

ROLE OF PRIVATE SECTOR ENGAGEMENT IN REIMAGINED PRIMARY HEALTH CARE DELIVERY: COMPREHENSIVE REVIEW

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Comprehensive Review

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Health, Nutrition, and Population (HNP) Discussion Paper

Role of Private Sector Engagement in Reimagined Primary Health Care Delivery: *Comprehensive Review*

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Abstract

As World Bank Group Health, Nutrition, and Population (HNP) General Practice undertakes a strategy refresh anchored in a reimagined primary health care (PHC) agenda as the foundation for achieving universal health coverage (UHC), a knowledge product that examines the potential role of the private sector in transforming PHC delivery and shaping health markets is timely and relevant.

As PHC is being repositioned in the global health care ecology, the discussion paper provides a comprehensive review of promising private sector PHC service delivery models, and highlights recommended actions that can steward the contributions of public and private health actors toward achieving UHC goals.

The private sector plays a significant role in health care provision globally, and the opportunity to harness the private sector to reorient PHC delivery is driving a renewed interest in scalable private sector delivery models to advance UHC. Although essential information on private sector models is limited, a review of the available evidence of private sector interventions (such as franchising, contracting, accreditation, and regulation), has been conducted to understand lessons and transitions emerging to inform how governments can potentially develop more effective private sector interventions that are aligned with their UHC goals.

Using established typologies, the paper defines the role of the private sector relative to the different country policy objectives on private sector engagement, relevant health market failures being addressed, private sector constructs in mixed health systems, and the level of development of the country in terms of income levels.

Building more effective private sector partnerships will require deliberate efforts by governments to strengthen governance behaviors—on data infrastructure, policy direction, stakeholder platforms for engagement, and catalyzing innovative service delivery partnerships—to ensure the private and public sectors work together within a level playing field in ways that promote equity, access, quality, and financial protection for populations.

Keywords: Private sector, primary health care, franchising, contracting, innovation

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SECTION 1

CONTEXT AND INTRODUCTION

Even before the COVID-19 pandemic, many countries were undergoing multiple transitions including demographic, social, epidemiological, economic, and technological changes that began to shape the health and well-being of communities and populations. A proliferation of public and private providers has further complicated the landscape of service delivery. These transitions are likely to continue in the coming decades.

To meet the evolving transitions and demand for quality health care, all countries will need to undergo a redefinition of how primary health care (PHC) is defined, delivered, and financed. A forward-looking PHC agenda is therefore timely and relevant and must adapt to the changing global and local contexts, tackle emerging challenges, and proactively transform PHC to meet evolving and future needs.

This repositioning requires a reimagined PHC delivery model, with a more comprehensive, people-centered platform within the context of universal health coverage (UHC). Reimagining PHC delivery will require a new approach that goes beyond the status quo and positions PHC as the first point of contact with the health system, and as an anchor to deliver a comprehensive set of health care services to meet the changing health needs of the population while coordinating care across different levels. Reimagining PHC delivery will entail a transformation of the perspective away from patients as passive recipients of care to co-producers of gains in health outcomes. It will require empowering individuals and communities as active partners who will seek to improve their own health and well-being and hold health systems to account to ensure accountable, consistent, and high-quality care.

This emerging consensus offers a vision for modern PHC driven by patient- and community-centered care, multidisciplinary care teams, financial risk protection, efficient two-way referrals, a multi sectoral approach to health and wellness, and strategic deployment of information and communications technology (ICT). The vision of reimagined PHC in this context makes a unique contribution to previous efforts by marrying a forward-looking vision, already expressed by others, with transformational transitions and reforms driven by a demand-side approach.

The centrality of PHC to comprehensive and sustainable UHC has been further reinforced by the 2018 Astana Declaration and remains supported by an ever-increasing, multi stakeholder array of initiatives, including the Primary Health Care Performance Initiative (PHCPI), the World Health Organization (WHO) and United Nations Children's Fund's (UNICEF) Vision for Primary Health Care in the 21st Century, and the WHO's Framework on Integrated People-Centered Health Services. These initiatives and agendas provide an overarching blueprint for global development and highlight the role of partnerships and collaboration between government, private sector providers, businesses, and civil society in achieving sustainable development goals (SDGs). For health sector-related goals, this translates to a call to action to support all countries to better manage the private sector and mixed health systems to ensure that all providers, public and private, effectively contribute to a reimagined PHC model and accelerate the progress in achieving UHC goals.

Achieving universal health coverage requires health systems geared toward primary health care, which has been shown to be the most equitable, effective, and cost-effective way to enhance the health of populations (Morgan, Ensor, and Waters 2016). Reimagining PHC within the context of universal health coverage provides a renewed focus on taking a system perspective in engaging and managing the private sector (WHO 2018). UHC seeks to improve equity, access, and financial protection for health care; and its pursuit means that countries need to take ownership of health care, as a whole, irrespective of where—public or private sector—health care is delivered.

In recent years the tone globally has changed from a historically polarized debate between the public and private sectors, to a more compromising one of how to make both systems work effectively and efficiently, thereby providing universal and comprehensive coverage of health services to populations. The private health sector's role within the health systems of many high-income countries (HICs), and low- and middle-income countries (LMICs) is evolving and generally expanding (Soderlund, Mendoza-Arana, and Goudge 2003). Its role in health care delivery is increasingly seen as a continuum, within mixed health system constructs, ranging from private provision and financing at one extreme, to full public provision and financing at the other—and anything in between (Fidler 2014).

This report provides a comprehensive review of the private sector service delivery landscape from existing evidence, and focuses on private sector engagement models in primary health care delivery settings. The report excludes private financing, which is only referred to in the report to the extent that health financing is relevant to private service delivery. The report provides an overview of the context, rationale, and role of the private sector in primary health care delivery, particularly as primary health care is evolving and repositioning in the new health care ecology. It describes promising private sector engagement and innovative service delivery models; and highlights recommended actions that can steward the contributions of all public and private health actors, in HICs and LMICs, toward achieving universal health coverage goals, through PHC transformation.

DEFINING THE PRIVATE HEALTH SECTOR

There is substantial heterogeneity in the way that the role of the “private health sector” in health care delivery is defined, and related concepts, such as “private sector engagement” are used inconsistently. The private health sector is generally defined as individuals and organizations providing health services that are not owned or directly controlled by government, that is, all non-state actors involved in health care service delivery, including for-profit and not-for-profit entities (Harding 2001). These include private institutions (including nongovernmental organization [NGO] clinics, for-profit and nonprofit primary health care clinics, informal clinics, and pharmacies or drug shops) and private individuals, such as general practitioners (GPs), nurses, and consultants. While recognizing the multitude of actors in the private health sector and potential roles they play in advancing UHC, including in health care financing, this report will focus primarily on the role of private providers in health care service delivery, particularly in primary health care. As such, the term “private sector” or “private health sector” in this report refers to private service delivery. Given the report’s focus on both HICs and LMICs, the distinction between primary care and primary health care is also discussed. Primary care describes a narrower concept of “family doctor-type” services delivered to individuals; primary health care is a broader term that describes an approach to health service provision that includes both services delivered to individuals and population-level “public health-type” functions (Muldoon, William, and Levitt. 2005).

In this context, private providers can be classified into different types based on three dimensions (Montagu et al. 2016; Bennett et al. 2005; Harding 2001):

- **Objectives** (for-profit or nonprofit), the organizational objectives of private providers vary. Providers are typically divided into for-profit and not-for profit, with the former aiming to *maximize* financial gain, and the latter having a mandate to protect the health of a specific population.
- **Size of organization**, ranging from small-to-medium private practices to large facilities that can share inputs across many patients, cover larger numbers of similar cases to improve staff expertise, and ensure that a wide range of skills is available at all times (Mackintosh et al. 2016).
- **Competence of staff** (proxied by licensed or unlicensed frontline staffing), defined as professional knowledge and skills, assessed by case scenarios or vignettes, provider interviews, or formal tests, and related to overall technical quality (Leonard, Masatu, and Vialou 2007).

Table 1. Typology of Private Sector Providers

	Unqualified		Qualified	
	For-profit	Not-for-profit	For-profit	Not-for-profit
Small	Low-quality underqualified providers	Limited presence	E.g., Sole practitioner physician practice	E.g., Faith-based clinics
Large	Limited presence	Limited presence	E.g., Corporate hospital chains	E.g., Network of nongovernmental organization providers

Source: Adapted from McPake et al. 2017.

Drawing from these metrics, four prominent stylized private provider types have emerged in the literature; these are the following:

- **Formally registered, for-profit small-to-medium private practices**, such as sole practitioner physician (or nurse or midwife) practices. Small, trained, sole practitioners (GPs, nurses or midwives) probably form a substantial share of the private sector, although comprehensive data are not available at the system level (Montagu et al. 2016).
- **Formally registered, not-for-profit providers** that operate on a range of scales including small faith-based clinics to larger networks of NGO providers (domestic and international). These nonprofit providers are highly diverse and typically aim to serve the public interest. They range from large-scale provider networks run by national NGOs; to faith-based providers that can operate as part of provider networks; to organizations largely supported by external funds to provide targeted services, often to vulnerable groups (Stallworthy et al. 2014).
- **Low-quality, underqualified (unlicensed) providers**, such as informal drug shops that serve poor people in many countries. These providers comprise a large component of health systems in developing countries (Sudhinaraset et al. 2013) and include those providers who have not received formally recognized training from an institution or are not (typically) registered with any government regulatory body (Sudhinaraset et al. 2013). The convenience, accessibility, and affordability of these small private providers make them attractive to patients (Marten, McIntyre, and Travassos 2014; WHO 2018).
- **The corporate commercial hospital sector**, which is growing rapidly (Morgan, Ensor, and Waters 2016). Examples of these providers include conglomerates operating internationally, such as hospital chains and large corporate hospitals. The sector is underpinned by a viable business model, in serving both better-off people and an international market for which its low-cost base is an advantage. These hospitals often serve as referral hospitals.

