can be argued that such markets can enable governments to refocus their resources away towards the poor, experience suggests that this approach tends to result in a pro-rich distribution of health resources, leading to restricted access and coverage for poor people. In general, when engagement by international agencies leads to the development of commercialised (e.g. self-pay) markets, there is potential for a 'two-tier' system to emerge, one in which resources are concentrated in affluent areas and cater only for individuals who can pay. Such a health system is unlikely to deliver the levels of equity of access and financial protection required by UHC.

Examples of IFC investments under the Health in Africa programme

IFC Direct Investments
- Hygiea (Nigeria/$2.2m) - Hospital & HMO
- Life Healthcare (South Africa/$100m) - Hospital
- Nakasero Hospital (Uganda/$3m) - Hospital
- IMG (Uganda/$2.2m) - Hospital & HMO

Fund Investments - Investment Fund for Health in Africa (IFHA)s
- Hygeia (Nigeria/€2m) – Hospital and HMO
- Pyramid Pharma (Tanzania/€1.4m) – Pharmaceutical distributor
- AAR (East Africa/€7m) – HMO
- Sourcelink (€2m) – Singaporean diversified medical holdings company active in Africa

Fund investments - Equity Vehicle for Health in Africa (EVHA)
- Nairobi Women's Hospital (Kenya/$2.67m) – Hospital
- Revital (Kenya/$2.75m) – An early stage manufacturing company
- Avenue Group (Kenya/$2.5m)–Hospital & Managed Healthcare plan provider
- Bridge (Nigeria/$5) - specialized fertility treatment and medical laboratory services

Table 4: Goals and foci of international organisations' activities in private sector engagement (PSE)

Organisation	Goal(s) of PSE	LMIC focus for PSE	Client(s) for PSE	Programmatic/product focus
DfID	To enhance the value for money and quality of health-related products and services across private sector categories	Sub-Saharan Africa	• Government • Local private sector • (I)NGOs • CSOs	Horizontal and vertical dimensions, focused on specific services (relating to preventative, primary, maternity care); and products (for FP and SRH, nutrition, malaria, ARI, diarrhoea, HIV, TB)
USAID	To create and/or support the growth of the commercial market for key health products, services, and private insurance	• South- and south-east Asia • Sub-Saharan Africa • Eastern • Southern Caribbean	• Government • Local private sector • (I)NGOs • CSOs	Mostly vertical and product-focused, in relation to prioritised disease/health areas: HIV, malaria, TB, MCNH, FP, nutrition
KfW	Create demand for high-quality FP/RH products, oral rehydration salts (ORS) and insecticide-treated bed nets (ITNs)	Global	• Government • Local private sector • (I)NGOs • CSOs	Mostly vertical and product-focused, in relation to prioritised FP/RH products, ORS and ITNs
World Bank (HNP)	To enhance government stewardship of private sector; and encourage private providers to improve the value for money and quality of their products	Global	• Government (a loan to the government and policy support)	Mostly horizontal – e.g. focused on enhancing data (via funding for private sector assessments), and providing technical assistance for effective governance of the private sector, and strategic purchasing of private sector-provided services and products
IFC	To support the growth of the private health sector by increasing access to capital and advising governments on policies that engage businesses	Global	• Government (policy support/ transactions advice) • Private sector (equity/debt financing)	Project- of firm-specific. The IFC's focus differs by region, i.e. in sub-Saharan Africa, the focus is on secondary/ tertiary hospitals and insurance; in south- and south-east Asia, it is integrated systems: outpatient care, diagnostics, e-health, and supply chains
GFF	To leverage, through policy support and funding, private sector capacity in countries to deliver on GFF objectives	Current activity focused on: • Bangladesh • Ghana • Indonesia • Kenya, Myanmar • Mozambique • Nigeria • Uganda • Zambia	• Government (a loan to the government and associated policy support)	Vertical in terms of disease/health area focus, but horizontal in delivery, due to range of services and products implicated in the RMCNH domain and the importance of primary care in particular
BMGF	Build government capacity to purchase both MCH-specific and general health products & services from private actors	Sub-Saharan Africa	• Government • Academic institutions • NGOs	Can be vertical (SP4PHC); or horizontal in some cases (SPARCS)
WHO (TB)	To support improved engagement of private providers through PPM, contributing to universal access to quality, affordable prevention and care	Focused on high burden countries with dominant, poorly regulated markets: • India • Pakistan • Indonesia • Philippines • Myanmar • Bangladesh • Nigeria	• Government • National Treatment Programmes (NTPs)	Vertical in health area focus (TB), focused on services (private facilities, physicians and laboratories) and products (medicines)
WHO (Malaria)	To support improved engagement of private providers through PPM, contributing to universal access to quality, affordable prevention and care	Focused on high burden countries where a high proportion care is privately provided: • Chad • DRC Kenya • Ghana • Niger • Nigeria • Tanzania • Uganda	• Government • National Treatment Programmes (NTPs)	Vertical in health area focus (TB), focused on services (diagnostic) and products (diagnostic testing kits and malaria medicines)
EMRO	To assist Member States in the EMRO region to strengthen their capacity to engage with the private health sector in a strategic way to advance UHC	EMRO countries	Government	Horizontal and UHC-focused (though agenda is currently at the development stage)

There is an absence of engagement activities aiming at improved governance

Governments are in a unique position to leverage private sector capacities (e.g. its ability to respond to patient preferences, its ability to raise capital, its strong incentives to innovate etc) for the public health interest. Commercial incentives may compromise public health if they are not moulded by effective government stewardship. The fact that in many low-income countries, the capacities needed to effectively steward the private sector are weak or non-existent implies major risks to public health.

The World Bank (HNP) has numerous bank loans supporting performance-based financing (PBF) and other health financing reform initiatives focused on social health insurance which, it is assumed, will result in stronger strategic purchasing of privately delivered health services. Similarly, USAID's health financing projects provide technical assistance to help countries increase their domestic resources for health, manage government resources more effectively, and make more efficient purchasing decisions. Finally, BMGF's Strengthening Strategic Purchasing in Africa (SPARCs) and Strategic Purchasing for Primary HealthCare (SP4PHC) assist Ministries of Health in LMICs to create the institutional arrangements and build capacity to buy health services that will use public health funds efficiently to deliver affordable, high-quality health services to more people in an equitable way. However, these projects do not systematically include the private sector – inclusion of private providers may happen, but is largely country driven. Indeed, most of the country's request to include the private sector in their insurance and contracting reforms is driven by the imperatives of the UHC and not the development partners' recognition of the reality of a mixed health delivery system.

There are a number of agencies involved in (a) reforming policies and regulations that present obstacles to private provision of specific services and products (USAID, WHO Global TB Programme, WHO Global Malaria Programme Malaria), and (b) conducting assessments on private sector activities (EMRO, USAID, World Bank, GFF and WHO). Yet, as Table 5 shows, only two organizations – the World Bank (HNP) and GFF are routinely carrying out strategic governance-related activities with a focus on UHC. For example, under the Health in Africa programme, the Bank provided policy support to governments in sub-Saharan Africa to enable public/private dialogue to emerge for service areas related to the investment programme. In addition, GFF's country programmes focus on public-private dialogue and the reform of policies to shape service markets of relevance to RMCNH. Although these organisations are in a good position to play a leading role in providing support to LMICs on governance, they are constrained by their mode of engagement (i.e. loans to government, and/or performance-based financing and contracting of private sector providers) - and, currently, limited numbers of specialist staff with experience in private sector engagement in health systems.

Governance and policy framework to support private sector engagement and strategies to align private sector services and investment to national UHC goals and objectives are critical gaps in the collective activities of development partners.

Table 5: Methodological approaches to private sector engagement

Operational approaches	Description	Programme focus	International organisation	Examples
Governance	Efforts to strengthen the capacity of governments to constructively engage the private sector in providing health services & products.	Horizontal	World Bank (HNP)	Health in Africa: initiative to provide policy support, and to government in sub-Saharan Africa, and to enable public/private dialogue for service, product and insurance provision.
Strategic purchasing	The allocation of pooled funds (usually contingent on levels of performance), to providers of health products or services on behalf of a specified population.	Horizontal	BMGF	Strategic Purchasing Africa Resource Centre (SPARCS): demand-driven resource platform for LMICs in sub-Saharan Africa implementing strategic purchasing.
		Vertical – maternal health	BMGF	Strategic Purchasing for Primary Health Care (SP4PHC): use strategic purchasing for delivery of FP and MCH services in primary care settings.
Market-shaping	Seeks to achieve health goals by changing the institutional environment in which market actors –manufacturers, distributors, buyers, regulators, and donors – choose how to produce, distribute and deliver global health products.	Vertical – disease-specific products	• USAID • DfID	DFID-Clinton Health Access Initiative (CHAI): 'Market-Shaping' for Access to Safe, Effective and Affordable Health Commodities: accelerating access to new and improved health commodities across the areas of HIV, TB, malaria, hepatitis, family planning and vaccines.
Managing Markets for Health	Centring on the government's role in shaping health markets to improve the range and quality of health products and services available to the population while insulating people against direct costs.	Horizontal	• DfID • BMFG	African Health Markets for Equity (AHME): multi-year project to increase the use of private sector-provided health services by poor people in Kenya, Ghana and Nigeria using an MM4H approach.
Private sector development	Seeks to encourage the development of the commercial markets for health products, services, and insurance in LMICs by enhancing access to capital, market information and addressing regulatory barriers.	May be horizontal or vertical but tends to be firm-specific.	International Finance Corporation (IFC)	Health in Africa (HiA): initiative, initially valued at $1bn, to enable engagement with and growth of the private sector in sub-Saharan Africa; underpinned by provision of capital financing (equity and debt) provided by IFC.
Total market approaches	Seeks to establish sustainable markets for needed health products by increasing demand for across consumer segments, enabling private actors to address demand.	Vertical – disease-specific products	USAID	Sustaining Health Outcomes through the Private Sector (SHOPS): harnessing private sector capacity to improve health outcomes in family planning, HIV/AIDS, and maternal and child health.

Recommendations for WHO-HGF

As highlighted, parts of WHO have already made substantial progress in recognising and engaging the private health sector. The Global TB Programme has, for example, championed investment in data about the private sector, and has used this to demonstrate the scale of the private sector in target countries, and the need for engagement with the sector to optimise TB prevention, care and control. Outside of TB, however, progress on this agenda has been muted. Indeed, our key informants expressed scepticism that a "one disease at a time" approach is optimal.

WHO have already made substantial progress in recognising and engaging the private health sector.

It is encouraging, therefore, to observe EMRO's approach. It is leading the calls for a new strategic approach to private sector engagement that has a clear 'horizontal' focus(*16*). A resolution of the Regional Committee for the Eastern Mediterranean endorsed its approach (EM/RC65/R.3), and called on Member States in the region to (i) incorporate effective engagement with the private health sector into their national policy, strategies and plans for UHC and (ii) build capacity in ministries of health to design, manage, monitor and evaluate effective engagement strategies. EMRO's initiative with its Member States can inform, and move forward in synergy with, WHO-HGF's own activities in this area. However, catalyzing action within LMICs will be challenging. Government officials may be reluctant to assume accountability for the private sector, over which they have limited influence.

In this context, our specific recommendations, organized by target audience, are as follows:

For the Global Health Community

Provide the data on the private sector
A common theme among our key informant interviews is the lack of data and information on the private health sector, especially outside of those areas prioritised in the large disease-specific programmes. For example, there are many LMICs where the scale of private expenditure as a proportion of total health expenditure is known to be large, but there is little knowledge of where this is going – and what the delivery system looks like. The key informant interviews revealed the difficulty for Member States and global health practitioners to access data on the nature and extent of the private health sector at the country level to inform policy and planning, and to strengthen the case for recognising the importance of engagement. As one informant commented: "It is time for WHO and its Member States collectively to develop some new sensory organs so that they become better at evaluating what's actually happening on the ground."

WHO Headquarters (HQ) can play an instrumental role in centralizing and curating information on private health sector engagement in LMICs. Other organizations, such as the USAID private sector projects (e.g. PSP-One, SHOPS and SHOPS+) have fulfilled this role for upwards of 15 years. However, this function may disappear due to the vagaries of donor funding; and, for reasons already considered, donor agencies are not best placed to provide technical leadership on cross-cutting areas such as UHC. WHO can provide the consistency and sustainability of this function for the global health community.

As a first step, WHO can create a "clearing house" on the WHO's website that centralizes WHO's documentation on current private health sector activities (e.g. Stop TB, EMRO policy analyses, etc.), tools and methodologies, publications and research. Other activities may include: (i) coordinating with Tier 1 partners to find a way to link with their resources on private health sector activities, tools and methodologies and research, (ii) producing a series of WHO Bulletins curating these technical resources from WHO and others, and (iii) "push out" new research and tool and methodologies to subscribers as they are catalogued in the resource centre.

As a first step, WHO can create a "clearing house" on the WHO's website that centralizes WHO's documentation on current private health sector activities.

In addition to creating a clearing house on private health sector engagement, WHO can also help shape and coordinate the research required to generate the evidence on private sector engagement. In its role as "honest broker", WHO can: (i) convene strategic development partners and research institutions to develop a common research agenda, (ii) advocate with other development partners to invest in building the evidence and documenting successfull approaches to private sector engagement, (iii) encourage and assist Member States to document and conduct operational research on private sector engagement, and (iv) partner with strategic development partners to sponsor dissemination event globally and regionally on the latest developments and evidence on private sector engagement.

WHO is in a unique position to play an honest broker and leadership role on private sector engagement. WHO should constitute a standing Technical Working Group comprised of Tier 1 and 2 organizations as well as experts and practitioners in private sector engagement. The TWG can help build consensus among the global health community on a strategic approach to private sector engagement aligned to UHC.

Frame private sector engagement
There is a pressing need for WHO to facilitate a commonly shared framework with a UHC-oriented lens for private sector engagement that can be used by the global health community. Currently, WHO and other development partners (e.g. DFID, USAID, the World Bank (HNP)) are leading the way in private sector engagement with heavy emphasis on disease-specific programmes. Progress towards a more systemic approach is variable and patchy as this report demonstrates. WHO can facilitate a consensus process similar to the one that created the Strategy Report to develop a common framework for private sector engagement aligned with UHC agenda. Through this process, WHO-HGF can co-develop a common language with clear definitions supporting the consensus framework, so that all stakeholders within the global health community can communicate effectively with one another.

There is a pressing need for WHO to facilitate a commonly shared framework with a UHC-oriented lens for private sector engagement that can be used by the global health community.

Coordinate approaches to private sector engagement
WHO can also play a crucial coordinating and clarifying role on private sector engagement approaches. As our data sources have demonstrated, there is a large amount of activity in relation to private sector engagement. But not all of it is well-aligned with UHC. Member States are struggling with multiple conflicting priorities driven by development partner agendas. Some donors (e.g. development banks) are focused on private sector development including commercial approaches (self-pay and private investment) while others (DFID, USAID, WB) are focused on enhancing government stewardship of the private health sector and ensuring private sector participation in national health insurance.

WHO can also play a crucial coordinating and clarifying role on private sector engagement approaches.

These priorities are different. At times, they may be in conflict (e.g. should countries view their private sectors as the delivery system for their national health insurance programmes, or as a complementary source of provision for the better off?). WHO can help coordinate the approaches by:

- sponsoring round-table meetings and regional symposia that disseminate the evidence and research on effective engagement approaches;
- facilitating honest discussions among development partners on potential conflict and divergence in different private sector engagement approaches, and
- creating clarity and a common understanding on the different private sector engagement approaches - particularly on the current generation of market-based approaches – their respective goals and applications.