RATIONALE FOR PRIVATE SECTOR ENGAGEMENT

The private sector plays a significant role in health systems in LMIC and HICs. The rationale for engaging the sector is well-documented and includes the following:

- **Established demand:** The demand for private health sector service delivery is well established—especially for primary health care services and for the poor and underserved globally. For instance, among 27 high-income countries, only 6 have majority public ownership of the primary care sector, whereas in 21 countries, primary care is mainly owned by the private sector (OECD 2010). A household survey of 70 low- and middle-income countries showed that private services provide about 65 percent of care for childhood illness, but the proportions varied widely by country (Grepin 2016). This established demand for private delivery varies by country's income level and use of the private sector. In some LMIC settings, the lack of public provision or perceived poor quality care in the public sector creates the opportunity for the private sector to fill a gap. Whether poor or rich, urban or rural, people already seek care from the private sector, which means that governments need to engage with the private sector to ensure that the health sector as a whole is positioned to deliver the best health outcomes for the population (Hozumi et al. 2008).
- **Growing and evolving sector:** The private health sector, though often loosely regulated and highly fragmented, has grown exponentially in most of the world's health systems and remains an untapped strategic partner in strengthening primary health care delivery systems to advance the drive toward universal health coverage (WHO 2019). Through sound policies and regulations (to level the playing field), countries must deploy governance arrangements to identify, shape, and ensure appropriate roles for private providers and for health markets, to steer mixed delivery of health services in a way that is consistent with their UHC aspirations (Advisory Group on the Governance of the Private Sector for UHC 2019).
- **Complementary partner:** The private sector often offers an attractive complementary alternative where public services are geographically inaccessible and unaffordable, and it is often the only acceptable and available option for users (Preker and Harding 2001).
- **Innovation and agility:** The private sector can be an important source of innovation and technology for the health sector. The sector is also disposed to agility. Globally, several private health market developments are also creating opportunities for increasing access to health services by developing inexpensive diagnostic technologies, increasing access to mobile phones and the Internet, and growing availability of the use of artificial intelligence to address common health care service delivery problems (DFID 2005). There may also be a range of skills, capacities, and comparative advantages within the private sector that can have positive effects on service delivery and health outcomes (Dimovska et al. 2008).

SECTION 2

PRIVATE SECTOR CONSTRUCTS IN MIXED HEALTH SYSTEMS

Private sector service delivery is situated within the context of mixed health systems and can therefore only be effectively governed by understanding the mixed health systems of which it is a part. The literature in this area has converged around a set of metrics that can be combined to provide a useful starting point for describing and classifying the private sector in mixed health systems (Montagu et al. 2016). Mackintosh et al. (2016) summarized three commonly cited metrics. They include the extent and pattern of private finance within health care expenditure as a whole; the scale and level of private sector enterprises in health care, indicated by their weight in the use of ambulatory and primary, and clinic-based and secondary care; and the accessibility of the public sector, proxied by the extent to which the public provision relies on fees (Mackintosh et al. 2016).

Further descriptions of these metrics are provided below:

- **Scale and level of the private sector enterprises in health care, indicated by their weight in the use of ambulatory and primary, and clinic-based and secondary care.** Data on private sector activities in this regard are sparse. Various country-level Demographic and Health Surveys (DHS), WHO World Health Surveys, and other household survey data are therefore used, alongside facility surveys (Hanson and Berman 1998).
- **Accessibility of the public sector, proxied by the extent to which the public provision relies on fees (commercialization). Fees charged in public facilities also affect private health market activities and the incentives that public providers respond to.** Public sector accessibility is measured using country-level data for the proportionate reliance of the public sector on fees and charges, mainly estimated from information in National Health Accounts (Mackintosh and Koivusalo 2005).
- **Extent and pattern of private finance within health care expenditure as a whole.** The extent of each type of private finance is a proxy indicator of the characteristics of the private supply sector, since private insurance generally funds larger licensed private providers, whereas much out-of-pocket (OOP) spending funds smaller-scale, often unlicensed, provision (Onwujekwe 2011). However, OOP spending also includes fees for public services and medicine purchases (Rannan-Eliya and Lorenzoni 2010). As such, this indicator does not necessarily capture the share of private supply in total supply of health care (Mackintosh et al. 2016).

Prominent examples of relevant types of private sector in mixed systems include a dominant private sector (e.g., India and Nigeria); a private sector complementing universalist public sector (e.g., Sri Lanka and Thailand); high-cost (insurance-driven) private sector heading a stratified system (e.g., Argentina and South Africa); and a socially stratified private health sector (e.g., Tanzania, Ghana, Malawi, and Nepal), among others. These are briefly summarized below.

- **Dominant private sector** (e.g., India and Nigeria): Countries with a dominant private sector display high shares of out-of-pocket spending in total health expenditure, a

private sector dominating activity in both primary and secondary care, and public sectors with varying reliance on fee payments (Stallworthy et al. 2014). India and Nigeria, for example, share three features: a relatively high private share of total health expenditure and low ratio of public health expenditure to gross domestic product (GDP); a private sector that dominates health care provision at all levels and incomes; and highly public health sectors in which scarcity of public sector availability forces patients to turn elsewhere (Government of India 2009).

- **Private sector complementing universalist public sector** (e.g., Sri Lanka and Thailand): Countries with this type of private sector have moderate to low private expenditure shares, mainly OOP expenditures; moderate private share of primary care and low private share of hospital care; and very low or no public sector fees. Sri Lanka and Thailand's health systems differ substantially, but they share a key characteristic: public spending supports an accessible and universalist public sector whose role and limitations shape private sector investment into complementary roles within the health system. Both countries obtain good health outcomes from this pattern (Govindaraj 2014).
- **High-cost (insurance-driven) private sector heading a stratified system** (e.g., Argentina and South Africa). Countries with this type of private sector have relatively high shares of private and social insurance in health spending, and substantial private sector activity in secondary and primary care alongside low public sector reliance on charges. South Africa and Argentina are two middle-income countries in which the share of private plus social insurance in total health spending is greater than 40 percent (Van den Heever 2012). This health insurance finances a private sector of hospitals and clinics serving the higher-income population groups. In the two countries, the private sector therefore forms a private subsystem, providing high-quality care at the top of a stratified health system in which the poor generally rely on lower-quality public provision (Atun, de Andrade, and Almeida 2015).
- **Socially stratified private health sector** (Tanzania, Ghana, Malawi, and Nepal). Countries with this type of private sector have high private expenditure shares, mainly falling over time; a stratified private sector with hospitals and clinics for better-off population groups and substantial use of private shops, especially by poorer people; and varying public sector reliance on fees and charges, affecting private sector demand (Mikkelsen-Lopez et al. 2013; Morgan, Ensor, and Waters 2016). A diverse private health sector in many lower-income countries has been shaped by the changing characteristics of the public sector, driven by deregulation. Common trends are the rise of private shops and pharmacies as a location for treatment, which is often of poor quality, alongside increasing inequalities in the use of private secondary facilities for care (Montagu et al. 2016).

Other types of mixed systems including highly commercialized public sector undergoing reform such as China; and private sector service delivery purchased by the government (e.g., Canada, the United Kingdom) have also been widely reported (Morgan, Ensor, and Waters 2016). Most high-income Organisation for Economic Co-operation and Development (OECD) countries have health care systems dominated on the expenditure side by social insurance or tax-based universal provision, and private providers work either for those systems or as supplementary providers (OECD 2010).

A review of the different private sector constructs described shows that the public sector's behavior can affect the role and behavior of the private sector within mixed health care systems (Montagu and Goodman 2016).

PRIVATE SECTOR ENGAGEMENT MODELS

Private sector engagement models have gained significant global policy attention in recent times and have been implemented by a growing number of countries (WHO 2019). Private sector engagement in the health sector can be defined as an institutional relationship between the government and the private sector (formally registered for-profit and not-for-profit providers), to achieve a shared health goal on the basis of a mutually agreed division of labor (Buse and Walt 2000). It requires a written agreement that specifies the obligations of each party, the objectives of the partnership, and how the partnership will be managed or governed (Widdus 2003)

The literature (WHO 2016; Soderlund, Mendoza-Arana, and Goudge 2003) describes three broad categories of private sector engagement (or public-private partnerships [PPPs]) including the following:

- Influencing private sector service delivery behavior through regulatory and financing policy tools;
- Utilizing private sector actors in the development of public health policy and the development of ownership and contracting PPP arrangements; and
- Assigning “private attributes” to public sector organizations, for example, by giving them managerial autonomy and exposing them to market forces and incentives (WHO 2018).

Private sector engagement models are essential in moving toward universal health coverage, to fill gaps in coverage, prevent government from overstretching its capacity in delivering for all, and harnessing the rapidly growing private sector toward national and state policy goals.

Governments and international and local organizations have been using private sector engagement methods and leveraging existing private sector providers (formally registered for-profit and not-for-profit providers) for nearly 50 years (Patouillard et al. 2007). However, the number of private sector interventions has expanded greatly in recent decades, particularly in LMICs. The instruments used often work through intermediary actors, for example, NGOs or private entities, which are critical for organizing the heterogeneous private sector and providing a necessary channel for facilitated interaction (Prata, Montagu, and Jefferys 2005). A common typology of these private sector service delivery–intervention programs is well-documented in the literature and typically includes five common models, briefly introduced below (Patouillard et al. 2007; Smith, Brugha, and Zwi 2010):

- **Social and commercial franchising**, where a network of private providers is contracted to provide services under a common brand and platform. Most often operated by NGOs or for-profit franchisors, social franchises use commercial franchising techniques to achieve quality, access, equity, and financial goals (Prata Montagu, and Jefferys 2005). An estimated 15,000 to 20,000 individual clinics in

Asia, Africa, and Latin America now operate as part of social franchise networks (Montagu et al. 2016).