WHO HQ / regional WHO offices

Four distinct groups emerge from the analysis of our interviews with WHO staff:

- **leaders in the private sector engagement agenda**, such as the Global TB Programme and WHO-EMRO, who have championed the importance of engagement, and are making (incremental) headway in reaching their objectives with respect to the private sector;
- **other regional and country offices**, including those with high burdens of disease and PPM models at a less mature stage of development – who often field requests for technical support on the private sector, and are keen to learn more about how to provide this;
- **other WHO departments** (e.g. relating to malaria, HIV/AIDS and MCH) that are well-positioned to integrate private sector approaches into their "toolkit" and methodologies, and are simply waiting for, and keen to see, new guidance and central direction; and
- **staff in Geneva and the Regions**, who are suspicious of, and resistant to, working with the private health sector.

Four distinct groups emerge from the analysis of our interviews with WHO staff.

WHO-HGF can take a leadership role in setting central WHO policies/coordination that will help mainstream private sector engagement within WHO. It will be critical for WHO-HGF to form an internal "coalition of the willing" to widen the base of support, provide political cover, and create a shared understanding of the strong public health case for private sector engagement. The goals of the mainstreaming strategy on engagement would be:

- to build WHO leadership support;
- to broaden the base of support, in part by explaining and substantiating the nature of a UHC-oriented approach to engagement;
- persuade regional offices to engage their Member States; and
- provide the tools and resources.

Below are a few activities that this "coalition of the willing" under HGF's leadership can undertake together to build support for and normalise private sector engagement approaches within WHO.

Provide evidence-based advocacy to build support for private sector engagement
To date, there is still no clear vision or commitment from WHO's leadership on private sector engagement. As a result, some WHO departments and regional offices are reluctant to move ahead in this domain. Immediate steps to build political support include: (i) finalize the Strategy Report; (ii) make a summary version of the Strategy Report and disseminate this widely among WHO; (iii) bring WHO champions/leaders in private sector engagement together with WHO departments to share their experience and lessons learned; and (iv) assist these WHO champions/leaders to disseminate their messages and materials.

WHO-HGF can take a leadership role in setting central WHO policies/coordination that will help mainstream private sector engagement within WHO.

Provide international support among Member States for private sector engagement
Another important strategy will be WHO/HGF's initiative to pass another World Health Assembly resolution. This revised and more comprehensive World Health Assembly resolution should be focused on creating external pressure from Member States supporting the resolution to provide political cover for WHO regional and country offices who want to increase their work on this theme.

Provide evidence and resources to assist WHO colleagues in private sector engagement
There are potential champions within WHO HQ departments and regional and country offices that need guidance to integrate private sector activities into their programme and/or guidance to Member States. Immediate steps to assist this small group of potential champions: (i) form an internal community of practice on private sector engagement; (ii) share information on current best practices and tools and methodologies on private sector engagement; (iii) share WHO's best practices – for example, the patient pathway analyses undertaken within the Global TB Programme (helping to ground private sector engagement within the frame of people-centred health systems), and the disciplined UHC focus of the emerging EMRO in this area; and (iv) create a roster of international experts and institutions with experience in private sector engagement and match them to COP members to adapt and integrate private sector approaches to COP members' programmes of work.

Member States

WHO can play a valuable evidence-informed advocacy role with LMIC Ministries of Health by leveraging its long standing relationships and close engagement with Member States to introduce the concepts of private sector engagement and governance of mixed health systems. Moreover, WHO is well positioned to directly assist and/or leverage resources needed to assist Member States to tackle barriers to private sector engagement (e.g. government's reluctance to extend its activities into the private sector, lack of data on private sector to inform policy and planning, absence of formal mechanisms to engage private health sector to name but a few).

WHO is well positioned to directly assist and/or leverage resources needed to assist Member States to tackle barriers to private sector engagement.

In the short- and medium-term, WHO/HFG can:

Provide evidence-based advocacy to build Member States support
As an honest broker, WHO can assist country offices to address Member State's reluctance to engage the private health sector and/or to adopt best practices governing a mixed heath system. Extend the activities outlined but adapted to a country government audience: (i) identify the most promising countries who are open to private sector engagement and willing to implement aspects of the Strategy Report; (ii) translate the Strategy Report brief and develop a companion powerpoint; (iii) facilitate WHO champions/leaders to engage these target countries either in a regional workshop to share their experience and lessons learned; and (iv) facilitate opportunities to bring international experts and practitioners in private sector engagement together with these target countries through regional workshops or through other mechanisms (e.g. community of practice, routine webinars, etc.).

Develop guidance and evidence-based approaches
As part of WHO's mandate to provide the long-term support and guidance to LMIC governments, WHO – either directly or through strategic partnerships with other development partners – can: (i) develop policy frameworks, organisational systems and financing strategies for engaging private sector product and service providers in achieving public health objectives; (ii) develop strategic options for private sector engagement, including strategic purchasing, and facilitate and institutionalise private sector engagement; (iii) ensure that regulatory and quality assurance mechanisms include the entire health system and are enforced fairly in the private sector; and (iv) develop monitoring and reporting mechanisms that can hold both public and private health sector to account.

Collaborate with development partners to provide resources to assist Member States
Members States will require funding and technical assistance to move from theory to practice in private sector engagement. According to the key informant interviews, Member States do not perceive WHO as the "go to" expert on private sector engagement; they turn to World Bank and USAID. While WHO is building its capacity and credibility in private sector engagement, WHO in its facilitative and coordination role, can work with its Member States to identify the appropriate technical expertise and funds among its development partners to provide technical assistance.

WHO can leverage its resources as well as those developed my other partners to assist Member States engage the private health sector.

Members States will require funding and technical assistance to move from theory to practice in private sector engagement.

Conclusion

As one of our key informants noted, global and LMIC-based policymakers may be reluctant to devote serious attention to the private sector until becomes a priority on their policy agenda: "They will wake up when there is a problem that they can't ignore, and only then they'll look for remedial action." Considerable effort are required to draw global and local policymakers' attention to problems related to the lack of engagement, especially when these problems have persisted for a long time since policymakers have routinely ignored or even accepted them as normal or unavoidable.

In this context, there is both an urgent need, and a notable opportunity, for WHO-HGF to play a pivotal role in addressing this challenge. Many of our key informants see WHO as being in a unique position, given its mandate as the steward and normative leader of global health, and its strong legitimacy, credibility and relationships with international organisations and LMIC Ministries of Health alike. As one of our key informants stated: "WHO should get out of their headquarters more - out into the field, into the countries. We need their help in bringing the public and private sectors into one room to agree on how to move forward on the UHC agenda."

Considerable effort are required to draw global and local policymakers' attention to problems related to the lack of engagement, especially when these problems have persisted for a long time since policymakers have routinely ignored or even accepted them as normal or unavoidable.

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We therefore commit to scale up our efforts and further implement the following actions: [...] Engage all relevant stakeholders, including civil society, private sector and academia, as appropriate, through the establishment of participatory and transparent multistakeholder platforms and partnerships, to provide input to the development, implementation and evaluation of health and social-related policies and reviewing progress for the achievement of national objectives for UHC, while giving due regard to addressing and managing conflicts of interest and undue influence.

Political declaration of the UN high-level meeting on universal health coverage

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Private Sector Accountability for Service Delivery in the Context of Universal Health Care

Acknowledgements

Gabrielle Appleford (Impact for Health)

Executive summary

Increasingly, health services are delivered through mixed health systems in lower- and middle-income countries (LMICs). In many LMIC contexts, the private sector is an important source of health-related products and services for many people, including poor people and presents an important partner for universal health care (UHC). However, it will not self-regulate for UHC goals and requires stewardship. How accountable the health system is to citizens and consumers (which may include migrants and undocumented people) depends to a large extent on the degree of accountability between the public and private health sectors. In its place, a culture of mistrust and blame shifting may exist between sectors.

Based on expert interviews, accountability gaps have been mapped to the following domains at a global level.

This paper considers accountability and its arrangements for health service delivery in the context of UHC. This work is intended to guide the efforts of WHO Department for Health Systems Governance and Finance (HGF) and its Advisory Group on the Governance of the Private Sector for UHC. The paper drew on a short literature review, both academic and practice-oriented, on accountability and health service delivery. Primary data was collected through informant interviews with experts working on accountability, health sector governance and/or service delivery. The paper serves as an overview on the topic for WHO staff and Member States; and as an input for the Strategy Report being prepared by WHO expert committee on the private sector and service delivery.

Based on expert interviews, accountability gaps have been mapped to the following domains at a global level.

Accountability gaps

- **better diagnosis** - of the private sector and accountability environments in mixed health systems
- **formalise and organise** – the private sector and sectoral engagement
- **professionalism and ethics** - deepen conventions, norms and behaviours
- **systems, not symptoms** – retool for systems level, retire tools that are inefficient or not effective
- **data generation and use** – for correction, protection and empowerment

More detailed contextual diagnosis is needed at a country level to address accountability systems, and not just the symptoms of poor accountability. Irrespective of context, accountability cultures are needed. These require active entrepreneurs within global health and national health systems as well as the development of soft skills in negotiation, change management and good governance. Change is – or should be - a constant feature in efforts to strengthen accountability.

The following recommendations are put forth to the Advisory Group for consideration as part of the Strategy Report.

- package learning and advice on how to design and implement accountability systems. Develop diagnostic tools for the private sector and accountability environments in mixed health systems.
- support Member States with the development of transformative accountability agendas, based upon social compacts between sectors, grounded in diagnosis and dialogue.
- undertake research to understand the contextual factors that promote or hinder accountability environments in mixed health systems.

Introduction

Increasingly, health services are delivered through mixed health systems in LMICs(1). These systems, comprised of public and private sectors, are the product of interaction. While 'sector' is used to distinguish public from private orientation, in practice the private sector is less bounded and "generally large, poorly documented, and very heterogeneous"(2). It consists of both formal and informal providers ranging from drug shops to specialised hospitals, comprising both for-profit and non-profit entities, both domestic and foreign. Self-care interventions may also be catalogued as part of the private sector if models of self-care are provider-assisted and dependent on how the public sector interacts with or acknowledges these forms of care(3).

The private sector, in all its guises, may or may not be recognised by the public sector or included within its implementation network(4). However, private sector "economic and social patterning… is partly shaped by, and interacts with, the organisation and behaviour of the public sector in health care"(2). This can take a virtuous form, where competent health systems generate a "complementary, reasonable-quality private sector"(2); in contrast, the private sector may take on less scrupulous forms, if left unregulated. How accountable the health system is to citizens and consumers depends to a large extent on the degree of accountability between the public and private health sectors. In place of this, a culture of mistrust and 'blame shifting' may exist.

How accountable the health system is to citizens and consumers depends to a large extent on the degree of accountability between the public and private health sectors.

The private sector presents an important partner for UHC, if stewarded to do so. In many contexts, the private sector is an important source of health-related products and services for many people, including the poor(1,5). However, the private sector will not self-regulate for these goals and requires stewardship as markets contain no mechanism for achieving equitable distribution – only non-market institutions can do this(4). This paper considers accountability and its arrangements for health service delivery in the context of Universal Health Care (UHC). This work is intended to guide the efforts of WHO Department for Health Systems Governance and Finance (HGF) and its Advisory Group on the Governance of the Private Sector for UHC (herein referred to as WHO Advisory Group). The paper serves as an overview on the topic for WHO staff and Member States; and as an input for the Strategy Report.

Methodology

This paper drew on secondary and primary data. Secondary data entailed a short literature review, both academic and practice-oriented, on accountability and health service delivery. Primary data was collected through informant interviews with experts working on accountability, health sector governance and/or service delivery. Interviews were conducted in October 2019. Annex 1 contains a list of experts interviewed. Where quoted, they have been referred to as "expert interview."

What is accountability, and how does it relate to efforts to achieve UHC?

There are various definitions of accountability in relation to the health sector

All share the principles of answerability (sometimes referred to as responsibility), liability and enforceability. In simple terms, accountability considers who is accountable to whom and for what - that ultimately "blame worthy individuals or organizations will be held accountable for their actions"(6). While this may appear straight forward, "there is confusion about what accountability is or isn't, with many in the international health arena focused on social accountability... the soft outskirts of accountability" (Expert interview). There is also a tendency to view accountability as solely a health steward function, which may preclude recognition of oversight institutions that sit outside of traditional health systems. These include legislatures, supreme audit institutions, anti-corruption agencies and other bodies "charged with asking whether or not they [ministries of health] are in fact answerable, or calling them to account, for actions that they've taken" (Expert interview). This may also include actions not taken.

Within the health system, accountability is considered one of six sub-functions of stewardship (Box 1)[1]

Accountability, together with other sub-functions such as 'tools for implementation', seek to address "market failures common to health systems" as well as "potential public sector failure"(7). The perception of failed or insufficient accountability may trigger other stewardship sub-functions, such as policy or organisational reform. Accountability, therefore, should not be looked at in isolation from other stewardship functions. Furthermore, an accountability lens may be helpful in generating a system-wide perspective on health sector reform as well as interconnections among individual improvement interventions(*8*).

> **There is confusion about what accountability is or isn't, with many in the international health arena focused on social accountability... the soft outskirts of accountability**
>
> (Expert interview)

Box 1. Stewardship sub-functions

- generation of intelligence
- formulating strategic policy direction
- ensuring tools for implementation: powers, incentives and sanctions
- building coalitions / Building partnerships
- ensuring a fit between policy objectives and organizational structure and culture
- ensuring accountability

(Source: Travis, et al, 2002)

Stewardship encompasses the whole health system, including actors from the private and public sectors

National ministries of health are the "steward of stewards"(7), in recognition that other arms of government, including devolved structures, have a role in stewarding the health system. Consumers may also seek services outside of the health system, such as through informal static, itinerant or digital dispensers of health products and services. These forms of care challenge traditional boundaries of health systems, precisely because they are often unbounded or unrecognised by stewards (self-care runs the risk of falling into this category).

> National ministries of health are the "steward of stewards".

> Health actors from both sectors should be accountable to the delivery of health care to improve or maintain health outcomes.

There is no distinction by sector or actor in the outcomes of accountability

Health actors from both sectors should be accountable to the delivery of health care to improve or maintain health outcomes and avoid unnecessary or ineffective care; furthermore, as a normative system, the efforts of both sectors should establish a foundation of trust between consumer and health care provider, and be valued(9). These relations are characterised by asymmetries of power and information whereby consumers of health care services are reliant upon the professionalism and ethics of health actors and the institutions from which they seek care. In turn, health actors – from both sectors - must also trust the health system and may also suffer from asymmetries of power and information. In other words, they may not be empowered to act on their intent to improve or maintain health, to do no harm. Many governments are far from achieving these desired outcomes: only one-quarter of people in LMICs believe that their health systems work well, with poor-quality care a greater barrier to health outcomes than access(9).

1 Stewardship is sometimes more narrowly defined as governance and entails the wide range of functions carried out by governments as they seek to achieve national health policy objectives. https://www.who.int/healthsystems/stewardship/en/ The stewardship sub-functions have been adopted by WHO Advisory Group.

Accountability may be further classified based on the 'levers' used to hold actors and organisations to account

- legal (or professional) accountability means that, as a professional, being able to accept accountability for one's actions and being able to justify one's actions; in other words, knowing when to and when not to do something(*10*).

- performance accountability concerns how the health system, or a health programme delivers on its intentions based upon agreed-upon performance targets, in relation to services, outputs, and results(*8*).

- financial accountability refers to tracking and reporting on allocation, disbursement, and utilization of financial resources(*8*); "the money trail helps to determine who is doing what to whom, when and how"(*4*).

- social accountability refers to citizens' efforts for meaningful collective engagement with public institutions in the provision of public goods(*11*). This form of accountability seeks to empower and educate users to demand state obligated services, and support health-service actors to recognize and act on these demands(*11*).

- political/democratic accountability relates to the institutions, procedures, and mechanisms that "ensure that government delivers on electoral promises, fulfils the public trust, aggregates and represents citizens' interests, and responds to societal needs and concerns"(*8*).

Accountability levers are reflective of the different forces that buttress an accountable environment

For example, ministries of health may seek to shape market forces so that these operate in the best interests of citizens and the health system. They also need to self-steward so government resources are optimised, and health actors, from both sectors, are empowered to deliver quality healthcare. Finally, democratic and political forces confer rights and obligations through the establishment of social and institutional arrangements for health, as part of the social contract with citizens. Ideally, governments through the political/democratic system would hold to account the performance of the whole market health system, and providers, both public and private, would be held to account for their performance in contributing to social goals (Expert interview). However, while a 'forcefield quartet' (Figure 1) of social/citizen, democratic/political, steward and market may suggest a clear accountability environment, in practice, there are "layered webs of accountability"(*8*) within and between these forces. It's too simplistic to think of citizens only as part of civil society. Citizens are part of the state, as voters or recipients of government services. But citizens also play a role in the market as small producers and consumers (Expert interview). Dual practice and provider moonlighting between the public and private sectors further blurs positions within an accountability environment.

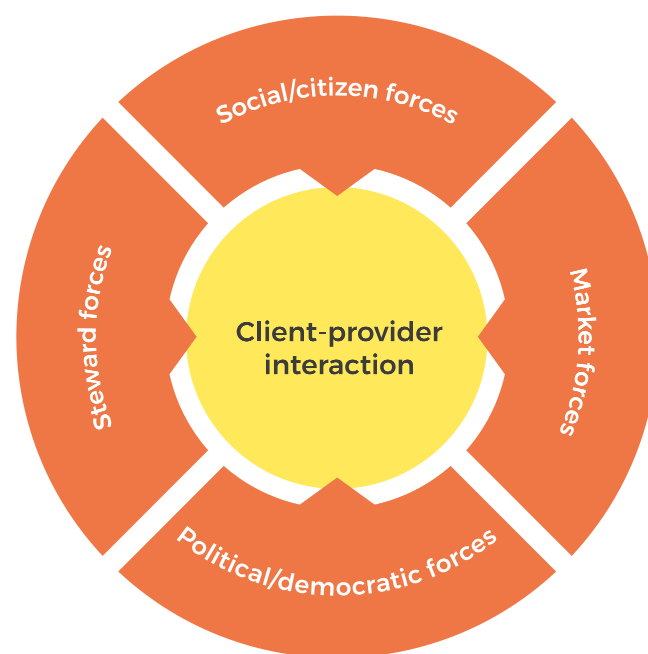


Figure 2: Accountability forces (author's depiction)

Marshalling necessitates stewardship, of both governmental and non-state actors, by establishing, promoting and supporting accountable relationships between actors.

All accountability forces need to be marshalled to achieve UHC

Marshalling necessitates stewardship, of both governmental and non-state actors, by establishing, promoting and supporting accountable relationships between actors(*12*). However, while the World Bank and WHO have identified governmental accountability as a pillar of UHC, accountability frameworks are often developed with only the public sector in mind(*13*). Additionally, non-state accountability actors may operate on one force, applying tools that respond to or marshal that force, without considering the wider accountability environment. As acknowledged through expert interviews, government and non-state actors are not always looking at accountability systemically, "often times it's kind of plugging holes where we see problems" (Expert interview). There has also been a tendency to see private sector accountability as different to the public sector as, with government, "there are accountability relationships that people can understand and follow" (Expert interview). However, for accountability to work, standards and systems should be universal, supported through incentive regimes (via financing and regulation) that align private sector goals with social goals (Expert interview). Addressing one force of accountability, such as social accountability, should be viewed as complementary to, and not a substitute for, other forms of accountability(*9*).

Taking a normative stance, the purpose of accountability should be to protect, correct and empower

(as a counter frame to 'answerability, liability and enforceability'). Foremost, regulation should protect consumers from unnecessary, ineffective or harmful care(*9*). It should facilitate access to quality care and optimise population and individual health outcomes. It should also ensure that the user experience of accessing care is a positive one as this fosters "confidence in the system, trust in health workers, and appropriate care uptake"(*9*). Accountable care should also protect health workers, ensuring that they operate from safe care settings and are motivated through decent working conditions. Accountability should correct, both processes and systems of healthcare delivery, so that this is optimized (financial, performance and legal aspects of care). Finally, accountability should empower systems and health actors deliver quality services through the establishment of incentives and sanctions that "orchestrate and modulate" positive change(*4*).

> **It's really about getting those incentives, rules and regulations in place to have a win-win for all actors across the board and really align all incentives towards public health goals. So, that it's in people's interest, whether you're making a profit or not, to contribute to public health goals** (Expert interview)

Role of different actors in accountability

Private sector patterns and public sector authority have a bearing on accountability roles

The role of government as health steward and service provider is reflected in the 'patterns and dynamics' of the private sector. These are described in Table 1 and are based on the typologies of Mackintosh et al(2).[2]

In contexts where the government is not stewarding the private sector – or predominant parts of the private sector – it will be difficult to ascribe a role for private sector accountability to social goals. Rather, the private sector will have other forms of accountability (e.g. to consumers) but in a context of asymmetric information, these are unlikely to function optimally. Similarly, in contexts where there is weak stewardship and poor accountability within the public sector, it will be difficult for the government to demand accountability from the private sector. In contexts where citizens cannot mobilise or express voice, they will not be able to apply "countervailing power"(*11*) on either the market or the state. An expert respondent equated an accountable environment with 'herd immunity', in which a sufficiently high proportion of health actors [both public and private] are answerable for their actions and held to account. If not, as in the case of an unchecked private sector and eroded public authority, unaccountable environments may prevail. "[Health] systems work because a large set of actors within these systems follow basic norms, basic professional norms, ethical norms. And so, if everybody stops doing that, these systems actually can't cope" (Expert interview). What may be a realistic role in one setting may not be feasible in another and signal more broadly, the demise of a "system" and the legitimacy of government as steward. "Our starting point tends to be that the government has legitimacy as the steward of the health system because it is to some degree accountable to the population and you see that varies tremendously between different jurisdictions, different country settings. In some cases, you could say that is simply not the case, and nowhere is it the case that accountability is perfect" (Expert interview).

Table 1: Patterns of private and public sector health systems

Accelerating	A deteriorating public sector accelerates growth of the private sector, both formal and informal providers as consumers lose trust in the public health system and "take their chances" with the private sector. The health system is characterised by poor quality and poor health outcomes as well as low entry costs into the market.
Complementary	The role of the private sector is shaped by the role of the public sector. Strong government investment in the public sector and stewardship of health system creates complementary patterns of care, characterised by high(er) quality and good health outcomes. Entry into the market is regulated.
Tiered	Two sub-systems of health service delivery co-exist with higher income populations seeking care from the private sector and poorer populations seeking care from the public sector. The health system is characterised by stratified quality and health outcomes and high entry costs into the market.
Socially stratified	Three sub-systems of health service delivery co-exist: a private sector for higher income populations, while poorer populations seek care from an over-stretched public sector and an accelerating low-cost private sector. The health system is characterised by stratified quality and health outcomes as well as low entry costs into the market.

2 Mackintosh et al define a fifth health system described as a "highly commercialised public sector under-going reform" however this is not widely prevalent and only China is given as an example.

Private providers within these very mixed health systems can be stewarded for public health goals

To do so, requires an understanding of "key health characteristics, including the pattern of stratification of private sector use, the scale and accessibility of public provision, and the extent of reliance of the poor on out-of-pocket payment"(*2*). Health systems that are inequitable and of poor or highly stratified quality, signal a weak accountability environment.

> **it is evident that where incentive and accountability regimes do not favour equitable, cost effective delivery of healthcare, we don't tend to find equitable, cost effective health care** (Expert interview)

Furthermore, evidence of a large, fragmented, unregulated private sector "may create an impossible accountability context" (Expert interview). For the private sector to play a role in public health goals, such as UHC, the structure of the market needs to be recognised, formalised and organised, "when fragmented, it's just about impossible to do anything" (Expert interview). In these contexts, the role of professional associations as a representative-based trust mechanism, remain largely underutilised and may compensate for other forms of accountability(*14*).

Formal and informal roles, sometimes conceptualised as horizontal and vertical accountability, are necessary parts of an accountability environment

Horizontal accountability relates to institutional checks and balances, the "capacity of state institutions to check abuses by other public agencies and branches of government, or the requirement for agencies to report sideways"(15). Vertical accountability relates to the public or citizens' ability to enforce standards of good performance on officials; this may be through enlisting horizonal accountability institutions(*15*), such as Ombuds offices and parliamentary committees. The public – sometimes referred to as the third sector - can wield pressure "that comes from outside of formal institutions and include… a lot of informal mechanisms that put pressure on the formal accountability system" (Expert interview). Reliance on informal pressure is not "evidence of a broken system, it's evidence of a functioning system" (Expert interview). However, over-reliance on one form of accountability over the other is unlikely to be effective and is more likely to be reflective of weak role execution, in which 'checks and balances' are circumvented (or to continue with the analogy, the herd is not immune).

Prevailing conventions and norms also play a role in how accountability roles are understood and executed

Accountability roles are reflective of social institutions and how the social contract operates within a given society. Simply put, some societies may be more conditioned to follow the rules, while others may be more conditioned to circumnavigate the rules. "There is a different cultural expectation in which you are going to comply with laws regardless of whether those laws are seen as legitimate. Some of its quite fundamental in terms of the way the social contract operates within society" (Expert interview). While all healthcare workers are conditioned to uphold the high standards and ethical behaviours exacted from the profession, when people don't feel valued, are overworked or underpaid, "people look for opportunities to justify breaking those norms" (Expert interview). Professional behaviours may also be countered by personal gain/gaming. Both situations can create a system in which basically "regular people do bad things…it may even be a system in which good people do bad things" (Expert interview). Systems can reproduce bad behaviours over time, to an extent that these become the prevailing conventions and norms. Given this, there is need to consider the temporality of accountability and not a snapshot, "because what has been going on has been eroding the capacity of the public sector to regulate the private sector for years and years and years" (Expert interview).

Key accountability strategies

Accountability strategies can be categorised in three ways: government-directed, self-instituted and citizen-led(13)

These strategies operate within the force-field of social/citizen, democratic/political, steward and market. Strategies require government to set "the rules of engagement and assert stewardship muscle" (Expert interview). This cannot be left to the market or to citizens. Simply put, governments must govern, set rules about "who gets what, where, when, and how" as well as the "symbolic resources that are the basis of legitimacy"(*12*).

- **government sets (or should set) the vision about what good care should look like**, through the establishment of normative frameworks and guidelines for standards of care, access to care and the financing of care. This may be done as part of UHC and existing "openings at the political level" afforded through UHC. These openings provide opportunity to establish or reset the "social compact" (Expert interview). Government also needs to set the framework and tempo for progressive realisation of UHC ambitions, "the how". More than slogans, this should be underpinned by legislation, regulations and judicial normative oversight that reinforce the social compact, reduce abuse and assure compliance with procedures and standards. It is the responsibility of government to align the interests of the private sector, through regulation of their actions and behaviours, with the best interests of citizens and the state(*16*).

Government also needs to set the framework and tempo for progressive realisation of UHC ambitions.

- **markets respond to the direction, tempo and rules of government**. They perform better when there are rules that are reinforced, as this creates some element of predictability and uniformity within the market. "Everyone should know what they are working for...business hates uncertainty" (Expert interview). Government-direction determines the shape of the private sector in relation to who operates, how they operate, who is reached, what is offered and how it is offered. In the absence of a normative framework and stewardship "muscle", the private sector may self-institute organisation into the market as a means of engaging government or reinforcing its legitimacy (or the legitimate parts of the market). Examples of this include voluntary membership in healthcare federations or professional associations as well as self-imposed peer review and benchmarking. While well intentioned, it is recognised that these forms are not enough on their own as they lack validation by independent sources(*13*).

- **citizen-led strategies may include the use of media as censure, civic action as redress, and consumer education and choice**, in which citizens seek out information and quality health care – be it public or privately provided. Ombuds offices may be called upon by citizens to investigate and resolve complaints and their maladministration. Civil society and NGOs may work with citizens to formalise mechanisms for redress through the introduction of fora and tools that facilitate interaction between community members and health care providers as a means of exerting communal pressure on the system (examples include social audits and scorecards). However, often these approaches do not percolate upwards and remain peripheral to the "inner workings" of health systems (Expert interview).

Accountability strategies often enlist a range of tools and tactics

These are directed at different accountability levers and towards different accountability actors. Table 2 provides a non-exhaustive list of tools. Some tools are ubiquitous across LMICs, such as many of the listed performance and financial management tools. However, these have largely been developed for and applied to the public sector; as health systems have become more mixed, and governments have less control over or proximity to service delivery, these mechanisms have become less effective (Expert interview). Increasingly there has been more attention to strategic purchasing and the use of formal contracts as a "vehicle for reconstructing norms and ethics" however it is important to understand the nature of existing social contracts on which formal contracting is grafted(*14*). In some instances, there may be deliberate intention to out-source tools, for example, when governments contract-out accreditation to a third-party administrator (which will operate within an accountability framework set by government).

Some of the newer accountability 'tools and tactics' may not be set or recognised by government

In some instances, tools and tactics may be introduced through civil society actors, such as NGOs. Increasingly, these may operate in the digital space, through social media, or bespoke apps, designed to elicit information and feedback, from providers and consumers. It is sometimes unclear to whom and for whom these tools of trade serve. While it is acknowledged that many countries need to catch up on regulating the private sector after years of its largely unregulated growth(*13*), there is also a case to be made for catching up with novel tools of technology. These examples serve to reinforce that new technologies present both opportunities and risks for accountability environments and that the 'tools and tactics' of accountability require stewardship.

Table 2. Accountability tools

Accountability levers	Tools
Legal	Professional codes of conduct, registration in professional associations, accreditation, licensing and certification, legislation
Performance	National compacts, programmatic commitments and targets, annual reports, league tables, peer benchmarking, policies, standards, guidelines, steering committees or task forces, surveys, health management information systems, maternal death surveillance and response (MDSR) systems
Financial	Budgets and workplans, performance-based contracts, vouchers, public expenditure reviews, budget execution reports
Social	Media, social media, digital technologies, scorecards, social audits, feedback mechanisms, Ombuds office, health committees, health councils, participatory budgeting, budget literacy, citizen-generated data, surveys
Political/democratic	Elections, electoral platforms (i.e. UHC), service and patient rights' charters, public participation, legislation, judicial review

Accountability tools should be considered in aggregate, as part of integrated strategies.

They should be grounded in contextual realities and work politically(17). Accountability tools that work in one context may not in another. They may be technically sound, derived from best practice, have form, but lack substance. This is sometimes referred to as "isomorphic mimicry", where governments adopt the form of functioning accountability mechanisms while failing to perform their actual functions(17). Necessary elements to strengthen accountability based on "emerging insights about more successful experiences" pick up on these issues as well as the importance of learning and adaptation (Box 2). Examples of accountability tools are considered singly for the purposes of illustration in Panel 1.

Accountability tools that work in one context may not in another.

Box 2. Elements to strengthen accountability

- Analysis and mapping of accountability systems, and their underlying power dynamics
- Strategies that emphasize integrated approaches, both vertically and horizontally
- Strategic use of varied and complementary tactics
- Embedding learning and adaptation in organizational approaches
- Politically informed practice, that focuses on addressing and shifting power relations that underpin accountability

(Source: B. Haloran, 2015)

Accountability strategies should work in concert, orchestrated and modulated by government

Strategies based on a single tool or approach, and isolated from other efforts, do not work(17). Whether this is construed as vertical or horizontal, top down or bottom up, government is the central player – either potentially or actually – whether it chooses to play that role or not(12). Within the context of mixed health systems, ideally governments set the accountability framework for health service delivery "where you have packages of regulatory and financing tools" (Expert interview). Simultaneously you have bottom up – citizen-led accountability "where patients are looking to serve their own best interests by seeking out information and seeking out the best providers that can best meet their needs" (Expert interview).