- **Contracting**, in which the government enters into a contract with registered for-profit and not-for-profit providers to deliver services to a certain population (Fidler 2014). Contracting with the private sector is structured in two ways: through contracting out, in which private organizations are engaged to take on government-financed services outside of the government health system; or contracting in, in which private organizations are engaged to manage or directly deliver services provided within existing government facilities (Cristiaa, García, and Pradob 2015). Examples include contracts for dialysis centers in South Africa and the Philippines, and laboratory or pharmaceutical distribution services in Tanzania, Zambia, and Mali. Contracts have also contained a range of financing, construction, and operations models for expansion of hospital infrastructure (and sometimes the provision of clinical services) in Brazil, Mexico, Lesotho, Thailand, and many other countries (Montagu and Goodman 2016).
- **Commodity social marketing**, where commercial marketing techniques are used to generate demand for health commodities that can achieve a high social good. The health commodities marketed are typically distributed through for-profit channels (pharmacies, drug shops, etc.), usually at a discounted price, making them more affordable to health consumers (Montagu et al. 2016).
- **Accreditation** is a form of external quality review and assurance of health institutions, based on agreed guidelines and standards, typically administered by an independent body, and focused on assessing compliance to standards and supporting process improvements (Liyanage et al. 2013). Accreditation is well-established throughout Europe and North America, where it provides a process for combined external and peer assessment of facility standards and quality processes (Shaw 2011). The use of accreditation systems is also growing in LMICs, where it is often a condition for reimbursement under national health insurance schemes (e.g., in Thailand, Kenya, Malaysia and the Philippines) (Velasco 2013). This conditionality of insurance payments is effective at modifying provider practices in a positive way, and, as a result, programs have often been started after the introduction or expansion of national or social health insurance (Marten, McIntyre, and Travassos 2014).
- **Vouchers can be used as a tool to fund specific services** for a target population, to be redeemed at specified providers. In a typical voucher program, donor or government funds are given to a targeted population for a targeted service in the form of a credit. This credit, is distributed to the target population and can be reimbursed at previously approved providers (Meyer Brody 2013). Although voucher programs are nominally a demand-side intervention, in practice they are often tied to specific providers and so also involve a strong supply-side component (Fidler 2014). The number of voucher programs has increased rapidly, building on the well-documented experience of the Instituto Centroamericano de la Salud in Nicaragua, where targeted payments for treatment of sexually transmitted infections have been in place for decades (Gorte, Grainger, and Okal 2012). Another well-documented example is the provision of vouchers to women attending antenatal clinics in Tanzania to cover part of the cost of the purchase of insecticide-treated mosquito nets from private retailers (Kramer 2017).

All private sector engagement models involve recruiting or contracting selected groups of private sector providers to deliver products or services to a defined minimum standard. The degree of complexity of the product or service provided differentiates these engagement models (see Table 2 below). Complexity can range from a simple product (such as a condom), to a product with a service element requiring the provision of a service or information, to an essential health care package delivered by a more qualified provider. The nature of the product and service (along with prevailing regulations) determines the appropriate private sector engagement model to deliver that service (Smith, Brugha, and Zwi 2010).

Table 2. Nature of the Private Sector Engagement Interventions

	Simple products (e.g., condom)	Product with significant technical/service delivery element	Essential health care delivery package
Strategies for engaging with PSEs			

Source: Smith, Brugha, and Zwi 2010.

Note: PSE = Private sector engagement.

Strategies for working with private providers are not limited to those described above. However, the report focuses on these five models, as a starting point, as they involve direct service delivery engagements with private providers and have received growing attention in recent times (Bennett et al. 2005). The choice of appropriate approach will vary substantially, depending on the health system failures being addressed, the nature of the health care product or service, the type of provider, and the level of development of the country both in terms of income level and mixed health system constructs (Montagu et al. 2016).

SECTION 3

REVIEW OF RECENT EVIDENCE AND TRENDS

Although essential information on private sector composition, service coverage, quality, affordability, and trends continues to be patchy, a review of the evidence base has been conducted to understand recent trends, lessons, or transitions emerging of how different private provider types and private sector engagement interventions support or detract from country efforts to achieve UHC. Few robust assessments are available, but some conclusions are possible (Montagu et al. 2016). The review will focus on the trends, evidence, insights, lessons, and opportunities in seven related themes:

- Attitudes or trends toward private sector collaboration;
- Performance of the private health care sector: quality, equity, and efficiency;
- Private sector provider types and their effectiveness;
- Health system factors affecting private sector performance;
- Trends in technology-assisted care;
- Trends and effectiveness of private sector engagement models or public-private partnerships to advance PHC delivery; and
- Barriers and market failures in advancing public-private partnerships in service delivery.

Attitudes or trends toward private sector collaboration

Growing numbers of policy makers are incorporating private PHC facilities and practitioners into overall sector policy (WHO 2018). An increasing number of references to the private sector in health policies demonstrate that most regions globally continue to engage or strive for collaborations with the private sector (see Figure 1).

For example (Advisory Group on the Governance of the Private Sector for UHC 2019):

- In OECD countries, the private sector is as predominant as the public sector in delivery of primary health care. Primary health care services in 15 out of 32 OECD countries is predominantly in the private sector.
- The private sector provides the majority of outpatient and ambulatory services and is highly utilized by the poorest quintile in the WHO Regional Office of the Eastern Mediterranean (EMRO)—see Figure 2.
- The majority of the population in South Asia first seek care in the private sector.
- The private sector is a major source of outpatient and inpatient health care for the rich as well as the poor for the African Region and South-East Asia Region (see Figure 3) (Advisory Group on the Governance of the Private Sector for UHC 2019).

Figure 1: Analysis by region of average # of mentions of the "private sector" and # of health policies reviewed

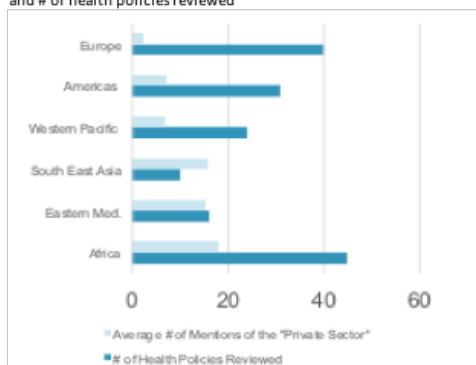
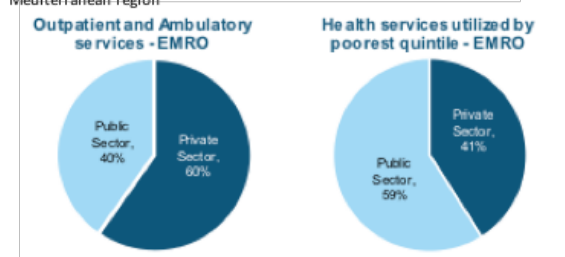


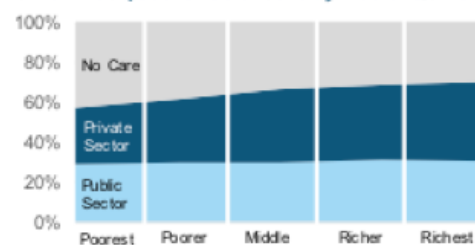
Figure 2: The private sector provides the majority of outpatient and ambulatory services and is highly utilized by the poorest quintile in the Eastern Mediterranean region



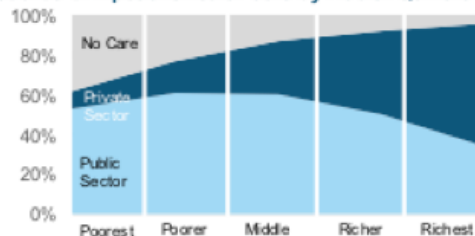
Source: (Advisory Group on the Governance of the Private Sector for UHC 2019)

Figure 3: source of outpatient care by wealth quintile in AFRO and SEARO. The private sector is a major source of outpatient and inpatient health care for the rich as well as the poor

Source of Outpatient Health Care by Wealth Quintile - AFRO



Source of Inpatient Health Care by Wealth Quintile - SEARO



Some governments—in both HICs and LMICs—are already successfully collaborating with and engaging the private health sector for service delivery. Recent examples include the following:

- The success story of India's tuberculosis (TB) public-private mix (PPM) model, which saw a vertical health program leveraging the private sector to affect health system change. Evaluations show important contributions to increased case detection and improved treatment results (Marten, McIntyre, and Travassos 2014).
- Near seamless integration of public and private primary and in-patient care in Thailand (Velasco 2013).
- Rapid expansion of trained provider attendance at delivery with the Private Midwife Initiative in Indonesia (Thurston et al. 2015).
- A well-documented presidential health compact in South Africa, which involved the private sector in its drafting, and specifically mentions engagement with the private sector as a primary focus area for health improvement (Van den Heever 2012).
- Contracting private providers for all primary care provision in a defined geographical area has also been implemented, most commonly in fragile and post conflict states. Such contracts have been studied extensively in Cambodia, Rwanda, and Afghanistan (Paola 2019).

Performance of the private health care sector

The heterogeneity and complexity of the private sector make any judgment about trends related to different private sector provider types and their performance complex and nuanced. Despite these difficulties, several studies have attempted to assess private sector effectiveness, usually through comparisons with the public sector. Most focus on

specific types of private providers and discuss factors that affect providers' performance; however, making overall conclusions about such factors is challenging. Most such studies include a small sample or narrow range of providers, but individual performance ranges widely and depends substantially on the context in which providers are operating (Morgan, Ensor, and Waters 2016).