Within a mixed health system, this combination "ought to lead to a situation in which we can be reasonably confident that high quality goods and services will be delivered" (Expert interview). This approach seeks to mobilise citizen-led sanctions as a counterweight to government mechanisms, through the exercise of voice (expressing preferences, complaining) or exit (choosing another provider)(8). However, in practice, exit may not be possible when there is lack of alternative provider for example and voice may favour the more articulate/vocal. Governments may also engage citizens and providers as shapers of policies and services, and in devolved contexts as service co-producers and partners(8). Interaction between actors and sectors, and a stake in the process, may improve compliance, "major policy decisions in any country should not be made without coordination, consultation with those who end up having to implement and those who have a stake in the matter" (Expert interview). While integrated strategies have produced more accountable health care environments, these remain more of a promise than effective practice in many LMIC contexts.

Accountability gaps

Based on expert interviews, the following accountability gaps have been mapped at a global level

More detailed contextual diagnosis is needed at a country level to address accountability systems, and not just the symptoms of poor accountability. Irrespective of context, accountability cultures are needed. These require "active entrepreneurs" within global health and national health systems as well as the development of soft skills in negotiation, change management and good governance. Change is – or should be - a constant feature in efforts to strengthen accountability(17).

Change is – or should be - a constant feature in efforts to strengthen accountability.

Gaps have been mapped against the following domains:

1. **diagnosis** - of the private sector and accountability environments in mixed health systems
2. **formalise and organise** – the private sector and sectoral engagement
3. **professionalism and ethics** - deepen conventions, norms and behaviours
4. **systems, not symptoms** – retool for systems level, retire tools that are inefficient or not effective
5. **data generation and use** – for correction, protection and empowerment

1. Better diagnosis – of the private sector and accountability environments in mixed health systems

As previously illustrated in Table 1, there is a complementary effect between sectors; this can be virtuous, where competency and accountability in the public sector beget competency and accountability in the private sector. This "ying-yang" effect led by government and shaped by accountability forces, can not be left to the happenstance of the market. Understanding the private-public mix in mixed health systems therefore is important, as "...the blanket acceptance that the private sector is always better, always more innovative is really, really impoverishing our ability to look beyond and to see nuances in what the private sector is" (Expert interview).

Better contextual diagnosis of the private sector can be used to determine appropriate roles for private providers within the context of UHC and direct stewardship muscle to better shape markets for health. To do this, information is key to describing, measuring, and classifying the private sector. Several LMIC countries have started to diagnose the private sector but it needs to be taken an analytical step further to inform understanding of accountability environments. This form of diagnosis and analysis can be used to clarify chains of accountability, shorten chains to make feedback on performance more direct and timelier, and/or 'power' chains by increasing incentives for responsive performance(8). It is foundational to other forms of accountability intervention and what is feasible in a given context. Tools from the Managing Markets for Health (MM4H) address accountability within the context of market reform and can guide diagnosis.

It is premised that only if the private sector is organised/consolidated and engagement formalized, can it be stewarded for UHC.

2. Formalise and organise – the private sector and sectoral engagement

Atomised relationships within the private sector divide up accountability relationships and loosen accountability chains. This may contribute to the aforementioned "impossible accountability environment." It is premised that only if the private sector is organised/consolidated and engagement formalized, can it be stewarded for UHC. Supporting private SME actors to engage within the health system milieu is particularly needed so that they get a "fair shake" and can participate in UHC schemes. As suggested by an expert respondent, there is need for "much more face time" to force "everyone to get together and talk even if they don't want to". Even if mechanisms are tokenistic at first, when used, they can evolve into more meaningful forums, "it's still better to talk rather than not talk even if you feel like you're not being heard" (Expert interview).

Foundational to engagement is the development of a "common language and social compact", founded in political commitment that health care quality matters(9). This foundation can be used to build better accountability tools, such as contracting so that these meet the needs of government, providers and citizens, "...how can we make sure that services provided under the contract reach our joint public health goals without putting a private sector entity in a disadvantage and in a way that they're not able to have the funds needed to function?" (Expert interview). To do this, there is need to develop government soft skills of dialogue and negotiation, "the skills that we need in 21st century ministries of health" (Expert interview).

3. Professionalism and ethics - deepen conventions, norms and behaviours

Government should set standards (or support professional associations to do so), provide a compelling vision and rules of engagement for UHC that evoke the professionalism and ethics of the health sector. Rather than starting with gaps, "start with what you have in order to get what you have not", by identifying examples of good behaviour, of positive norms and rewarding, sharing and expanding them (Expert interview, quoting Moses Coady). To build cultures of accountability within the "DNA" of health systems, the role of quality improvement teams, professional associations, and peer benchmarking could be harnessed, and may be "far more effective at changing norms than demand driven citizen accountability" (Expert interview). There is opportunity to learn from practice, "about what policy makers or client governments do to establish effective professional associations that can champion the development and institutionalisation of professional conventions, norms, behaviours and ethics" (Expert interview). This gap was also identified in the Lancet Commission on Quality, "health workers and their professional associations must redouble efforts to maintain and enforce high standards of practice to earn and keep the public's trust"(9).

Rather than starting with gaps, "start with what you have in order to get what you have not", by identifying examples of good behaviour, of positive norms and rewarding, sharing and expanding them.

Calls for "more accountability" are often related to changing the focus and purpose of accountability, rather than simply to do "more of the same".

4. Systems, not symptoms – retool for systems level, retire tools that are inefficient or not effective

There is need to reorient donor funded work around accountability to focus more on systems, and less on symptoms. This body of work, often implemented by NGOs within the social accountability sphere, has contributed to a proliferation of micro-level efforts(9). These may drain resources and shift attention from investment in system-wide strategies and their implementation. Systemic efforts may require re-tooling or, more likely, optimization of existing tools, and their institutionalisation. As noted, calls for "more accountability" are often related to changing the focus and purpose of accountability, rather than simply to do "more of the same"(8). This may require greater intentionality to accountability by design within new or existing systems, programmes and policies. These efforts should seek to apply the same accountability levers to the public and private sectors over the long-term, as these "take time, can be disruptive initially, but eventually start to function" (Expert interview).

5. Data generation and use – for correction, protection and empowerment

Irrespective of accountability strategy, tool or tactic, all require data. Only with the right data, of the right quality, used in the right way, can there be an accountable environment that protects, corrects and empowers, that is answerable, liable and enforceable. However, often there is a data lacuna when it comes to the private sector, with even basic information on the nature and number of private sector entities and their capacities, scarce(9). While there is more data available in the public sector often these are "incoherent... rarely actually used... and there's usually too much information for anyone to absorb" (Expert interview). Even when data of the right quality is available, it may not be used for accountability due to "gaps in governance and coordination, resources and monitoring systems" that hinder analysis or action(9). In recognition of the data lacunae and "know-do" gap, there has been a call for fewer, but better, measures of health system quality for use at national and subnational levels(9). This information should be available to public and private sector actors as well as the general public, in a digestible form, using key metrics that matter, such as "health outcomes, people's confidence in the system, system competence, and user experience along with measures of financial protection and equity"(9).

While there is more data available in the public sector often these are "incoherent... rarely actually used... and there's usually too much information for anyone to absorb" (Expert interview)

Areas for the Advisory Group to consider as part of the Strategy Report

The promise of UHC will not be achieved without more accountable health systems

These require foundational relationships between public and private sector actors as well as citizens and consumers of health services. While stewardship muscle is needed, strategies that leverage other accountability forces and reinforce accountable relationships are equally needed. UHC schemes offer opportunity for ministries of health to redesign accountability into health systems and close data and know-do gaps.

UHC schemes offer opportunity for ministries of health to redesign accountability.

Areas for the Advisory Group to consider have been derived from the accountability mapping and expert interviews and set out an agenda for the Strategy Report

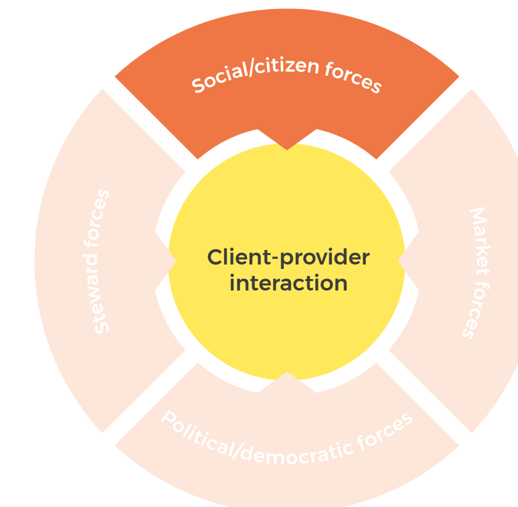
Provide normative guidance for accountability systems.
Package learning and advice on how to design and implement accountability systems. Develop diagnostic tools for the private sector and accountability environments in mixed health systems (this may include the development of an accountability module in the MM4H course).

Support Member States to apply normative guidance for accountability systems.
Support Member States with the development of transformative accountability agendas and change management practices. This should be based upon social compacts between sectors, grounded in good diagnosis and constructive dialogue.

Address knowledge lacunas.
Undertake research to understand the contextual factors that promote or hinder accountability environments in mixed health systems. Questions to consider include:

- how can accountable environments be strengthened in contexts of weak stewardship and an unregulated private sector? How can improved diagnostics and data be used to manage markets for health?
- how can prevailing conventions and norms be reoriented to uphold accountable environments? How do we professionalise and reinforce good behaviours and underlying incentive structures?
- how can we build stewardship muscle that can adapt and flex to the market and direct change? How do we develop the soft skills of dialogue and negotiation between sectors?
- what challenges and opportunities do novel service delivery models, such as digital health and self-care, pose for stewardship and accountability environments?
- how can good practices be shared and diffused between and within accountability actors and contexts?

Panel 1. Examples of accountability tools, what works and what does not

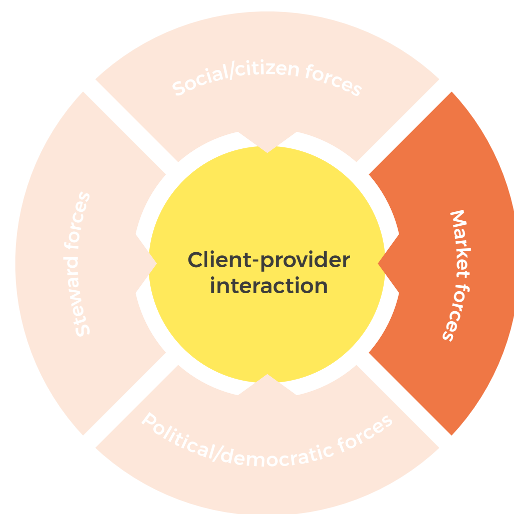


Accountability mechanisms at service delivery level may not induce systems level changes

There is a tendency for social accountability mechanisms, to operate at the service delivery level, with no horizontal accountability 'systems' anchor to regulation or purchasing mechanisms. While social accountability has its roots in citizen activism in response to a lack of political accountability, increasingly these approaches may take the form of non-confrontational 'widgets' (examples are included in Table 2) as opposed to organic political processes(*11*). This may be considered another example of isomorphic mimicry, or form over substance. The evidence suggests that success in social accountability has been "limited, local, and not always sustainable largely due to the prevalence of tool based, apolitical, and decontextualized approaches over strategic ones"(*11*).

Singular interventions may attract their own accountability problems through elite capture. Examples include health committees and health councils, which may "reinforce local discriminatory structures or local power structures where the marginalized still get left behind locally and where the local elite basically just get more power" (Expert interview). Service delivery deficits may also be reflective of accountability 'problems' being devolved from higher to lower levels of the system. It may result in "squeezing the balloon"(*17*), where local authorities blame other actors, arms of government or the private sector and thus avoid responsibility. This reinforces the importance of strategic use of varied and complementary tools and tactics, based on understanding of vertical and horizontal lines of accountability.

There is a tendency for social accountability mechanisms, to operate at the service delivery level, with no horizontal accountability 'systems' anchor to regulation or purchasing mechanisms.

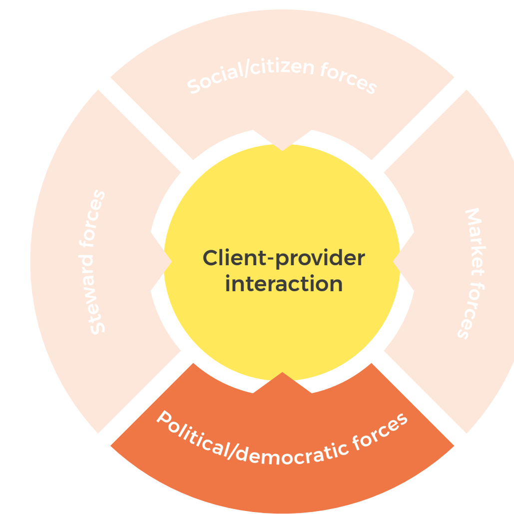


A fragmented private sector limits engagement with the public sector and the effectiveness of market-directed accountability mechanisms

As the literature and expert respondents noted, a large, fragmented private sector can create an impossible accountability environment; some of these were described in Table 1 and included scenarios of an accelerating, tiered or socially stratified private sector. Public-private collaboration for UHC and better "market shaping" requires organisation of providers and formalisation of engagement mechanisms. For example, government can orchestrate the shape of the market through mechanisms such as accreditation, licensing and certification, as a means of ensuring minimum entry requirements (in terms of qualifications, infrastructure, etc.).

These are often pre-requisites for private sector participation in UHC schemes, such as national health insurance or results-based financing initiatives. In some contexts, private providers may organise themselves, as a means of engaging with and shaping government policy and purchasing initiatives. An organised sector and formalised engagement may create an environment where there is better understanding of policy intent, its acceptance and implementation in practice(4). Formal communication channels may also act as mitigation mechanisms for managing conflicts and troubleshooting problems as they arise(4). In contrast, informal channels may not offer recourse for either party and may suffer from elite capture and cronyism (Expert interview).

As the literature and expert respondents noted, a large, fragmented private sector can create an impossible accountability environment.



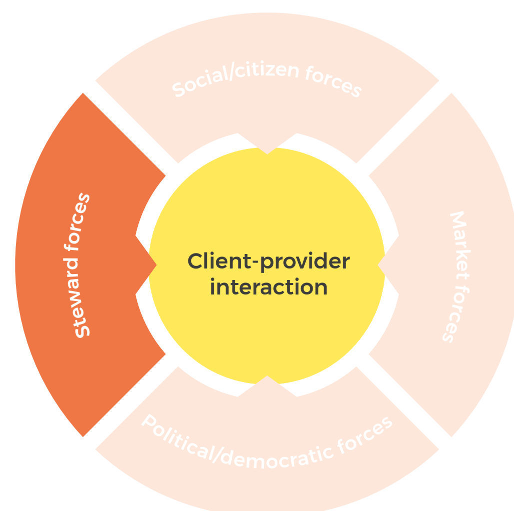
Political slogans and use of accountability tools apolitically may belie poor accountability environments

Maternal mortality is considered a highly politized indicator of the performance of health systems within and between countries and is reflective of gender equality and women's status more generally. Redress has prompted political attention and slogans - no mother should die while giving birth – in many LMIC contexts. WHO and other international organisations have promoted maternal death surveillance and response (MDSR) as a tool to increase accountability for maternal health in high burden maternal mortality contexts. This tool builds from the three-delay model: delay in seeking care; delay in reaching a health facility; and, delay in receiving appropriate care at a health facility. Both MDSR and the three-delays model are intended to guide accountable action to improve the quality of pregnancy and birth care.