Three general outcome measures are typically used to assess the performance of the private health care sector: quality, equity, and efficiency. These terms have been selected because they are widely used and encompass many other terms, such as responsiveness, access, financial risk protection, and appropriateness of care—given the perverse incentives that may occur due to supplier-induced demand, especially if there are no cost implications for the patient (Robertson-Preidler, Biller-Andorno, and Johnson 2017).

Quality has two main components: Service quality, including appropriateness of care and responsiveness of staff, which is often measured by patient satisfaction; and technical quality, incorporating the competence of providers and their adherence to clinical guidelines (Upadhyai 2019). Many comparative studies suggest that service quality is better in the private sector than in the public sector (Montagu et al. 2016; Liyanage et al. 2013; Morgan, Ensor, and Waters 2016). Likewise, results of a systematic review comparing the performance of private and public health care systems in low- and middle-income countries showed that clients thought service delivery by private providers was better as a result of shorter waiting times, better hospitality, increased time spent with doctors, cleanliness of facilities, longer and flexible opening times, and better availability of staff (Montagu et al. 2016). By contrast, technical quality across a range of private providers (registered for-profit and not-for-profit providers) seems to be inferior to the public sector, although many studies note that public sector services are also of a low standard (Basu et al. 2012). Globally, recent studies show that the private sector has fairly adequate services in middle- and high-income countries but needs quality oversight in low-income countries (OECD 2010).

Many studies rely on users to report the provider used, and private providers are often lumped into one category, masking any differences between types and context of provision. Few studies disaggregate contexts and patient groups served; when they do, different results may be found. In particular, studies done in sub-Saharan Africa use evidence from Demographic Health Surveys, which largely captures use of small, unregulated private providers in places where the public sector is weak (Gwatkin et al. 2007). In settings with a strong public sector, and a complementary and better-regulated private sector, different findings emerge. Results of a study in Sri Lanka showed evidence of much the same quality in public and private hospitals (Rannan-Eliya and Jayawardhane 2003; Liyanage et al. 2013). Most studies that explore quality in one or two types of provider fail to account for their contribution to the overall performance of the health system (Liyanage et al. 2013). However, when broader structural factors—such as the nature of the public sector and effective regulatory practices—are considered, a better understanding of how private sector performance affects the whole system begins to emerge (Montagu et al. 2016).

Equity is defined as the fair availability of, and access to, quality health care commensurate with need and without regressive financial implications (Basu et al. 2012). Private providers financed by individual OOP payments tend to exclude poorer patients and thus might be considered inequitable. Most studies have focused on the

direct effect of private providers on equitable access. Most private services in low- and middle-income countries are funded directly by patients (out-of-pocket). This feature tends to mean that private services from providers with qualified medical staff are more likely to serve affluent populations, presenting a critical challenge around financial risk protection (Onwujekwe 2011). Data from Demographic Health Surveys also suggest that the absolute levels of private sector use vary by region, but a gradient in use by socioeconomic status is apparent across all regions, with wealthy people more likely than poor people to use private providers (Gwatkin et al. 2007).

Where the public sector provision of essential services has gaps, poor people use some types of private providers disproportionately. In such instances, services are often of low quality and delivered by unqualified providers, but are accessible. According to Bloom and colleagues, the informal sector (low-quality, underqualified providers) provides most health care for poor people in many low- and middle-income countries (Bloom et al. 2011). Prata and coworkers reported that in 19 of 22 low- and middle-income countries, both wealthy and poor citizens received more care from the private sector than from the public sector, when private providers include informal low-quality, underqualified providers such as private drug shops (Prata, Montagu, and Jefferys 2005). The convenience, accessibility, and affordability of these small low-quality, underqualified private providers compared with public sector alternatives make them appealing to patients. However, a lack of effective regulation exposes poor patients to inadequately qualified practitioners providing low-quality care in many settings (Sudhinaraset et al. 2013).

Efficiency is the extent to which resources are used effectively or are wasted. From the perspective of universal health coverage, the literature is interested in the extent to which the presence of private providers affects overall efficiency, and thus the extent to which a particular level of health expenditure can cover a population with a range of services. Several studies (Basu et al. 2012; Brugha and Pritze-Aliassime 2003) focusing on the treatment of specific conditions suggest that private treatment results in high service costs, and thus potential inefficiency. The use of potentially unnecessary and expensive procedures is one source of expense.

Much of the evidence, particularly from sample surveys, focuses on small, and often unqualified, private providers operating within a weak public health system and regulatory framework (Montagu et al. 2016). In these circumstances, it is unsurprising that services seem to be inefficient. For example, average prescription drug costs in the private sector were higher than in the public sector for the same diagnosis in countries such as India, Tanzania, and Bangladesh, where public services are poorly resourced and regulation is weak (Morgan, Ensor, and Waters 2016). Delays in diagnosis caused by a lack of referral linkage between sectors further contribute to higher prices for service users. In their systematic review, Basu and colleagues found evidence that an absence of referral linkage between sectors and within sectors means that diagnostic investigations must often be repeated after referral because information is not passed between providers, resulting in high costs and low efficiency (Basu et al. 2012).

Private sector provider types and their effectiveness

The evidence comparing for-profit and not-for-profit private providers leads to mixed conclusions. Several studies (Leonard, Masatu, and Vialou 2007; Morgan, Ensor, and Waters 2016) suggest that decentralized decision making, combined with organizational objectives common to not-for-profit providers, enable them to deliver superior services compared with for-profit providers, even though the qualifications of practitioners are often lower than in for-profit private organizations. Results of a systematic review that explored the quality of private and public ambulatory health care in low- and middle-income countries suggest little difference between for-profit and not-for-profit private providers overall (Berendes et al. 2011). However, not-for-profit providers were better than for-profit providers in relation to structural quality (building equipment, material, drug availability) and quality of delivery (responsiveness but not patient satisfaction). In relation to technical quality, both for-profit and not-for-profit providers performed worse than public sector providers with respect to competence, whereas clinical practice was superior with for-profit private providers (Montagu et al. 2016; Liyanage et al. 2013).

The link between the organizational objectives of for-profit and not-for-profit private providers and quality, efficiency, and equity outcomes, and how this affects performance of a health system as a whole, is yet to be established (Grepin 2016). The size of private providers can affect provider performance (Halm, Lee, and Chassin 2002). Large facilities can share expensive items across many patients, provide larger numbers of similar cases to improve staff expertise, and enable health professionals to hone skills for the provision of better quality care (Das, Hammer, and Leonard 2008).

Health system factors affecting private sector performance

Several health system factors affect the functioning of the private sector as a whole: the structure and performance of the public health care sector, structure of the private sector, characteristics of patient demand for health care, and regulation of the private health care sector (Hanson and Berman 1998). The close links between public and private health care sectors mean they are likely to affect each other's performance and structure. Poor performance and lack of availability of the public sector, for example, create gaps in service provision that the private sector fills, often providing essential primary services to the population. This gap can be the result of low public health expenditure or low efficiency of public expenditure, leading to lack of capacity to provide services (Morgan, Ensor, and Waters 2016).

In Bangladesh, a shortage of qualified health care professionals in rural areas is a key reason why much of the population seeks assistance from unqualified allopathic providers (Ahmed and Hossain 2007). In Tanzania, the percentage of people using the private sector increases when public sector health care providers run out of drugs (Mikkelsen-Lopez et al. 2013). Private sector expansion, which has enabled small, cheap, and poor-quality facilities to grow in several sub-Saharan countries, is linked to high public sector user charges, as well as deregulation of private provision (Montagu and Goodman 2016). Conversely, Sri Lanka and Thailand show how higher, well-targeted public spending can create a more accessible and better quality public sector, restricting opportunities for private sector involvement mainly to higher-quality services for richer people (Sudhinaraset et al. 2013).

Trends in technology-assisted care

The advent of digital technologies of all kinds have become essential resources in primary health care, and their uptake is growing rapidly, with the past decade seeing an accelerated integration of technology in a range of areas that support primary health care and essential public health functions. The common use of technologies includes searching medical knowledge resources, facilitating clinical support, monitoring quality of care, and mapping and monitoring the spread of infectious diseases, as well as tracking medical supplies (Advisory Group on the Governance of the Private Sector for UHC 2019). The combination of rapidly increasing access to the Internet, low-cost diagnostic technologies, and evidence-based treatment guidelines are creating opportunities for improving health care (Bloom et al. 2017). Big Internet platforms are making substantial investments in digital health. New partnerships are emerging between the health and communications sectors and between government and the private sector (Bloom et al. 2017).

Private sector is also changing the way health care products and services are delivered to providers and consumers. The potential for e-commerce direct to consumer services and telemedicine may improve coverage of priority health products and services, while removing the connection to the traditional delivery models (Hansen Staples and Eldridge 2019). Digital health is challenging a historical focus on regulation. Governments (not just ministries of health) have an important role in ensuring that digital health meets the population's needs, rather than those of specific interest groups or of only the more affluent (Advisory Group on the Governance of the Private Sector for UHC 2019).

Trends and effectiveness of private sector engagement models

Global evidence provides encouraging and significant evidence of the overall impact of public-private partnerships on increasing the use of primary health care services, but there is an uneven increase across different services, and much depends on the PPP design (WHO 2016). Attention is increasingly turning to private sector interventions that encourage both private for-profit providers and not-for-profit providers to improve the quality and coverage of their care, while advancing their own interests (Montagu and Goodman 2016). These engagement approaches include social marketing, social franchising, accreditation, vouchers, and contracting (Montagu et al. 2016).

Evidence shows that social marketing and vouchers can increase coverage of targeted services and commodities in PHC settings, though there are clear limits to the types of interventions that social marketing can deliver, since it is unsuitable for even mildly complex services (Mackintosh et al. 2016). By contrast, robust evidence on the effect of social and commercial franchising, accreditation, and contracting is promising but less available; despite some positive outcomes in terms of broad areas of service availability and perceived quality of care, the literature has not documented strong evidence that they can improve technical quality of care (Montagu and Goodman 2016). For all these interventions, the evidence of their ability to reach poorer groups is weak, and little is known about their cost-effectiveness (Montagu et al. 2016).

With most private sector engagement interventions, key challenges are likely to be the expansion in both scale and scope. For example, vouchers might work well for a

targeted set of services, but would be hard to use for provision of health services more generally (Kramer 2017). Sustainability is also a concern, since strategies such as social marketing, social franchising, and vouchers require substantial continued subsidies, and are almost entirely funded by donors and implemented through NGOs and registered not-for-profit providers (DFID 2005). However, there are opportunities to combine innovative low-cost commercial franchising models with prepayment models for a reimagined PHC service delivery at scale (Montagu et al. 2016).

SECTION 4

BARRIERS AND MARKET FAILURES

Beyond scale, scope, and sustainability concerns, private sector engagement interventions face major barriers and market failures in advancing public-private partnerships in service delivery. These challenges are driven partly by the complexity and diversity of the private sector, a lack of conceptual clarity about the role of the private sector, and limited evidence base and institutional platforms for policy dialogue, among other factors (DFID 2005). These challenges are driven by interrelated market, system, and governance failures.

Market failures

A health care market that functions well will assure quality of services, deliver services in response to health needs, and ensure that poorer groups are well served (WHO 2018). The issues to be addressed, therefore, include not only the standard “market failures,” where allocation of goods and services is inefficient but also concerns related to inequity in distribution of income and information (WHO 2016). Market failures may manifest as issues of under- or overconsumption related to positive or negative externalities; imperfect information that can allow poor-quality providers to flourish or lead to insufficient demand for needed services; and principle-agent problems such as provider-induced-demand, when providers have perverse incentives and knowingly sell unnecessary or ineffective treatments (Montagu et al. 2016). Central to these market failures is asymmetry of information between consumers and providers in health care. For example, imperfect information not only leads to poor demand for services but in higher-income markets (with diagnosis-related group [DRG]-based financing mechanisms), it can cause cherry-picking that cripples public sector providers and limits patient choice, competition, and integrated care. In addition, in certain conditions, the blurring of the distinction with dual practice in public and private facilities may have negative effects. For example, physicians may attempt to transfer the most profitable patients from the public sector to their own private sector practice or order unnecessary, expensive tests to create a good personal reputation at the cost of overall public health care delivery (González 2005). As a result, many countries have sought to limit dual practice through regulation, either by implementing a complete ban or implementing restrictions on dual practice, with varying degrees of success. Turkey, for example, managed its challenges with dual practice by first increasing salaries and performance benefits for physicians to enhance productivity and performance, leading to physicians closing their private practice for public practice before a ban was subsequently implemented (Socha and Bech 2011).

System failures

The private health service delivery sector is highly heterogeneous and fragmented and very difficult to engage, with poor or highly variable quality of care. Issues related to inequities in access to quality care and limited efficiency and continuity of care have been widely documented (Kwan et al. 2018). The sector is also difficult to evaluate or survey as the data and information systems are not always easy to work with (Balabanova, Oliveira-Cruz, and Hanson 2008). The sector is favorable toward tertiary hospital care, increasingly monopolized by large, super specialty hospitals, at the

expense of primary health care (Advisory Group on the Governance of the Private Sector for UHC 2019).

Policy, governance, and regulatory failures

Obstacles to engagement include limited capacity on the one hand and a relative lack of incentives to engage on the other. In addition, there are reports of lack of trust between sectors (WHO 2018). In many LMICs, the government's enforcement and institutional capacity is limited, alongside poor coordination, dialogue, and engagement with the private sector (Dimovska et al. 2008). Many challenges surrounding conflicts of interest spawn corruption and are ubiquitous (Montagu et al. 2016). There are often policy gaps, as many countries do not have an explicit policy position on the private sector and health systems, and as a result there is no basis for establishing the means to steer and manage private provision (Montagu and Goodman 2016). There is a lack of clear and comprehensive standards and frameworks to guide a country's efforts to make and use effective regulatory and financing tools that steer private provision and mixed health systems toward universal health coverage (McPake and Hanson 2016).

SECTION 5

LESSONS AND IMPLICATIONS FOR UNIVERSAL HEALTH CARE

The evidence review highlights the limited evidence base for rigorously assessing most private sector engagement interventions. There is evidence that social marketing, contracting, franchising and vouchers can improve access and utilization, and some indication that franchising can improve quality, though the evidence across all of these program methods remains limited.

Returning to the four stylized private provider types on the basis of the three dimensions described earlier, the review provides insights into the appropriate engagement opportunities and responses that may be available to address their unique challenges in different contexts.

Registered for-profit and not-for-profit providers

Registered for-profit and not-for-profit providers, which are formally registered and run by qualified providers, might be good targets for private sector engagement mechanisms such as franchising and accreditation, which improve quality of care and achieve scale in some contexts. The increasing adoption of commercial franchising by for-profit private sector providers and investors offers a promising opportunity to address underlying sustainability and scalability issues experienced by social franchising providers. Although the academic basis for supporting franchised delivery of public health services remains limited, policy makers; program implementers; and a host of private, bilateral, and national funders are investing in commercial franchises for a growing range of services in a growing number of countries (Thurston et al. 2015; Montagu et al. 2016). The same dichotomy exists for contracting, voucher-based funding initiatives and accreditation programs. Accordingly, for registered for-profit and not-for-profit providers, two related solutions described below that prioritize scalable approaches may have a role in supporting relevant countries in transforming PHC delivery.

- **Broader-based solutions** potentially exist in the form of a combination of franchising, accreditation, contracting, and regulation. The implementation of broader-based combinations, responsive to different needs, is becoming increasingly feasible as incomes and capacity rise in low- and middle-income countries, and collective financing and purchasing can be used to effectively steer private sector development (Montagu and Goodman 2016).
- **Strategic purchasing** from these providers (from both profit and nonprofit providers) that use pooled public sources of funds offers some potential for governments to exert greater influence over both what is provided (range and quality of services) and under what contractual terms (to encourage efficiency and high quality). Strategic purchasing, which is the application of funds to ensure efficiency, adequate quality, and fair distribution of services to the population whether through public or private providers, is broader in its scope than contracting (Fidler 2014). It involves a systematic approach to establishing service entitlements, usually on the grounds of both equity and cost-effectiveness; choosing which providers to purchase from, taking into account both quality and physical distribution; and selecting a mode of contracting, including provider payment and other provisions that will encourage efficiency, equity, and continuous quality improvement (Montagu et al. 2016).

Registered not-for-profit providers have sometimes been contracted to provide specific services, such as family planning or reproductive health services, whereas in other settings they have been responsible for providing comprehensive primary care services, although often in only some parts of countries (e.g., urban services in Bangladesh, specific parts of Afghanistan and Cambodia) (Islam et al. 2018). Other examples of strategic purchasing in low- and middle-income countries are rare, but include the National Health Security Office in Thailand, which purchases for the universal coverage scheme, showing the capacity and willingness to use its authority to shape the health care system on behalf of the 70 percent of the population it covers (McPake and Hanson 2016).

Low-quality, underqualified providers

The strength, scale, and scope of low-quality, underqualified provision are established mainly by the effectiveness of the public sector in its provision of an accessible, affordable, and reasonable quality alternative. Regulation cannot effectively intervene when such providers are the only credible source of care for large populations, even in HICs where regulatory capacity is large. In such circumstances, an effectively subsidized health service that is recognized by users as being of adequate quality is needed (Morgan, Ensor, and Waters 2016). This solution can drive out the low-quality element of the private sector in a process of regulation by competition, sometimes referred to as beneficial competition (Mackintosh et al. 2016). Such an approach takes advantage of the effects of self-interest and incentives rather than control, and is therefore not reliant on external regulation or professional self-regulation that generally fails to impose rules against popular perceptions of self-interest of both providers and patients (Montagu et al. 2016). As part of this solution, although public (or donor) financing is crucial, several alternative mechanisms exist through which funding can be channeled to reasonable quality providers. The first is through a directly financed public sector. This approach has been adopted by a few low- and middle-income countries, including Sri Lanka and Thailand, which have both succeeded in ensuring universal access to a publicly financed and provided health system by crowding out low-quality, underqualified providers (McPake and Hanson 2016). Achievement of UHC requires pooled, mainly public financing, but can be compatible with various roles for private health providers, under effective public stewardship.

As most health financing in LMICs is out-of-pocket, broad-based solutions and strategic purchasing options that ensure patients get better value for money will be critical. Success in stewardship of the health system through the transition to universal health coverage in pluralistic health systems will require policies that recognize the links between the public and private sectors and work at the system level to improve performance throughout.

The review also highlighted the relative effectiveness of policies that are compatible with the financial incentives of providers, allowing them to pursue their own interests and objectives while at the same time achieving public goals. Together, these insights imply that government policies that support widespread availability of financially accessible and competent providers, whether public or private, have the greatest potential to ensure a public-private mix that services the population as a whole (Soderlund, Mendoza-Arana, and Goudge 2003). This approach operationalizes the notion of UHC within the realities of pluralistic health systems.