The 'practiced norms' of the MDSR however, may reflect a lack of trust between health actors and unclear accountability environments. Health worker and managers may fear legal accountability for maternal deaths through implementation of MDSR, a performance accountability tool. A study by Melberg et la(*22*) showed that accountability fears, in this instance personal and political, strongly influenced MDSR reporting practices as well as clinical care decisions (accountability to women and communities was not mentioned). Health workers and their managers resorted to minimizing the number of maternal deaths recorded, with only 10% of the expected number of deaths reported(*22*). They also deflected responsibility for adverse outcomes to the first and second delays – decisions to seek and reach care – as well as infrastructural factors beyond their control(*22*). Fear of reprisal from the 'political hierarchy' and higher levels of the health system pervaded decisions to refer patients, so that their deaths would be attributed to other facilities or ambulatory care(*22*). For the aggrieved, recourse to judicial review was mentioned but not acted upon. The study concluded that while political commitment is needed for the implementation of maternal health policy and a MDSR system, the broader political culture influences practiced norms of implementation, and ultimately effectiveness to protect, correct and empower health actors.[3]

The broader political culture influences practiced norms of implementation, and ultimately effectiveness to protect, correct and empower health actors.

3 Of interest, the study was well received by a professional association, which provided feedback and an opportunity to present study findings as part of their annual conference, suggesting professional interest in remedy.



Regulation is a critical – non-negotiable - mechanism for health service accountability

Regulation entails a "spectrum of rules, procedures, laws, decrees, codes of conduct, standards" that guide a health system(7). These require active stewardship. Active stewardship entails analysis on whether appropriate tools and rules exist, are used, and are contributing to health system goals(7). There are several ways to approach an effective regulatory framework. There is also an argument to be made of doing less, well, in line with the Pareto principle, by focusing on the vital few (20%) to get 80% of the result. This may entail regulation of common market failures to address asymmetric information between patient and provider, or provider and purchaser. It may also focus on the ease in which private sector enters and exists the market. Another approach may be to focus health system goals, and address problems of behavioural alignment of actors towards those goals(7). Governments need to strike the right balance between too much and too little regulation(*13*), since overregulation may reduce compliance and depress private sector engagement.

Discretionary use of regulatory tools may result in their being wielded unaccountably by regulatory actors

Tools may be applied more rigidly in the private sector as compared to the public sector, or with different cadres of private provider, based on qualification, age, gender, location and facility type. In particular, the small to medium enterprise (SME) private sector, entailing nurse and midwife run maternity homes and clinics for example, may be discriminated against, "probably many of them don't get a fair shake because health systems are plagued with cronyism and the closer to the ground and the less power and influence you have, the less of a fair shake you're going to get" (Expert interview). SME providers often have greater congruence with public health goals as they offer primary health care and serve poorer, more rural communities, in many contexts. However, these providers may experience the greatest barriers to participation in government UHC schemes.

"Probably many of them don't get a fair shake because health systems are plagued with cronyism and the closer to the ground and the less power and influence you have, the less of a fair shake you're going to get" (Expert interview)

Purchasing levers may offer opportunity for reinforcing regulation and organisation within the health system

Tracking the flow of funds is considered one of the most reliable mechanisms to monitor performance as well as ensure accountability(*4*). UHC schemes allow government to redefine its role as purchaser of services and develop its capacity for contracting the private sector. This has several advantages over direct public sector provision: contracted providers may be held to a higher level of accountability, as governments are likely to be more objective in evaluating the work of contracted providers than in evaluating their own(*19*). A contract allows the government to shift its role from the provision of health care to the tasks of stewardship, such as financing health care, monitoring provider performance and consumer protection. This shift from passive to more strategic purchasing entails the "continuous search for the best ways to maximise health system performance by deciding which interventions should be purchased, how, and from whom"(*20*). It is viewed as a means of improving quality and efficiency, however, poor targeting, inadequate use of evidence, and fragmented financing may continue to reduce the efficiency of such investments(*21*). This is not immutable and is likely to improve over time as stewards gain skills in strategic purchasing.

Tracking the flow of funds is considered one of the most reliable mechanisms to monitor performance as well as ensure accountability.

Expert interviews

Name	Title	Affiliation
David Clarke	Team Leader, UHC and Health Systems Law	Health System Governance, Policy and Aid Effectiveness Health Governance and Financing Department, World Health Organisation
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Mark Hellowell, Ph.D.	Director, Global HealthPolicy Unit	University of Edinburgh
Alicia Ely Yamin, JD MPH	Senior Fellow	• Petrie-Flom Center for Health Law Policy, Biotechnology and Bioethics • Harvard Law School
John Gaventa, Ph.D.	Professor, Director of Research	• Institute of Development Studies • Sussex University
Jason Lakin, Ph.D.	Head of Research	International Budget Partnership
Courtney Tolmie	Senior Program Director	Results for Development

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7

Engaging the private health sector to advance Universal Health Coverage:

A case study from WHO Regional Office for Eastern Mediterranean Region

Acknowledgements
Joel Shyam Klinton (Impact for Health)
Cynthia Eldridge (Impact for Health)

Executive Summary

In 2018, 22 Member States of the Eastern Mediterranean Region Office (EMRO) endorsed a framework for private sector engagement. The EMRO framework recognised variation in Member State contexts, alongside a dominant - and common - contextual feature: high out-of-pocket expenditure by the poor in an environment of growing private health service delivery. EMRO spent considerable time and effort to evidence this context. The process of developing the framework – from evidence gathering, consultations, to strategic discussions – has informed EMRO's plans for engaging the private sector. The case study is instructive for other WHO regional offices and Member States seeking to deepen engagement with the private sector as part of universal health coverage (UHC). WHO Department for Health Systems Governance and Finance (HGF) and its Advisory Group on the Governance of the Private Sector for UHC is working to support such initiatives through its work on a strategy for governance of mixed health systems.

Introduction

In January 2015, the Member States of the United Nations adopted the 2030 Agenda for Sustainable Development Goals(*1*). In support of this and the UHC agenda, Member States increasingly recognise that the private health sector has become a dominant provider of health services especially in low-and-middle-income countries (LMICs)(*2*). The private health sector generally includes a heterogenous group of non-state actors in health comprising of formal and informal, profit and not-for profit, domestic and international providers(*3*). Governments in LMICs are grappling with how to work with the private health sector. A resolution to strengthen the capacity of governments to engage the private health sector was agreed by Member States in the Sixty-third World Health Assembly in 2010(*4*). Supporting this resolution remains a priority for WHO.

Governments in LMICs are grappling with how to work with the private health sector.

WHO EMRO has invested in building the capacity of Member States to engage the private health sector. Since 2009, EMRO has amassed a rich pool of information on the private health sector landscape in the region and held numerous consultations to develop a "Framework for Action on Effective Engagement of the Private Sector to Expand Service Delivery for UHC" (herein referred to as the Framework), which was endorsed by the 22 Member States of the region in the Regional Committee 65, 2018.

Other WHO regions are also exploring partnership with the private sector, through official declarations(*5*), regional assessments(*6*), or specific interventions(*7*),. EMRO's experience of developing the Framework, and the Framework itself, contributes to this body of work. This case study aims to capture information and lessons learnt from key informants who have been involved in developing the Framework and its implementation. This case study explores replicability of the EMRO approach in other WHO settings.

Methods

The case study considered EMRO's rationale for focusing on the private health sector, the process involved in developing the Framework, what worked and what didn't, and lessons learnt. The case study draws on primary and secondary data. Primary data was collected by through stakeholder interviews (Table 1). These individuals were selected based on their role in the development of the Framework. Where quoted in the case study, key informants are referred as respondent. Secondary data included review of relevant documents, provided by EMRO. Study limitations included the absence of government and private sector key informants and the small number of key informants overall, due to budget constraints.

The case study was funded by the Health Systems Governance and Financing department of WHO HQ in support of their work on governance of private health sector service delivery. The data collection and production of the document was done by Impact for Health International over a period of two months in early 2020. WHO's Advisory Group on the Governance of the Private Sector for UHC provided expert review of the case study.

The case study begins by providing a background on the Eastern Mediterranean region (EMR) and the scale of the private health sector in this region. This is followed by the findings section which outlines how EMRO responded to the growth of the private health sector and the process used to develop the Framework. The discussion section highlights the key insights and lessons that emerged from the Framework process. The case study concludes with a set of recommendations for stakeholders involved in similar work and its complementarity with the recent Strategy Report.

The case study begins by providing a background on the Eastern Mediterranean region (EMR) and the scale of the private health sector in this region.

Table 1: Key informant interviews by name and affiliation

Member	Affiliations
Dr. Hassan Salah	Regional Advisor, Primary and Community Health Care, WHO – EMRO
Dr. Fethiye Gulin Gedik	Coordinator of Health Workforce, WHO – EMRO
Dr. Adham Rashad Ismail Abdel Moneim	WHO Representative and Head of Mission, Iraq, WHO – EMRO
Dr. Awad Mataria	Director, Universal Health Coverage, WHO – EMRO
Prof. Venkat Raman	External Consultant
Monica Villaneuva	Senior Health Advisor of Middle East Bureau, USAID

Primary data was collected by through stakeholder interviews (Table 1). These individuals were selected based on their role in the development of the Framework.

Background: Context and Challenge

EMRO serves 21 Member States and Palestine (West Bank and Gaza Strip)(*8*) with a combined population of approximately 679 million people (Fig 1). Member States represent a range of socio-economic contexts.

- **high income:** Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and United Arab Emirates
- **middle income:** Egypt, Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Syrian Arab Republic, and Tunisia
- **low income:** Afghanistan, Djibouti, Pakistan, Somalia, Sudan, and Yemen

Despite these differences, all EMR countries have mixed health systems, in which the private health sector plays a growing role, with potential to contribute to UHC. According to the global monitoring report of WHO, an average of only 53% of people in the EMR have access to basic UHC services(9).

All EMR countries have mixed health systems, in which the private health sector plays a growing role.

In some EMR contexts, a strong public health sector operates alongside a rapidly growing private health sector. Examples include Egypt, Islamic Republic of Iran, Pakistan, and Afghanistan in which a major portion of the pharmacies or health clinics are privately owned, whereas the public sector is a major provider of inpatient care. EMRO also includes four of the six high emergency Member States found globally - the Syrian Arab Republic, Yemen, Somalia, and Sudan(*10*). In these contexts, the public sector has been severely weakened due to prolonged emergency crises, which the private health sector has partly filled. Similar phenomenon of an expanding private sector amidst weak public sector are currently observed in other states in conflict; not surprisingly, the data from these countries are limited.

In the EMRO context, similar to other LMIC contexts, there is high OOP, in return for unknown quality of care. The global health expenditure database reported that in EMR, USD 153 billion was spent on health in 2014. This constitutes 1.8% of the total world health expenditure. The share of OOP expenditure was highest in a low-income country, Yemen (76%), and lowest in a high-income country, Oman (6%). Although OOP is a proxy indicator of the utilisation of private services, the average OOP expenditure in EMRO low-income countries was 61.6% whereas in in high-income countries it was just 15.3%. Given this, poorer households in low-income contexts are more likely to face catastrophic health expenditure due to ill health and associated high OOP.

Table 2 presents further analysis of Member State health systems using WHO's six health-system building blocks(*11*) and grouped based on economic status.

Fig 1: Countries covered by WHO office of Eastern Mediterranean region

Data source: http://www.emro.who.int/fr/countries.html.
World Health Organization © WHO 2014. All rights reserved.

Fig 1: Countries covered by WHO office of Eastern Mediterranean region

			% Percentage of private				Private sector per 10,000 population		
		Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE)	Hospital beds	Health clinics	Pharmacies	Diagnostic facilities	Physicians	Nurses	Medical schools run by private sector
Group 1: High Income	Bahrain	34	18	88	78	43	8.3	10.3	2
	Kuwait	13	15	75			6	12	
	Oman	6	6	79	59		4	5.3	
	Qatar	7							
	Saudi Arabia	14	23	15	27	89	16.4	38.1	3
	United Arab Emirates	18	26	89	93		15	17	
Group 2: Middle Income	Egypt	56	25	78	97				2
	Iran	41	13	5	91	52			17
	Iraq	40	7						
	Jordan	21	33	78	65		16.5	20.2	
	Lebanon	36	83	82	99	18	32.9	20.1	5
	Libya	26	9	23	58				1
	Morocco	58	27	10			2.5		
	Palestine		14	29	79		12	8.6	
	Syrian Arab Republic	54	28	5					3
	Tunisia	38	20	75					
Group 3: Low Income	Afghanistan	64			98				na
	Djibouti	36	7	19	22	22	0.3	0.5	
	Pakistan	56	16	92	73	60	19	1.9	39
	Somalia						0.1	0.3	
	Sudan	76	9	27	96	61			11
	Yemen	76		45			2.8	5.5	1

na

Findings: The Framework

Figure 1 presents the chronological process that was followed by EMRO to produce the framework. Three distinct phases were noted: data collection, sensitization, and consensus building (Figure 1).

Phase 1 – Data Collection

The first and longest phase focused on collecting data to understand the private health sector landscape. As a respondent explained, the "private sector is a blind box. We use private health services, but we do not know much about them." Assessments began in 2007 and collected data on the private health sector from 12 countries in the EMR. Additional data was collected in 2012 from 11 more countries and the data collected in the first phase was also updated. The data from these 22 countries were analyzed in 2013 and revealed that the private health sector was delivering a large portion of PHC, contributing to high OOP health expenditure and was inadequately regulated. This was the first time that EMRO had analysed the private health sector to this extent: "We [EMRO] looked at this reality and looked at what we were involved in. There was a total misalignment in our focus and that was a critical lever to help start the conversation." Previous to this, EMRO had prioritised other aspects of service delivery to improve access(*13*) and had been working exclusively with ministries of health (MOH) (expert interview with Dr Hassan Salah on 05 February 2020).

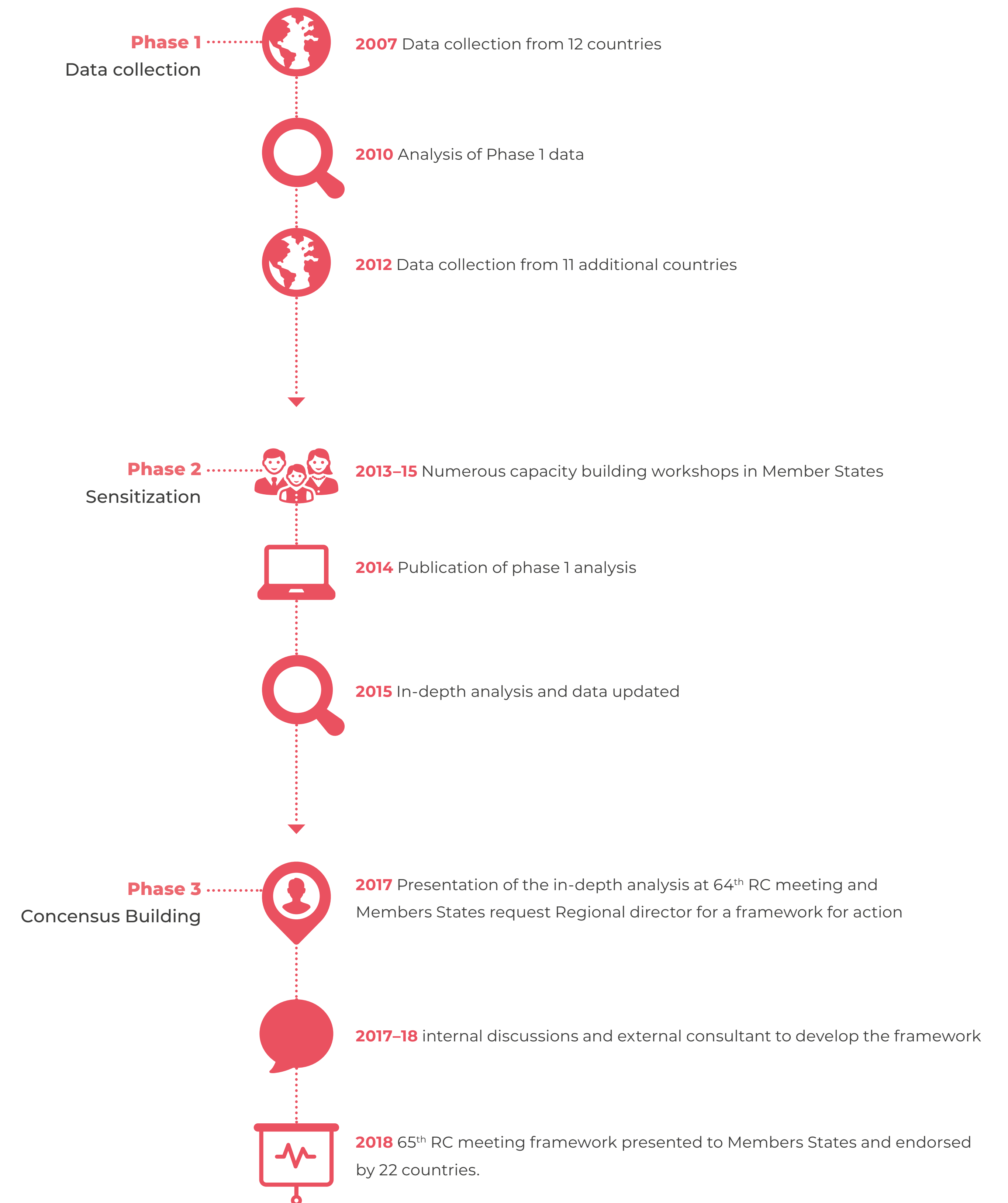
Phase 2 – Sensitization

With the data and evidence in hand, EMRO still had to convince other stakeholders of the importance of private sector engagement; as noted by a respondent, "despite the data and evidence, the staff still (didn't) feel it." A high-level consultation meeting in 2014, with senior ministers and subject experts from across the globe, was used to build understanding that the private sector needed to be engaged to improve service delivery. A resolution was passed after the Sixty-third regional committee session to strengthen public-private-partnership in service delivery by scaling up family practice(*14*). Capacity-building workshops were held in various EMR countries to raise awareness among health policy implementors on the importance of effectively engaging the private health sector and as a means of sharing analytical tools, mechanisms for engagement and best practices(*15*). Concurrently, the importance of the private health sector was also emphasized in EMRO frameworks for action on advancing UHC(*16*) and health workforce development(*17*). Although these efforts were well received, countries still struggled to formulate an evidence-based policy to engage the private health sector. As a respondent noted "...a strategic pathway to pursue this agenda was still absent as EMRO remained predominantly public with no internal platform to start talking about the private sector."