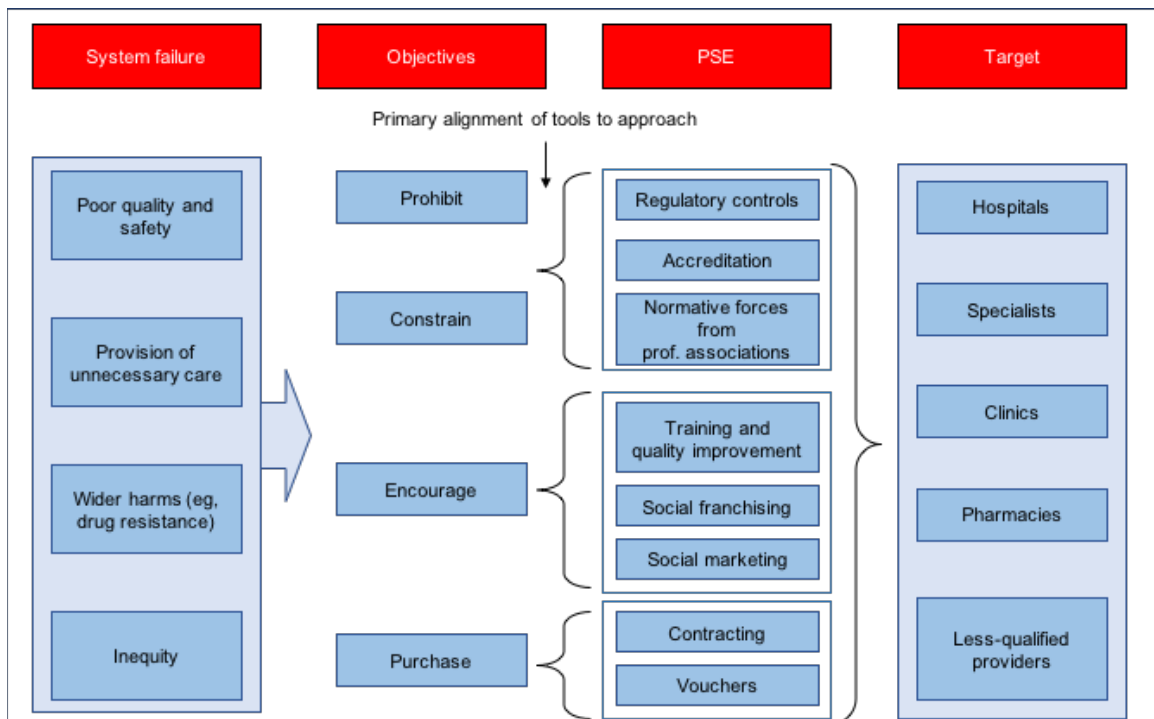
SECTION 6

ROLE OF PRIVATE SECTOR IN REIMAGINED PHC DELIVERY

As discussed in the evidence review, the choice of appropriate private sector engagement intervention to use in different HIC or LMICs will vary substantially, depending on the health system failures being addressed (different objectives with respect to their private sector engagement), the types of private providers available, and the level of a country’s development both in terms of income level as well as health system constructs, described earlier.

As a result, the role of the private sector in reimagined PHC delivery is relative to different country policy objectives on private sector engagement—meeting countries where they are in their respective pathways toward UHC (Advisory Group on the Governance of the Private Sector for UHC 2019). The private sector’s role should support countries in their transition toward a new primary health care paradigm. Four scenarios (or objectives) have emerged in the literature (Montagu and Goodman 2016) of country objectives for engaging with private providers, linked to patterns of failure in private provision and engagement models that may be applicable (see Figure 4).

Figure 4. Approaches and Devices for Private Sector Engagement in Service Delivery



Source: Adapted from Montagu et al. 2016.

Note: PSE = Private sector engagement.

Prohibit

This objective refers to attempts by countries to prohibit the activities of private providers, done through statutory control. An example is a formal ban on private practice. Bans on practice by unlicensed unqualified providers are often the most visible type of prohibition, but examples of failure are many (Montagu et al. 2016). In Tanzania, the banning of private providers during the presidency of Julius Nyerere, from independence in 1962 to 1985, forced them to practice undercover and within faith-based organizations but never eliminated private practice (Kumaranayake et al. 2000). Changes in the legal status of abortion services in many countries have forced women to, or away from, informal providers and their unsafe practices, but have had little effect on the overall number of abortions provided (Montagu and Goodman 2016). Examples of successful bans have also been documented, though rare in LMICs; they have been reported in strongly controlled socialist economies such as China and Vietnam (Montagu and Goodman 2016).

Constrain

This objective refers to attempts by countries to constrain the activities of private providers, most commonly through regulation. The term regulation is agreed to include statutory rules laid down by government, and also generally considered to include self-regulation and normative forces implemented by professional bodies (Lagomarsino, Nachuk, and Kundra 2019). Many studies emphasize the importance of thinking of regulation more broadly to encompass community accountability, subsidies, contracting arrangements, provider payment systems, accreditation, and quality improvement or assurance activities (Morgan, Ensor, and Waters 2016). Implementation and enforcement of statutory regulations are weak in many African and Asian settings, with some notable exceptions, such as South Africa and the Seychelles (Marten, McIntyre, and Travassos 2014). The regulations are often underdeveloped and outdated. The operation of unregistered hospitals and clinics is very common; in two Indian states these outnumbered those with formal licenses, and in Africa only 6 of 45 countries were reported to have a comprehensive registry of private facilities, with most lists incomplete and often inaccurate (Spreng 2011).

Grow or harness

This scenario refers to attempts by governments to provide positive incentives to encourage the private sector to increase access to key health care interventions or to improve quality, or to leverage the private sector to fill identified gaps (Harding 2001). Governments either encourage the private health sector to expand to increase access or the size of the overall health sector; or channel private health sector activities to perform specific identified activities or functions. To achieve its objective, governments in this scenario are likely to be open to adopting private sector innovation, technology, data infrastructure, and support services in the provision of PHC services, defining a potential role profile for the private sector.

- **The role of the private sector in this scenario** will therefore be expansive, complementary, and innovative. The private sector's role will include four prominent offerings:

- **Direct provision of quality health services** (e.g., physicians, pharmacies, primary health care centers, and referral hospitals), to offer access to greater service capacity. As a system progresses toward universal health coverage, the private sector could be involved as providers of publicly funded, high-quality promotive and preventive services for everyone (e.g., in the United Kingdom, where private general practitioners provide the universal primary care system; or in Bangladesh, where that role is increasingly delegated to nonprofit providers), or as providers of services beyond those of the basic universal entitlement—such a supplementary service seems to have made a significant contribution to the sustainability of Sri Lanka’s model (Govindaraj 2014).
- **A source of (service delivery) innovation and technology-enabled care.** The private sector can facilitate much needed innovation and technology in the provision of PHC services. To enhance the effectiveness of this role, governments in, for instance, Nigeria, Rwanda, and Kenya have facilitated the creation of private sector health innovation accelerators or health innovation market places to identify, nurture, connect, invest and scale-up promising PHC service delivery innovations and technologies.
- **Data intelligence and precision.** Information provision, use and data exchange, and driving data-driven precision public health (WHO 2018).
- **Support services and integration** through diagnostic centers, laboratories, and referral hospitals.
- **The private sector–engagement interventions** required to achieve the objective of this scenario may include social or commercial franchising, social marketing of commodities, private sector health innovation accelerators, among others.
- As described above, these engagement interventions may involve **registered for-profit providers, not-for-profit providers, and corporate commercial hospitals**; and aim to assure and improve the quality of care delivered through supply-side incentives and requirements (Morgan, Ensor, and Waters 2016). Alongside the aforementioned private sector engagement interventions, strategic purchasing arrangements can also be incorporated to incentivize volume, equity, efficiency, and quality-based purchasing that hold private providers accountable for patient outcomes and continuous quality improvement.

Purchase

This scenario refers to attempts by governments to purchase (or contract out) primary health care services from the private sector. In many instances, contracting arrangements are a recognition that private expertise can fill a specialized need better than government or allow more rapid expansion of service provision (WHO 2016). Contracts have also contained a range of financing, construction, management, and operations models for expansion of hospital infrastructure (and the provision of clinical services) in HIC and LMICs (Montagu and Goodman 2016). Contracting for all primary health care provision in a defined geographical area has also been implemented, most commonly in fragile and post conflict states (Paola 2019). In addition to directly contracting private services, governments can also indirectly purchase services by providing vouchers to users, which can facilitate targeting subsidies at a particular group, such as poor people. In a typical voucher program, donor or government funds are given to a targeted population for specific goods or services in the form of a voucher that can

be used at previously approved public or private providers, who are subsequently reimbursed (Kramer 2017). In some cases, voucher payment initiatives have been added to established clinic social franchises (Haemmerli et al. 2018).

- **To meet their objectives**, the countries in this scenario will have similar needs as described in the “grow and harness” scenario, but, additionally, may be more likely to seek value in (or to emphasize) private sector PHC management, financing and compliance management capacity, community accountability systems, and multi sectoral health interventions; alongside private sector innovation, technology, data infrastructure and support services in the provision of PHC services—also defining a slightly different role for the private sector.
- **The role of the private sector in this scenario** will therefore include the following types of offerings:
 - **Management (and organization) of primary health care** institutions and compliance systems;
 - **Data intelligence and precision**: Information provision, use, and data exchange; data-driven precision public health;
 - **Community engagement** and strengthening the citizen’s voice for accountability;
 - **Partners in multi sectoral health improvement**;
 - **Direct provision of health services** to offer access to greater service capacity;
 - A source of (service delivery) innovation and technology-enabled care; and
 - **Infrastructure and service delivery–financing** support.
- As described earlier, these engagement interventions (contracting and use of vouchers) may involve registered for-profit providers, not-for-profit providers, and corporate commercial hospitals.

Given the interdependencies described between the public and private sector, the role of the private sector in a reimagined PHC will require deliberate efforts to strengthen governance behaviors to ensure the private and public sectors work together to drive UHC in ways that promote equity, access, quality, and financial protection for the population (Advisory Group on the Governance of the Private Sector for UHC 2019).