Phase 3 – Consensus Building

To define a strategic pathway, additional in-depth analyses were conducted during the period 2015-17. The findings of these analyses were presented to the Member States at the Sixty-fourth regional committee meeting in 2017. This approach once again evidenced the prominence of the private health sector in the region and created demand from Member States for a technical paper. This request triggered internal discussions among a team of experts at the EMRO office who led the process. Most of the budget of the EMRO PHC Unit for 2018-2019 was directed to private health sector assessments. EMRO also drafted an initial Framework outlining how countries could engage the private sector. The goal of the framework was "to simplify the complex environment that we are working in", but it also helped in tracking progress and identifying challenges. The "Framework for Action on Effective Engagement of the Private Sector to Expand Service Delivery for UHC" was validated with support of an external expert and Member State feedback was also incorporated. The Framework was presented as a resolution at the Sixty-fifth Regional Committee meeting in October 2018 and endorsed by the 22 EMR countries. This endorsement offered a legal and political commitment for work on the private health sector.

Figure 1. Timeline for the development of the Framework.



The Framework

The data collection, sensitization and consensus building phases resulted in a Framework with four overarching objectives:

- expanding and improving equitable access to health services;
- establishing a national health service for UHC with the participation of the private health sector;
- assuring improved quality of services provided by the private health sector through agreed standards, regulation, and incentives; and
- enhancing the financial protection goal of UHC through strategic purchasing from the private health sector.

The Framework proposes five strategies for action to engage the private health sector to expand service coverage for UHC

- develop a policy framework, organizational systems, and financing strategies for engaging private health sector providers in national health systems;
- develop strategic options for private health sector engagement, including strategic purchasing, and facilitate and institutionalize private health sector engagement, including capacity-building;
- improve the quality of services in the private health sector;
- ensure that regulatory mechanisms for health systems are enforced effectively in the private health sector; and
- develop monitoring and reporting mechanisms for private health sector providers.

Limited additional details are noted, although three levels of engagement are proposed: consultation, involvement, and partnership(*18*).

Post-Framework Implementation

The development of the Framework was followed by private health sector assessments in selected countries using a standard assessment tool. These assessments are in the final stages of analysis and will be published in quarter 4 of 2020. These will be instrumental in guiding Member States on options for private sector engagement and capacity building (expert interview with Prof. A. Venkat Raman on 20 February 2020).

The focus of 2019 was to create awareness among Member States on utilising the Framework for effective engagement of the private sector.

The focus of 2019 was to create awareness among Member States on utilising the Framework for effective engagement of the private sector. Despite the endorsement of the Framework, the implementation by Member States as well as the regional office has been limited(*15*). As a respondent explained, "We are drowning in frameworks. Many frameworks are sitting on shelves collecting dust." The reason, there are many theoretical frameworks and guidelines that come from WHO but national MoHs do not have the capacity to put them to action.

United States Agency for International Development (USAID) is supporting implementation of the Framework in a few countries. The assessment of the private health sector in the region by USAID through their Sustaining Health Outcomes through the Private Sector Plus (SHOPS Plus) initiative(*19*) supported their decision to invest in policy dialogue in a subset of EMR countries: Iraq, Libya, Morocco, Tunisia, and Yemen. Oman is planning to host one of the workshops, and, as a by-product of hosting, they have become interested in the work as well. The policy dialogues are expected to help to support the development of a country action plan to operationalize the regional framework for action on effective engagement with the private health sector.

Alongside plans for public-private policy dialogue, consultation with other departments of WHO is underway. For example, EMRO has engaged focal persons of 'The Global Action Plan' on EMR health matters, including private sector engagement(*20*). EMRO will also be launching a 'Regional Health Alliance' by partnering with development partners for several accelerators and private sector engagement is one of them (Expert interview with Dr Awad Mataria on 20 February 2020). The private health sector became part of the regional joint collaboration work plan for EMRO with United Nations partners, including United Nations Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF) and World Organization of Family Doctors (WONCA) to help ensure the engagement of private health sector in response to COVID-19.

The policy dialogues are expected to help to support the development of a country action plan to operationalize the regional framework for action on effective engagement with the private health sector.

Discussion

From the chronology presented in the findings section, we have identified key insights of relevance to regional WHO offices and Member States, to reflect on the process of development of the Framework and its application.

The process to develop the Framework was protracted and relied upon successive private health sector assessments

The number of assessments conducted as part of the process to develop the Framework took significant resources and time. As these are done as discrete assessments, they tend to become outdated, and require reassessment given evolving contexts and dynamic private health sectors. While they are useful to inform private sector engagement, they are not intended to be a tool for public-private partnership dialogue. In place of one-off analyses through large assessments other, less resource-intensive tools and metrics, should be developed and applied consistently across countries and over time.

Most WHO resolutions and frameworks were centered around the public sector and did not align with private sector engagement.

EMRO had to navigate institutional biases against the private health sector within WHO country offices and ministries of health

Most WHO resolutions and frameworks were centered around the public sector and did not align with private sector engagement. As a result, promotion of the Framework was met with resistance, "I really had a hard time over the past two years. So many people questioned my focus on the private sector" (Respondent). Resistance was less ideological, and more pragmatic, grounded in concerns with institutional capacity, "It is not an ideological position but more of apprehension about the change without appropriate capacity" (Respondent). The data and analyses were not sufficient to overcome these apprehensions, which were overcome through persistence and teamwork, "Joint work across teams made it more acceptable" (Respondent). Member State and other organizational champions also helped. Additional creative advocacy facilitated Member State support. This included a documentary film from senior policy makers of Jordan, Pakistan, Saudi Arabia, Morocco, Lebanon and Libya about the importance of private sector, played prior to the presentation to the Sixty-fourth regional committee meeting(*21*). This set a positive tone during the 2017 meeting and helped overcome some political resistance to private sector engagement.

The process to develop the Framework required WHO to be an interlocutor for the public and the private sectors, a role it had not assumed before

As a single coordinating body working with ministries of health and development partners, WHO was well positioned to play the role of interlocutor. However, since WHO has not traditionally engaged with private sector partners, considerable effort was needed to establish and nurture public-private dialogue. An external respondent recognized the efforts of EMRO, "WHO put lot of time in building relationships." They let the ministries call the meetings and promote robust participation from the private sector.

Recommendations

Based on the EMRO experience, the following recommendations are proposed for other regions and Member States interested in more effective private sector engagement.

Resource and develop WHO's role as convenor of private sector engagement and public-private partnership dialogue

WHO is well placed to play a convening role given its unique and long standing relationships with governments and other stakeholders, including development partners. To do this, WHO needs to build the trust of private health sector stakeholders and facilitate their engagement and perspectives in governance processes. To play this role effectively, WHO must resource the role with dedicated staff.

Appraisal of the political economy should inform engagement and Framework development strategies

Private sector engagement should be informed by political economy analysis and underpin strategic engagement. This form of analysis would facilitate understanding of the institutional biases that may exist within and between key stakeholders – including the private sector, ministries of health, development partners and WHO offices. This analysis should inform stakeholder engagement and framework development, early in the process. In the EMRO case, the early phases of the process were focused on technical assessment, which did not adequately consider political economy analysis, or existing mechanisms of engagement.

In place of one-off analyses through large assessments it is recommended that other, less resource-intensive, tools and metrics are developed and applied consistently across countries and over time.

Develop tools and metrics that enable more nimble and generative understanding of the private health sector and their role in mixed health systems/whole society approach

EMRO relied upon technical assessments in the development of the framework, which were time consuming and costly and did not allow for more dynamic appraisal of mixed health systems. In place of one-off analyses through large assessments it is recommended that other, less resource-intensive, tools and metrics are developed and applied consistently across countries and over time.

Establish the EMR Private health sector advisory group (PHSAG)

PHSAG will carry out strategic sectoral analysis and identify high-priority health areas and promising approaches for private sector regulation and engagement in the context of WHO GPW13 goal of 1 billion more people benefiting from UHC.

Conclusion

Both the technical and political elements of EMRO's experience in developing the private sector engagement framework are aligned with the private sector governance behaviors outlined in WHO's Strategy Report(*22*). This outlines six governance behaviours that are critical to develop to align private health sector service delivery with UHC goals. They include build understanding, deliver strategy, enable stakeholders, foster relations, align structures, and nurture trust.

The governance behaviours were present in the EMRO process, however, they were not evenly addressed and relied heavily on technical assessments, creating a protracted process of engagement and Framework development. EMRO sought to build understanding through the country technical assessments and consultations. The discussions around the creation of the Framework helped to create an agreed sense of direction and an openness to change for Member States to deliver strategy. The decade long work on evidence gathering and discussions nurtured trust between stakeholders and fostered relationships to support the work (but may not have been the most efficient or effective way to approach this). As EMR Member States work to implement the Framework, they will, no doubt, work more closely with private sector service delivery partners to further articulate the roles and responsibilities that will help deliver strategy, enable stakeholders and align structures.

Governance systems need to be calibrated to mixed health systems. These systems must be flexible enough to adapt to innovation, including private sector service delivery through digital health and self care, which challenge traditional boundaries of health systems. As much as our systems need to adapt so do system users, policy makers and technical partners, including WHO. Frameworks for public-private sectoral engagement and dialogue, may not covey the importance of change management

Governance systems need to be calibrated to mixed health systems. These systems must be flexible enough to adapt to innovation, including private sector service delivery through digital health and self care, which challenge traditional boundaries of health systems.

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Principles for Engaging the Private Sector in Universal Health Coverage

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Introduction

The concept of "health system governance" incorporates a wide variety of steering and rule-making functions carried out by governments in pursuit of policy goals. The "mixed health system model" – in which commercialised provision of health services in the private sector coexists with free or low-cost care in the public sector - is the norm in low- and middle-income countries (LMICs)(*1*). In this model, financial, managerial and performance gaps in the public sector combine with "market failures" in the private sector to exacerbate inequities in access and financial protection (see box 1). Several leading global health agencies have noted that this is a model which calls for effective cross-sectoral approaches to health system governance. Some have called on LMIC governments to develop strategic options for private sector engagement (henceforth: PSE) and build capacity to implement these.[1]

However, the response to this call has so far been muted. Most LMIC governments focus most of their attention on the public sector – e.g. broadening the base of financing or addressing performance problems within organisations and facilities directly administered by the state - while the private sector is (usually) a more peripheral concern.

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That is not to say that government are entirely inactive in this regard. Ministries of Health (MoH) usually have in force a small number of process-oriented regulations for the private sector – such as setting compulsory standards on premises, or certifying professional qualifications. However, far less attention is paid to actual performance – e.g. the range of products and services that are delivered in the private sector, the quality of the outputs delivered (e.g. their safety, appropriateness, efficacy and so forth), or their prices (which are usually paid by users directly). This represents a partial, and inadequate, approach to health system governance - especially when services are predominantly provided in the commercial market, as is the case for many critical service areas, in many countries(*2*).[2]

To address this gap, governments will need to develop or enhance their capabilities to:

- adopt a set of relevant 'governance behaviours' (as outlined in the current WHO Strategy Report) that can be regarded as the 'software' of PSE(*3*) as well as;
- design and implement new policy frameworks, incorporating novel tools and strategies, that will reliably influence the incentive and accountability environment in which the private sector operates - which can be regarded as the 'hardware' of PSE.

The aim of this report is to present a set of evidence-based principles.

The aim of this report is to present a set of evidence-based principles that will help to influence (a) how stewardship behaviours are realised, and (b) how new policy frameworks and tools are deployed to effectively serve the public health interest. Through a comprehensive document analysis, alongside a set of key informant interviews with senior staff in WHO departments, WHO regional offices, and key development partners and INGOs[3] we identified four principles of effective PSE that should underpin such efforts:

- **principle 1:** Well-functioning mixed health systems rely on strong governance
- **principle 2:** Effective PSE approaches are defined by "problems" not "solutions"
- **principle 3:** Successful governance of the private sector requires good data
- **principle 4:** The private sector needs to be engaged in a meaningful dialogue

In this study each of these principles is outlined and explained in detail.

Box 1. "Failures" and other incentive problems in healthcare markets

It is a commonplace that markets in healthcare "fail" to maximise social welfare in a number of specific ways. Suppliers in markets distribute goods (products and services) to individuals according to their demand for them, a concept that includes willingness and ability to pay.

However, in healthcare, individuals may not have the information needed to make the "right" choices about what to buy, or how much to pay, and so they may have demand for the "wrong" things – e.g. goods that will not effectively prevent, diagnose, or treat illness. In some cases, demand for such goods may also be "induced" by suppliers, exposing the patient to health and financial risks.

For example, the demand for some highly cost-effective goods is far lower than is optimal from a public health point of view – e.g. the demand for preventive health goods is much lower than is required to achieve key goals in relation to immunisation, or the prevention of malaria or water-borne diseases, so that people are reluctant to pay even very low prices for them. In addition, patients are often unable to assess the safety, efficacy and quality of goods available from different providers, and make ill-informed decisions about where to receive care.

This means that low-quality providers can enter markets and sustain their activities (however damaging to the health interest) for long periods, as patients continue to purchase their products and services. And finally, of course, patients may be unable to access the health products and services they "need" - simply because they lack the funds to buy them or can do so only by foregoing other basic necessities (food, fuel, shelter etc.).

1 As reflected in the 63rd WHA, which passed a resolution on Strengthening the Capacity of Governments to Constructively Engage the Private Sector in Providing Essential Healthcare Services.

2 Research shows that the private sector is the dominant source of treatment for children with diarrhoea, fever or cough in a sample of 70 LMICs.

3 See the acknowledgements section for a list of the experts consulted in the research. The authors are fully responsible for any inaccuracies in this report, and it is not necessarily the case that the experts consulted endorse the analysis herein.