As the world gradually contains the COVID-19 pandemic, there is a window of opportunity to break out of established paradigms and leverage a wide range of capabilities of private providers and corporates to curtail the epidemic and build a more resilient health system to prevent future pandemics. Private sector capabilities range from innovative data collection technologies to enhance disease surveillance: to supply chain management practices to improve the storage and delivery of essential health supplies; to their vast geographic presence and workforce to deploy personnel, resources, expertise, and infection control systems for emergency preparedness and response. Many private providers and companies are already engaged in these efforts. Engaging the private sector early and establishing structured relationships and alliances ahead of a crisis allow for faster, stronger, and more resilient responses.

SECTION 7

THE WAY FORWARD AND RECOMMENDATIONS

Stewardship and governance considerations

Effective stewardship of mixed health systems involves deploying policy mechanisms that create a level playing field for private and public health markets to achieve aligned goals while providing a strong state-led governance and enforcement infrastructure for health markets (Lagomarsino, Nachuk, and Kundra 2019).

The literature (Lagomarsino, Nachuk, and Kundra 2019) outlines three categories of stewardship mechanisms at the state's disposal for governing mixed health systems, particularly as it relates instruments that can shape and control the private health sector. The three categories are, as follows:

- **Regulatory and information provision–related policies** that assure and improve the quality of care delivered by public and private providers, while unlocking the market potential of the health sector. Information for regulation, such as a database of private providers, and monitoring and inspection systems, are essential steps (WHO 2016).
- **Financing policies** that support risk-pooling mechanisms, reduce OOP, and improve access to quality care for the poor and underserved.
- **Purchasing policies** that create performance incentives that encourage efficiency, equity, coverage, and continuous quality improvement (WHO 2016).

These mechanisms often operate alongside public sector health care delivery systems, with countries adopting various blends of direct government provision and stewarded private markets. Combined, they serve as useful tools to influence the performance of supply and demand of private health service delivery. For example, combinations of these three levers have contributed to better health outcomes and higher quality of care delivered in the private sector in a number of high-income countries (such as France, Japan, and Switzerland) and in an increasing number of middle-income countries (including Chile) (Stallworthy et al. 2014). However, although proven in HICs, these mechanisms have not been fully developed and enforced in most LMICs (WHO 2018) as a result of several constraints. The literature highlights four common challenges LMICs face:

- **Lack of data about health system participants and performance.** The limited information and visibility on private provider distribution, characteristics, services, and performance impede governments' ability to understand and regulate the sector. Health market fragmentation as well as private provider incentives related to avoiding taxation and formal administrative processes that may appear on the books compound data collection and integration challenges (Bennett et al. 2005).
- **Weak capacity for enforcing stewardship functions.** Limited compliance management, delivery, and execution capabilities as well as inadequate resources for regulatory enforcement dominate the cited institutional limitations in LMICs (Hozumi et al. 2008).
- **Corruption.** Perverse incentives exist in government regulatory systems that manifest in various forms such as kickbacks; these expose regulatory regimes to

behaviors that undermine the effectiveness of policies. Documented cases exist of policy and legislative capture using mechanisms that serve predetermined interests or when private providers pay bribes to regulators to overlook lack of compliance (Savedo, Kotalik, and Rodriguez 2006).

- **Failure to provide strategic direction and set a high priority for the stewardship of whole health systems.** Many LMICs fail to articulate a coherent long-term strategy, and set a priority agenda that informs the stewardship functions and regulatory architecture of whole health systems that help make progress toward public health goals (Balabanova et al. 2008).

Given the report's exclusion of financing-related technical areas, more guidance on regulation and information mechanisms pertaining to the private sector is provided, particularly as a substantial part of the literature has focused on private financing and purchasing mechanisms, with private sector regulation receiving less attention (Mackintosh et al. 2016).

Private sector regulation

As highlighted earlier, the private sector is confronted with several market failures, ranging from variable quality of care and products, high pricing of services, and inequitable distribution of providers, to dual practice of providers between the public and private sector, among other shortcomings. Perverse incentives related to supplier-induced demand leading to high cost or unnecessary diagnostics, procedures, and services have been widely reported (Kumaranayake et al. 2000).

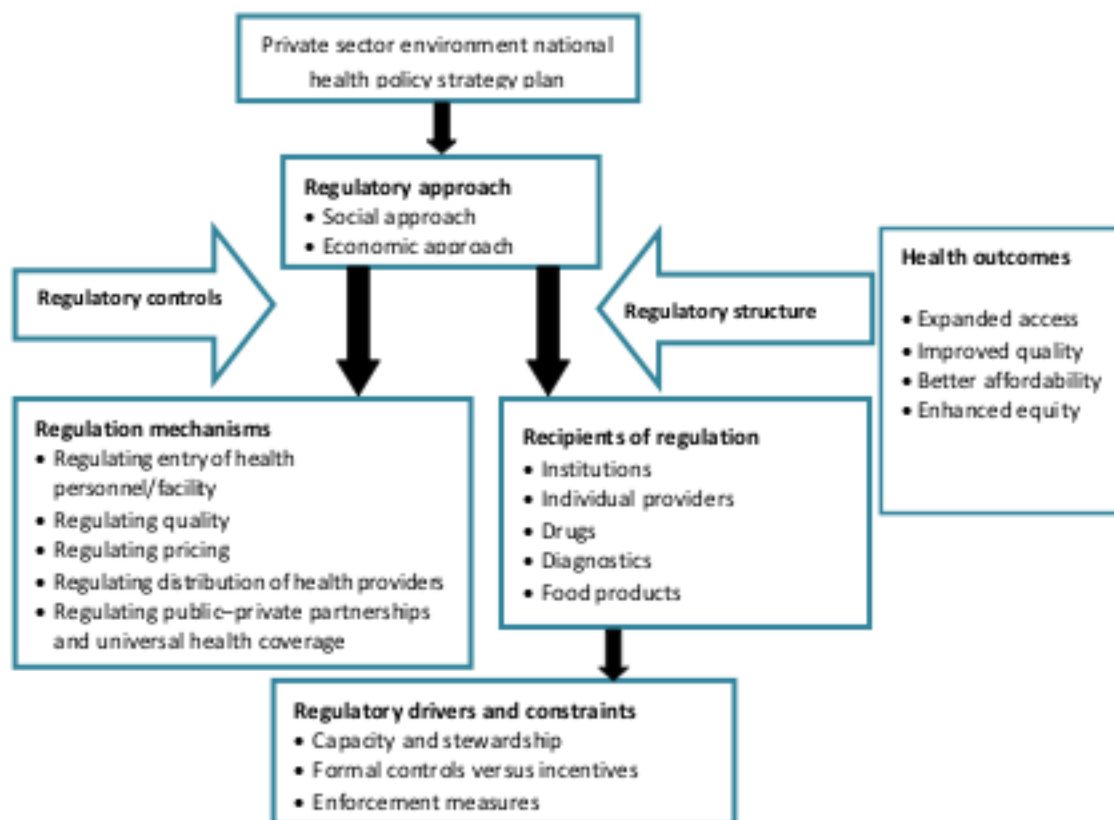
Regulation plays a critical role in preventing and addressing these failures, while steering the private sector toward quality universal health coverage goals of countries (Velasco 2013). In general, the regulation of the private sector typically involves the following functions (Lagomarsino, Nachuk, and Kundra 2019; WHO 2016):

- Setting standards for private and public providers and facilities;
- Monitoring, supervising, and enforcing adherence to standards and policies;
- Creating or reviewing legislation to define the entry, distribution, quality, and price control of providers;
- Testing and prototyping self-regulation and peer systems;
- Setting up regulatory entities backed by fiscal and human resource; and
- Undertaking licensing and accreditation initiatives and providing opportunities to build the capacity of providers.

These activities, commonly used in many HICs, are geared toward influencing the behavior of providers, particularly as it relates to the quantity, quality, price, distribution, and provision of services necessary to promote health system goals (Kumaranayake and Lake 2002).

Several published reports from the World Bank (Harding 2001) and World Health Organization (WHO 2016) have documented the essential building blocks of a private health sector regulatory framework, adapted in Figure 5. The regulatory framework reinforces the need for a balanced toolbox of sticks (controls) and carrots (incentives), enabling regulatory drivers, approaches, mechanisms, and structures (Harding 2001).

Figure 5. Regulatory Framework for the Private Health Sector



Source: Adapted from Kumaranayake et al. 2000; WHO 2016.

The literature in this area describes two types of regulatory approaches—the social and economic—that may inform the types of regulatory mechanisms and controls countries adopt. While the social approach prioritizes quality-related interventions, the economic approach focuses more on macro and health market issues such as quantity of private sector providers/facilities, distribution of providers, fees charged for services, reimbursement or payment incentives, and fiscal policy and access to capital issues that, if addressed, can unlock the market potential of the private health sector (Kumaranayake 1997). Economic regulatory approaches have received relatively less attention in LMICs but have been a core piece of policy innovations and private health market reforms in more established economies (Preker and Harding 2001).

Beyond the government-led regulation described, self and peer (network)-based governance mechanisms are also increasingly being tested and adopted in both HIC and LMICs (Lagomarsino, Nachuk, and Kundra 2019). Private providers can use various methods and structures to self-organize into networks that establish peer-based rules of engagement, including establishing quality standards and developing inspection and enforcement feedback systems to facilitate compliance (Balabanova et al. 2008). Such governance arrangements come with various types of benefits, including higher demand for services, linkages with health insurance schemes, access to cross-referrals, as well as opportunities for knowledge-sharing with a trusted group of other providers (Lagomarsino, Nachuk, and Kundra 2019). Providers may also be motivated by their desire to maintain and enhance their reputation. These types of networks can be self-

imposed through professional associations and private sector federations, or by integrated delivery organizations. For example, social or commercial franchisors establish operating systems and standards and take responsibility for monitoring their franchise members (Bishai et al. 2008).