The Principles of Engagement

Principle 1: Well-functioning mixed health systems rely on strong governance

As Box 1 highlights, without government intervention, markets in healthcare fail to provide the “right” range of services, to the “right” people, at the “right” price. Governments need to intervene in health markets to correct such failures - and, more generally, ensure that incentives and activities in the market are aligned with health policy goals, such as UHC. There are a number of well-functioning health systems in which policymakers have learned how to do this – how to govern markets in the health system in ways that reliably address key failures.

This approach to indirect governance (i.e. governance over parts of the health system legally outside of the state) is based on the routine deployment of private sector-focused ‘tools of government’ (see Box 2).

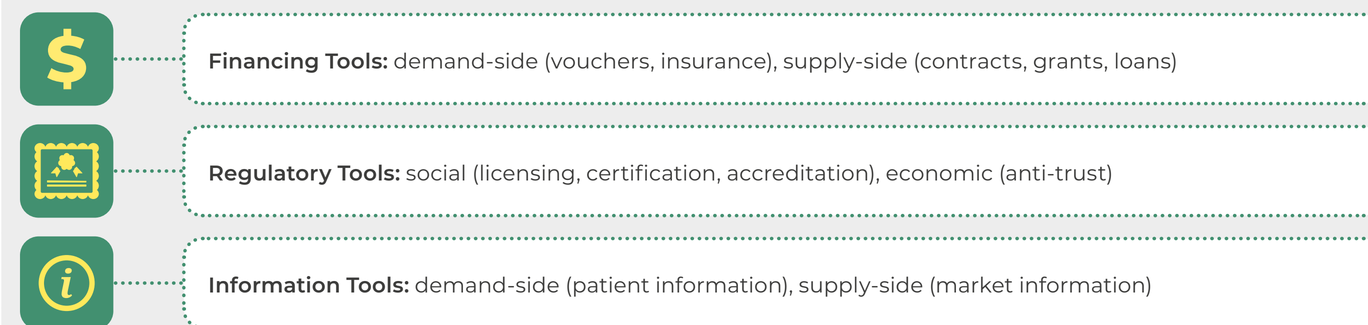
Tools of government, then, are mechanisms used by policymakers to shape the incentive and accountability environment in which market actors operate. In well-functioning health systems, governments tend to deploy such tools as a ‘package’, which influences different aspects of a market’s operation simultaneously. For example, a financing tool (vouchers or insurance) can be used to strengthen demand for essential health services, while a regulatory tool (accreditation or licensing) can ensure that demand is addressed only by competent providers. Demand-side information can also be used, e.g. to inform patients’ decisions about what to ‘buy’ (and from whom), while market information can be provided so that providers understand patient demand and preferences, shaping key decisions regarding investment and promotion.

Box 2. Stewardship of the private sector using ‘tools of government’

In the public policy literature, mechanisms used by states to influence the behavior of individuals and organisations in response to a defined problem (e.g. reducing financial barriers to access; enhancing the supply of products and services; enhancing the level of demand for qualified medical knowledge; ensuring that only safe, effective and appropriate care is available to the population) are called tools of government.[i]

- first, Financing Tools - such as grants, loans, voucher payments and contracts - are used to increase consumption of goods that would be under-utilised in a ‘free’ market.
- second, there are several Regulatory Tools that rely on the state’s power to compel certain behaviours, and/or prohibit others, or use information to ‘nudge’ actors’ behaviours towards alignment with policy goals.

Figure 1. The tools of government for indirect governance of the private health sector



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Our review of the institutional arrangements that exist in well-functioning mixed health systems reveals a pattern: some service areas are more market-oriented than others (see Figure 2). In 58 countries surveyed by the OECD in 2012 and 2016, ownership of provider organisations was predominantly in the private sector in relation to retail pharmacies, outpatient specialists and primary care; and predominantly in the public sector in relation to hospital services(4).

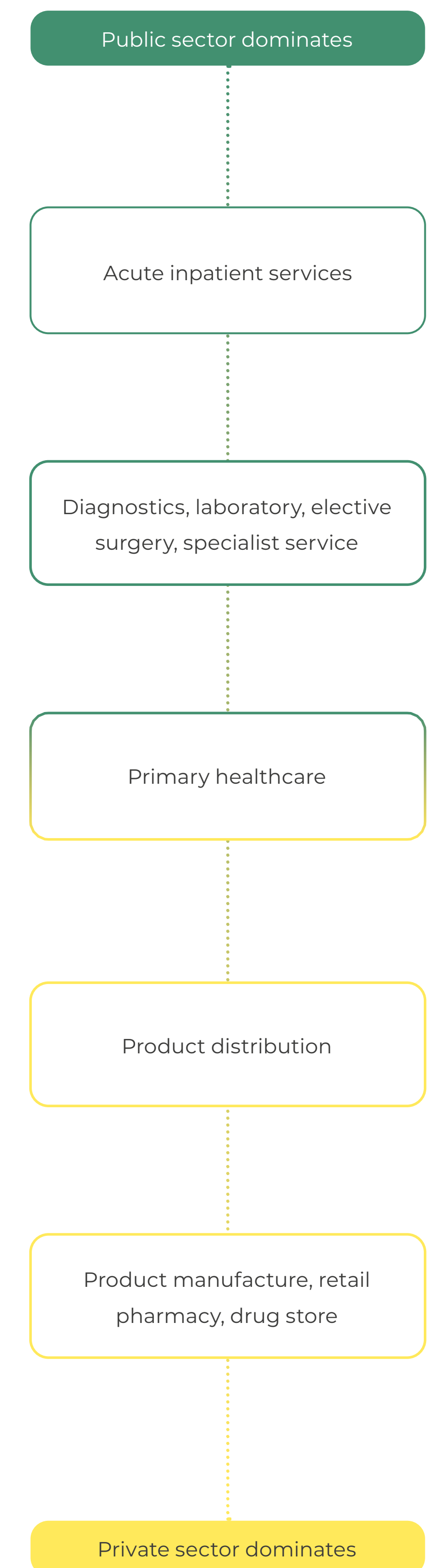
Our review of the institutional arrangements that exist in well-functioning mixed health systems reveals a pattern: some service areas are more market-oriented than others.

This variation between services is widely recognised, even if the reasons for it are less well-understood. Experts point to two key features of service-specific markets that seem to influence governance approaches:

- the degree of “contestability” in the market (i.e. how competitive it is) and;
- the “measurability” of the related product(s) (i.e. how easy it is to specify what we ‘want’, and verify whether this is being obtained)(5).

For example, the pharmacy sector tends to be highly competitive because barriers to market entry are low; and, also, the required ‘products’ are relatively easy to specify and verify. Therefore, a limited package of regulatory tools – often focusing on licensing, as a means of ensuring that only qualified providers are able to operate in the market – have in practice been sufficient for effective governance of this sector.

Figure 2. The balance between public and private provision varies across service areas



Box 3 illustrates how France deployed a variety of tools of governments to harness the market while ensuring safety and accessibility to needed medicines.

One interpretation of Figure 2 is that some markets are more difficult to regulate than others. For government organisations (such as MoH) with nascent or emerging organisational capabilities in indirect governance – i.e. the normal case in LMICs – it may be prudent to concentrate initial PSE activities in more market-oriented segments of the health system. Then, over time, as government organisations become more experienced in PSE, and enhance their capabilities to do this successfully, they may be able to tackle more complex, and perhaps more contentious, markets through indirect governance.

In well-functioning mixed health systems, governments have managed to do so. For example, they have built and sustained the organisational capabilities (underpinned by substantial public financing) required to specify and verify required standards of primary health care. Hence, health systems in these countries are able to take advantage of the benefits of private provision (e.g. greater responsiveness to patient preferences and strong incentives to manage costs) while ensuring that patients' interests are protected, in essential health services (see Box 4).

In contrast, governments typically find it more difficult to adequately specify and verify the range of services provided in more complex service areas, such as acute inpatient care. Effective governance in such areas requires a far more interventionist approach (and therefore much stronger government capacity). Indeed, even in many well-functioning mixed health systems, governments have taken steps to ensure that most acute inpatient care providers (i.e. hospitals) are predominantly owned by the public sector and/or not-for-profit organisations.

Box 3. Regulating retail pharmacies to 'harness' market forces for the public interest

Most retail pharmacies in France are privately owned and operate in a competitive market, in which patients are free to choose from whom they buy their medicines. However, the incentive and accountability environment in which providers operate is highly regulated. To maintain their license and be eligible to receive social insurance reimbursement, pharmacists must abide by a range of regulations relating to key aspects of provision, including dispensing, opening hours, and quality standards. In addition, pharmacists must maintain their registration with the relevant professional body. Prescription prices are standardised, based on outcomes from a process of public-private dialogue institutionalised under a government commission. Patients are reimbursed for the majority of their costs under the social insurance scheme (mostly funded via income-based contributions, topped up by general government budgets), and make a co-payment only if they request a branded drug rather than a generic equivalent(4).

In this market, a combination of financing and regulatory tools are being deployed to:

- create the rules in which retail pharmacies are legally obliged to operate (economic regulations), enabling public agencies to influence both the nature and extent of provider-patient interactions;
- enforce quality standards (social regulations) and encourage the retail pharmacy sector to take additional responsibility for quality assurance via co- and self-regulation; and
- facilitate voucher-style payment to pharmacies (i.e. social insurance reimbursement for eligibleproviders) (financing), supporting access, and ensuring that money follows the patient.

The result is that, while the retail pharmacy sector in France is largely owned by the private sector, the government is able to create an incentive and accountability environment that safeguards quality of care, value for money, and, to a large extent, equity of access (at least for the insured population).

Box 4. Indirect governance of health markets through using a 'package' of tools of government

In the majority of OECD Member States, primary care services are offered to the population through a large number of small-scale clinics – operating as SMEs . As Table 1 shows, primary care is in this sense predominantly a small-scale private sector 'industry', in most OECD countries. However, it is an industry that is heavily regulated by governments – indeed, to such an extent that that it resembles in many respects a public sector 'industry' (and may be perceived as such by patients!). These OECD countries rely on indirect governance (i.e. deployment of a range of tools) to ensure that private provider actions are aligned to public health objectives:

- delegate authority to professional bodies with the legal power to control entry into the 'industry' and the responsibility to assure members continuously quality meet standards in providing goods/services (social regulations);
- provide grants and service contracts to address spatial inequities in access (supply-side financing); and
- facilitate voucher-style payment to clinics (i.e. government/ insurance reimbursement for eligible providers) supporting access and ensuring that money follows the patient (demand-side financing).

As Table 1 makes clear, OECD countries have achieved private provision of private health care through different paths based on the selection and combination of the tools of government. Regardless of the path chosen, the majority of public and private primary care clinics are reimbursed for the cost of service-delivery through social insurance (sometimes referred to as the Bismarck Model) or by government directly in NHS-style system (also referred to as the Beveridge Model), and face a range of regulations they must comply with to remain eligible for such payments.

Table 1. Predominant form of ownership and the share of total primary care provision accounted for by the private sector 'segment' in 26 OECD countries

Country	Predominant ownership	Private segment %
Australia	Private	89
Austria	Private	80
Belgium	Private	75
Canada	Private	52
Denmark	Private	-
Finland	Public	88
France	Private	65
Germany	Private	76
Greece	Private	60
Iceland	Public	95
Ireland	Private	-
Israel	Public	-
Italy	Private	65

Country	Predominant ownership	Private segment %
Japan	Private	-
Korea	Private	-
Luxembourg	Private	-
Netherlands	Private	54
New Zealand	Private	52
Norway	Private	-
Portugal	Public	100
Spain	Public	97
Sweden	Private	-
Switzerland	Private	-
Turkey	Public	-
UK	Private	90
United States	Private	90

Principle 2: Effective PSE approaches are defined by "problems" not "solutions"

Development partners play an important role in providing technical support to MoHs in LMICs. Officials tend to view development partners as sources of objective, evidence-based advice. However, development partners' advice can be influenced by organizational priorities, or swayed the latest development 'fad' in PSE. If there is over-reliance on pre-designed solutions – a process called "isomorphic mimicry" – or on available tools and methodologies – a phenomenon called "Maslow's Hammer" – this can lead to negative impacts from PSE (see Box 5).

Indeed, the history of health system strengthening in high-income countries highlights this key attribute of effective PSE: the focus on problems as the driver of solutions. After the Second World War, governments in western Europe, Canada and Japan faced a common set of problems. However, each country responded in a unique way, according to an in-depth understanding of the problems to be addressed and an objective appraisal of existing governance capabilities.

A key development across these countries was the attempt to insulate people from direct healthcare costs. Most governments explored a range of strategies and introduced some form of financing tool: in some cases, a voucher-style payment to individuals (i.e. insurance), and/or direct ownership of the public health delivery system(6). These reforms reduced the direct individual costs of service use, thereby enhancing equity of access and financial protection. However, these reforms also created new "problems" – the increased demand for, and the rising cost of, healthcare. Accordingly, several countries introduced new tools of government aimed at containing costs without reducing quality of care – a goal that included an increase in government ownership in some service areas (especially acute care) but, in most other areas, a strengthening of indirect governance capabilities, and a shift from 'passive' to 'strategic purchasing' approaches with respect to the (often quite extensive) private sector.

> **I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail.**
>
> Abraham Maslow, The Psychology of Science, 1966.

Box 5. Avoiding "Maslow's Hammer"

The concept known as "Maslow's Hammer" is a form of cognitive bias that stems from over-reliance on an available tool. Increasingly, LMICs are establishing specialist public private partnership (PPP) units, and are drafting legal and regulatory reforms that encourage health authorities to undertake specific forms of PPP. In this context, Ministries of Health are armed with a hammer – a highly complex tool that bundles together in a single contract an extensive range of complex services – and they need only to find a suitable nail. The consequences of this process - finding a problem to match a solution - can be dire. In 2008, the government of Lesotho procured a PPP project incorporating the part-financing, construction and operation of a 425-bed hospital, a gateway facility and three 'filter' clinics in Maseru. The transaction was modelled on PPP contracts undertaken for similar infrastructure in high-income countries – though it was more ambitious in terms of the range of activities transferred to the private sector – which included primary, secondary and tertiary care services. The Ministry of Health in Lesotho had limited capacity to plan, procure, manage and pay for this deal, leading to a monopolistic procurement process (there was only one bidder), errors in the payment mechanism (the failure to share demand risk with the private sector) and severe affordability problems, leading to a distortion of government resources to acute care and, ultimately, a series of creditor defaults (as delays in payment undermined the ability of the contractor to meet scheduled debt payments).

Source: Hellowell M, Are public–private partnerships the future of healthcare delivery in sub-Saharan Africa? Lessons from Lesotho, BMJ Global Health 2019;4:e001217.

There were some common features in the responses. For example, in the retail pharmacy sector, all countries required service providers to be licensed and/or contracted by state agencies. However, there were important differences in the range of tools deployed. For example, in the United States, government agencies achieved downward pressure on prices largely through incentives and requirements put in place by insurance companies (include social insurance organisations), thereby impacting whole supply chains, while in Canada, and in western Europe, government achieved equivalent effects through centralised price regulation(7).

> In the retail pharmacy sector, all countries required service providers to be licensed and/or contracted by state agencies.

These experiences highlight how effective PSE activity needs to be founded on how the market system needs to change to address a prioritised problem. The solution to be implemented needs to match that problem (i.e. what actors and actions are implicated in the problem; how can incentives be re-shaped to change related behaviours, and what capabilities - e.g. what skills, what data, what dialogue platforms - are needed to implement the required tools of government). As such, they provide a useful source of information to guide the future PSE efforts of LMICs without encouraging direct mimicry or adoption of pre-defined solutions.

> These experiences highlight how effective PSE activity needs to be founded on how the market system needs to change to address a prioritised problem. The solution to be implemented needs to match that problem.

Principle 3: Successful governance of the private sector requires good data

Designing sound policy to harness private sector capacity to advance UHC objectives requires sound data.

How, for example, can a government enter into contracts with a network of primary care providers without knowing some basic facts, such as how many providers the network includes, and where they are located? How can you determine if quality is good or bad in the network without data on the quality standards in use, or the status of self- or peer-regulation in the field? All LMIC governments collect (at least some) equivalent data for public sector providers – and often, also, faith-based and non-governmental organisations (FBOs and NGOs). However, data on the private sector, in particular the for-profit sector - are often lacking.[4] This has not prevented Ministries of Health in LMICs from designing health policies and regulations that have a material effect on private sector activities – for better or worse.

Box 6 illustrates how such well-intended policies and programmes can go wrong in this context.

How can you determine if quality is good or bad in the network without data on the quality standards in use, or the status of self- or peer-regulation in the field?

4 Based on USAID and World Bank experience of conducting over 36 private health sector assessments.

Designing sound policy to harness private sector capacity to advance UHC objectives requires sound data.

Box 6. Right problem, inadequate data, wrong solution

A donor project's goal was to support Ethiopia's Federal Ministry of Health to increase access to TB services through the private sector. However, there was limited accurate data on how many private providers had the capacity (e.g. the clinical skills, equipment, and access to medicines) to diagnose and care for TB patients in accordance with specified clinical standards. Moreover, the designers of the project failed to review existing regulations to determine if private providers were actually authorized – and they were not – to deliver TB services. The project was delayed for upwards of two years while the regulation was modified.

A project was designed to increase access to modern family planning methods through private sector providers in rural areas of Kenya. Ultimately the project failed because the project designers did not conduct market research to determine the number of private providers in the targeted rural areas, their capacity, or their interest in providing FP services. Once they collected the necessary research, the implementers of the project concluded there would be insufficient supply of essential healthcare workers (i.e. doctors, nurses and formal pharmacists) available to address programme objectives through the private sector.

Data on the private sector is typically poor in LMICs for several reasons.

Data on the private sector is typically poor in LMICs, for several reasons:

- government's attitude that the private sector is 'someone else's problem' means that it is not regarded as a priority to collect data on it;
- development partners do not recognise the private sector's contribution to healthcare supply, and therefore do not routinely collect data on related activities;
- government agencies may not have the systems or staff to undertake the necessary data collection;
- LMICs Ministries often lack the capacity to analyze data, particularly market data, on private sector activities;
- on the private sector side, private providers do not report to the Ministry of Health for fear of increased taxation and other forms of state scrutiny;
- lack of reciprocity (i.e. MOHs often to do not consistently share information - particularly on policy reforms and regulatory changes).

There is a growing experience in collecting data on the private health sector in LMICs (NB. our focus here is on local data collection approaches). There are different types of research approach and they fall into four broad categories: (i) Sector Analysis; (ii) Health Market Analysis or feasibility studies that relate to a specific sub-market or a market related to a particular procurement; (iii) Provider Research; and (iv) Consumer Research (see Figure 3).

Each of these approaches aims to address basic facts about the market, including:

- the scale and composition of the private health sector;
- the product/service areas it works in;
- the consumer groups for which they perform these activities;
- any geographical locations and urban/rural division;
- their approaches to revenue collection, and the prices being charged; and
- policy-relevant aspects of demand (e.g. preferences and price/income elasticities).

Figure 3. Types of data collection exercises relating to the private health sector in LMICs

The following is a brief description of each of approach outlined in Figure 3.

Private health sector assessment (PHSA).[5]
The PHSA is considered the "gold standard" in this research area because it allows policymakers to explore the full range of market actors relating to a specific product or service area. The PHSA draws on existing data sources – both international (Demographic Health Surveys, National Health Accounts, World Bank Statistics), domestic sources (MOH service statistics, legal frameworks and regulations, and national health sector and financing strategies) as well as the published literature. However, primary data is also collected in-country. For example, stakeholder interviews are conducted with a broad range of public and private stakeholders in both urban and rural settings to complement the review of secondary sources. Box 7 illustrates the types of data generated by the PHSA.

Box 7. Data generated by a typical Private Health Sector Assessment

- landscape of all actors in health sector and/or sub-sector;
- public-private mix of health facilities, pharmacies and drug stores, and medical labs;
- public-private mix of supply chain sub-sectors;
- public-private mix of human resources in health by cadres and geographic locations;
- public-private mix of health training institutes;
- health financing trends including overall private expenditures and by sub-sectors;
- public-private mix of key health areas;
- policy review influencing private health sectors.

Many approaches are used to provide a descriptive account of a health market's core characteristics.

Health Market Analysis
Many approaches are used to provide a descriptive account of a health market's core characteristics (e.g. Box 8 shows the type of data generated from Market Scoping Exercises). Such methods can serve to make the private sector more 'legible' to policymakers, thereby providing a starting point for diagnosing problems, identifying the most promising opportunities for leveraging the private sector, and ensuring that the right organisations are 'at the table' when defining PSE policies and/or implementing them in the market. International consulting firms, such as PricewaterhouseCoopers and KMPG, have developed standardised approaches to market-scoping, based on methods used in other sectors. Development Banks have also developed similar tools to determine the viability of private investments in specific health markets/businesses, alongside methods for conducting financial and economic analysis for public-private partnerships.

Box 8. Data generated by market research

- market size;
- effective demand;
- market segments;
- market trends;
- market barriers;
- market competition;
- cost;
- price.

Provider Research
Both qualitative and quantitative methods are used to collect data on private sector providers, their location, their capacities and interests. In high-income countries, a lot of useful data is collected through routine regulatory systems (e.g. facility licensing, HR certification, accreditation, facility inspections and capital planning processes). In contrast, LMICs do not always have these tools in place - and if they do, they do not collect the data systematically. Moreover, the private sector under-report to DHIS – health information system widely used in LMICs. To compensate for this gap, an increasing number of LMICs is investing in master facility lists, facility census and GIS mapping. The quantitative data is combined with qualitative data to assess:

- what the private sector can feasibly offer in terms of PSE (e.g. its clinical skills, infrastructure, quality standards, etc.);
- its willingness to partner with government and;
- the key barriers to partnership (e.g. regulatory, market conditions, access to capital, business skills, etc.).

Consumer Research
In high-income countries, larger healthcare groups will tend to collect data on key aspects of consumer behavior and preferences, including the service and product attributes most valued by consumers, and how these differ among consumer groups (e.g. different demographic, socioeconomic, education and gender groups). This type of research assists businesses to adapt their resource allocation and marketing decisions to expand their market share and revenues. In most cases, they hire marketing firms that specialize in healthcare. Key actors in the global health community, through implementing partners such as Population Services International and Johns Hopkins Population Center, have leveraged traditional consumer research methodologies in OECD markets and applied them to health in LMICs. Of the three methodologies most used, focus groups and exit interviews are the most common while opinion polls and consumer surveys less so. Box 9 shows the type of data collected.

Box 9. Data generated by consumer research

- current demand;
- potential demand;
- consumer preferences for providers / products;
- consumer ability to pay;
- consumer willingness to pay.

While not specifically designed to focus on the private sector, the Patient Pathway Analysis (PPA) method is also relevant as a methodology to understand patient use of public and private services. This approach describes the steps that individuals with a specific need, like treatment for tuberculosis, or maternity care, take between their initial presentation of their symptoms to cure. The results of a PPA reveals key gaps in care-seeking, diagnosis, treatment initiation, and continuity of care (whichever sector such gaps relate to), and can be used as inputs into an evidence-based process of identifying and developing private sector engagement actions to address gaps in patient care.

Collecting data on the private health sector is expensive.

Collecting data on the private health sector is expensive. The cost can range from as little as $25,000 for a small-scale market scoping exercise, to $150,000 for a comprehensive PHSA, and even $500,000 for a large-scale project such as a nationwide facility census.[6] However, governments should not shy away from making such investments. So long as a government is clear about what the research is for, how it will be used, and how this will help contribute to strategic objectives, the research is likely to generate significant net returns in better problem-identification and policy design. In addition, data can also help to raise awareness of the private sector as a cause of, and a potential source of solutions to, problems that have been prioritised by local actors. Indeed, both PHSA and Patient Pathway Analysis have helped, and are helping, to raise policymakers' awareness of problems with regard to the private sector(8). Box 8 offers guidance in selecting which research to undertake.

5 The PHSA approach was developed with support from USAID and World Bank. Consult https://assessment-action.net/ for more information on the methodologies employed.
6 Estimates based on USAID and World Bank projects located in LMICs. Costs will be higher in OECD countries.

Principle 4: The private sector needs to be engaged in a meaningful dialogue

In the past two decades, a new development paradigm has emerged. Increasingly, developments partners, governments, and private health sector alike agree that sustainable development requires all key players to work together for change(9). Several factors have contributed to this change in view:

- the long history of failed development approaches that focus exclusively on strengthening the state and its administrative apparatus;
- the increasing emphasis governments place on participation and dialogue as methods for bolstering their legitimacy, fostering transparency and strengthening accountability;
- changing expectations about the role of non-state actors in policy processes, demanding greater transparency and accountability between governments and those actors.

Box 11. Definition of PPD

"PPDs are structured mechanisms – both temporary and permanent – anchored at the highest practical level, coordinated by a light secretariat, that facilitates a process involving a balanced range of public and private sector actors to identify, filter, prioritize, accelerate, implement, and measure policy reforms and actions." (Adapted from Herzberg, 2011)

Increasingly, developments partners, governments, and private health sector alike agree that sustainable development requires all key players to work together for change.

The experience of high-income countries suggests that successful collaboration in the health sector requires effective engagement and dialogue. High-income countries have a long tradition of working with the private health sector through established, formal mechanisms to tackle difficult issues - such as physician reimbursement, benefit packages and quality assurance. For example, in France, as we have seen, prescription prices are standardised, based on outcomes from a public-private dialogue (PPD) platform organised under a government commission. Similarly, in Germany, the fixed "per case" prices of hospital services are negotiated between sickness funds and hospital organisations through a dialogue platform that brings together a wide range of stakeholders (providers, insurers, unions, employers, and state actors) at the national level. In primary care, high-income countries have a variety of procedures in place but, in each case, a platform exists in which key stakeholders - including professional associations – participate to agree on outputs, standards and/or prices.

Figure 4 illustrates six key attributes of successful public-private dialogue.[7] These are:

- leadership by a core group of local public and private sector champions who "own" and "drive" the PPD process;
- balanced representation between and within sectors;
- organisational structures including budgetary resources and staffing to ensure the capacity exists to manage day-to-day operations;
- a common agenda that aligns partners and is focused on delivery;
- shared metrics that use data to make decisions, inform the dialogue process, demonstrate results and hold partners accountable for their (in)action; and
- mutually reinforcing activities that harness the collective actions of all stakeholders.

7 The work of Herzberg and Wright (2006), on which these good practices are based, is the product of a comprehensive review of case studies and synthesis research papers on techniques for promoting successful dialogue, including major studies by the World Bank, DFID, and the OECD Development Centre.

Figure 4. The six key attributes of an effective public-private dialogue platform

Where PPD forums exist in LMICs, they tend to not possess these attributes. There is still considerable mistrust between the public and private sectors due to the lack of understanding of the private health sector's intentions, and suspicion of the profit motive. Also, deep rooted philosophical beliefs and negative personal experiences are cited as major barriers to interactions between public and private stakeholders(10). In many developing countries, interactions between the public and private health sectors are punitive, with LMIC MOH regulations and guidelines implemented more strictly than in other sectors. The lack of understanding between the two main players in health systems burdens the very population groups who need the services the most (see Box 12).

Deep rooted philosophical beliefs and negative personal experiences are cited as major barriers to interactions between public and private stakeholders.

Box 12. African Health Markets for Equity (AHME)

Many LMICs have embraced social health insurance (SHI) as a mechanism for achieving UHC. By giving private providers the right to be reimbursed under SHI, governments can increase access to health services for covered populations while enabling private providers to grow their businesses. Realising this potential is difficult, especially in primary care, a sector that tends to be highly fragmented.

The African Health Markets for Equity (AHME) project - financed by DfID and the Bill and Melinda Gates Foundation - worked to address these challenges in Nigeria, Kenya and Ghana. The project aimed to help poor people enrol in SHI schemes. AHME also worked with small-scale private providers to assist them to become accredited so that they could provide free services to poor people and be reimbursed under SHI. While the quantitative analysis of enrolment outcomes achieved under the project is still being undertaken at the time of writing, extensive qualitative research on the project has been completed.

This research has shown that, while some poor people were successfully enrolled under the AHME project, most failed to renew scheme membership. The costs of renewal were seen by many as poor value, given that accredited service providers were often hard to access. Two reasons emerged why there were few private providers participating in SHI. First, the process of accreditation was complicated and poorly understood by providers. Second, SHI payments to smaller facilities were often delayed, if they arrived at all, and small providers did not have the working capital to provide services based on unpredictable payments. In this context, it is no surprise that many providers were charging patients at the point of demand – undermining the UHC principles at the heart of the scheme.

Governments and regulators involved in the SHI scheme did not understand the constraints faced by small-scale providers which ultimately, lead to the project's failure to address the obstacle. AHME project supported a PPD platform to facilitate dialogue to address these implementation as they arose. But large healthcare businesses dominated the dialogue process and the voice of small-scale providers was not adequately heard. Although one small case, the AHME project's efforts highlight the need to ensure PPD processes follow the best practices. A more balanced and representative number of private sector providers as well as clear leadership of champions may have headed off the political capture of the strong interest group. Moreover, the lack of information and buy-in from the affected providers ultimately undermined the project's success.

Source: For a summary of the available qualitative research, see: Boddam-Whetham, L 2019. Leveraging private health providers to achieve Universal Health Coverage: Lessons from the African Health Markets for Equity project. Available at: http://www.hanshep.org/our-programmes/AHMEresources/LessonsfromAHMEfinal002.pdf

Conclusion

In this report, we have presented a set of evidence-based principles we believe can support LMIC policymakers to establish sustainable improvements in mixed health system governance.

Collectively, our four principles highlight the importance of building government's capabilities to engage the private sector in pursuit of its key objectives. Markets cannot deliver the equity of access and financial protection that is called for by the UHC ideal. Governments need to intervene – and by doing so in an informed, evidence-based way, they can leverage the advantages of the market while protecting the public health interest.

This means a new way of doing 'governance' that is more inclusive, and can deliver the key governance behaviours outline in WHO's Strategy Report. Key principles that underpin this are:

- the need to taking account of experiences in well-functioning mixed health systems, but not seeking to mimic these, or adopt wholesale a particular instrument or method;
- the importance of focusing PSE on problems that are prioritised by actors in the local context (and therefore command the support of key policy actors);[8]
- placing emphasis not on particular interventions but on the set of organisational capabilities needed to deploy tools of government as a matter of routine; and
- building solutions from prioritised problems by accessing good data on the private sector delivery system – its operations in different service areas, its sources of revenue and the prices it levies, and the nature of demand for its services.

Our four principles highlight the importance of building government's capabilities to engage the private sector in pursuit of its key objectives.

All of these goals are more readily achievable when there is a real, live, functioning dialogue between the government, development partners and the private sector. Over time, as such platforms are institutionalised, such that policy processes routinely include data on the private sector, and its interests and motivations, there is likely to be a profound and positive impact on the effectiveness of mixed health system governance.

All of these goals are more readily achievable when there is a real, live, functioning dialogue between the government, development partners and the private sector.

8 As a rule of thumb, defining which challenges/problems can be regarded as priorities can be done by examining key policy statements, such as National Health Sector Strategies, or National Health Financing Strategies. Ensuring that strategic options for, and capacity-building linked to, PSE is likely to be a sensible approach.

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Members States are urged to scale up engagement and leverage the capacity of private and other public health-care providers that are not linked to national TB programmes to deliver TB prevention, diagnosis and care services to reach the missing people with TB, including children, especially in countries with a large private sector

Report of the UN Secretary General for the Seventy fifth UN General Assembly

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> **Private sector involvement in the global #COVID19 response is something we @WHO have been advocating and working on.**
>
> Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization

World Health
Organization