Recommended actions

Based on findings of the literature and desk review conducted, this report summarizes several recommendations for overcoming barriers that countries face in stewarding the private sector of their health systems and steering public-private partnerships to support reimaged PHC systems. Four actions are recommended as a starting point:

- Building data intelligence;
- Developing strategic policy direction and blueprint for mixed health system stewardship;
- Strengthening stakeholder platforms for dialogue; and
- Catalyzing innovative service delivery models.

Building data infrastructure and intelligence

For governments to design and implement health interventions that align with their health priorities, governance institutions will need to be guided by systematic information about the capabilities, activities, distribution, characteristics, and performance of private health care providers. Information about key aspects of private health markets such as quality, quantity, scope of services, mortality and morbidity patterns, health service utilization, and price is critical in supporting governance institutions to regulate and shape health markets effectively and ensure more equitable access to quality care for all populations.

Many HICs invest in their health data infrastructure and routinely collect information on private providers or their patients. For example, in France, the National Agency of Accreditation and Evaluation in Health collects information about the operations and performance of public and private facilities, while in the United States, the Joint Commission on Accreditation of Health Care Organizations collects and assesses information on adherence to quality standards for nearly 19,000 facilities (Harding 2001). However, many LMICs do not collect information on private providers and are therefore unable to leverage the strengths of the private sector or address market failures associated with private provision.

In most cases, the government must take the lead in coordinating such data collection efforts and build mechanisms and incentives for the ongoing collection of health market data to develop sound stewardship policies (Balabanova et al. 2008). For example, in the United Kingdom, the regulatory infrastructure places the burden and cost of data collection on the private provider. If a private provider wants a license to operate, he/she must be willing to provide relevant information on request. In Nigeria and Ghana, one of the requirements for private facilities to renew their licenses to operate includes meeting data reporting compliance rates to the government's health management information system.

Strengthening the supply and demand for private sector data collection is also an area where donors could make a significant contribution in the short term, as a key first step in countries' private sector data reform (Lagomarsino, Nachuk, and Kundra 2019). Generation of private health market intelligence and building a common understanding through information provision will support consensus on the potential benefits of engaging more effectively with private actors and the problems that government interventions can prioritize and address (Advisory Group on the Governance of the Private Sector for UHC 2019). Building a shared understanding among public and private sector stakeholders will need reliable information on current and future trends in health system performance, and clear alignment on the experiences, opportunities, and challenges that private providers face, and on institutions available for influencing provider performance (Advisory Group on the Governance of the Private Sector for UHC 2019).

Data intelligence can come from studies conducted from a multiplicity of perspectives ranging from provider mapping, household surveys, facility-based surveys, and patient exit surveys to direct submission of operational data by providers—to track volume and types of services provided, disease surveillance data, and quality data, etc. (Lagomarsino, Nachuk, and Kundra 2019).

Developing strategic policy direction and blueprint

Following investments to collect evidence and private health market data, a series of actions to develop a vision of a desired state for the overall health system and distill priorities for private sector reforms are important for providing an agreed sense of direction and an appropriate stewardship model.

Governments, alongside private sector actors, must jointly identify policy options and funding needed to support these directions and to co-design strategies (interventions) that steer the private sector toward UHC. The private sector also requires such policy and strategy visibility to plan, commit, and support its own investments (Advisory Group on the Governance of the Private Sector for UHC 2019). In addition, efforts should be made to ensure that local experts have the capacity to support the implementation of interventions; and to utilize a process of reform in which initial success informs and strengthens coalitions, enabling further steps to scale up these interventions (Widdus 2003; Morgan, Ensor, and Waters 2016).

Key components of the blueprint may include health system goals and objectives, clear definition of roles, identification of policy instruments and institutional arrangements, guidance for prioritizing health expenditures, and outlines of feasible strategies and of arrangements to monitor performance (Marten, McIntyre, and Travassos 2014; Advisory Group on the Governance of the Private Sector for UHC 2019). The exact policy choices and private sector engagement strategies will vary across countries and will be determined by the context, including financing and delivery arrangements, skills and capacities, and the political economy of governments (Montagu et al. 2016).

Strengthening platforms for engagement

Creating or strengthening forums, platforms, or structures for systematic public-private dialogue, and communication and collaboration between sectors is important in building

trust, and in forming working relationships that advance the co-development of policies and implementation of market interventions (Spreng 2011). Given the complexity of health market failures, governments may be unable to manage mixed health systems on their own. The role of intermediary platforms that include public and private stakeholders in complementing more formal arrangements to build consensus, secure buy-in, exert influence, and achieve aligned policy objectives has been widely documented (Kumaranayake 1997; Balabanova et al. 2008). Intermediary platforms for private providers, for example the health care federations in African countries (Nigeria, Kenya, Ethiopia, Uganda, and others), are playing key roles in helping professionalize the private sector, and becoming a trust-building platform for continuous engagement with government counterparts (Advisory Group on the Governance of the Private Sector for UHC 2019).

Key activities undertaken in establishing effective intermediary platforms include enabling the setting-up of joint taskforces; building self-governance mechanisms and routines for communication and dialogue between state and private sector; including private sector in setting national health policies and strategies; and jointly setting up targets for PPPs and compliance-management processes. The rules of engagement for such platforms typically require delineating what each actor must do; how he/she must do it; and by whom and for whom. This covers several components, including the following:

- Mobilizing public and private stakeholders to determine the appropriate structure to avoid overlap, clearly separating functions and ensuring that communication channels are established between the functions (Advisory Group on the Governance of the Private Sector for UHC 2019);
- Exercising the powers to guide the behavior of different actors, and ensuring fit between policy and organizational structure and culture (Stallworthy et al. 2014); and
- Ensuring that accountability systems are put in place to foster trust in public-private relationships (Montagu et al. 2016; Advisory Group on the Governance of the Private Sector for UHC 2019).

Supporting the scale-up of private sector engagement models

Innovative service delivery models that can address the need for access, affordability, and quality at scale are important levers for transforming primary health care systems and achieving UHC. As part of these efforts, many HICs and LMICs have experimented with innovative PHC organizational and delivery models as well as information and communications technology, and reported gains that could serve as catalysts for broader PHC system wide improvement.

Curated learnings of promising innovations in HICs emphasize advances in a number of innovative PHC organizational and delivery archetypes (Shortell, Gillies, and Wu 2016; WHO 2019; Angeli and Anand 2016). They are generally characterized by the following types of features:

- Service delivery innovations that adopt e-health and digital technologies to improve networking and data sharing, thus enhancing efficiency, quality, coordination, and effectiveness of health care provision (Advisory Group on the Governance of the Private Sector for UHC 2019).

- Innovations in health financing that range from the implementation of social security and health insurance schemes with basic benefit packages; models that offer incentives to GPs to improve their performance, to innovative financing programs that target poor and underserved populations (Dimovska et al. 2008).
- Innovations to enhance management of PHCs that revolve around building business management capabilities, restructuring roles and responsibilities between institutions and GPs, contracting self-employed family doctors to extend service availability (WHO 2016).
- Innovations to empower individuals and communities that enable patients to choose their care providers and take a more active role in their health and well-being (Shortell, Gillies, and Wu 2016).
- Structural and administrative innovations that devolve decision making to levels of government, closer to the populations they serve (Angeli and Anand 2016).
- Integrated service delivery structures, such as coordinated patient-centered PHC services, that ensure the continuum of care, using interdisciplinary teams at different levels to deliver services at facilities and in communities (WHO 2019).

Countries such as China and the United States, have been implementing different combinations of these innovative features, with some success (WHO WPRO 2018; WHO, Office for the Western Pacific 2018; Shortell, Gillies, and Wu 2016). In China, important examples of PHC-oriented reforms are the County Integrated Healthcare Organization (CIHO) in Anhui Province, which focuses on integrated, people-centered health services for rural areas using multidisciplinary teams, and the Joint Management by Three Professionals (JMTP), which is a tiered integrated health service delivery approach to chronic disease management. To achieve “more health rather than more treatment” (World Bank 2016), the goals of both the CIHO and JMTP programs are to encourage patients’ use of community-level resources and to strengthen the delineation between levels of care (WHO, Office for the Western Pacific 2018), reinforcing two-way referral systems. The models have also been expanded into other health insurance and national essential public service package funds, providing a notable example of a successful prepaid capitation system (China Joint Study Partnership 2016).

In the United States, parts of Europe, Australia, Canada, New Zealand, and other developed countries, a number of new approaches to health care delivery and comprehensive population health management are commonly cited. They include the following:

- **Patient-Centered Medical Home (PCMH)**, which provides patients with a primary care provider and a multidisciplinary team that can deliver personalized, whole person, coordinated care across conditions, providers, and settings over time (Goldberg and Kuzel 2009; Shortell, Gillies, and Wu 2016).
- **Accountable Care Organization (ACO)**, which ties provider reimbursements to cost and quality of care provided to a defined population of patients, provides data on performance, and creates shared savings. This is particularly well-suited for accepting capitation and specific episodes-of-care–based payments (Hawnwan, de la Torre, and Varacallo 2020).
- **Population Health Management System (PHMS)**, which involves the development of cross-sector organizations or networks that collectively take responsibility for population health and pool together multi-sectoral actors to enhance population health (PHCPI 2020).

The extent to which these innovations in HICs can be brought to scale will depend on a combination of strong financial incentives, enhanced primary care capability, continuing advances in performance measurement and accountability, and local leadership (Shortell, Gillies, and Wu 2016).

As described earlier, particularly for LMICs, broader-based private sector service delivery solutions in the form of various combinations of franchising, vouchers, accreditation, contracting, regulation, and strategic purchasing are becoming increasingly feasible and relevant (Mackintosh et al. 2016). The private sector engagement models typically target five areas that address some of the failures of health markets in LMICs (Lagomarsino, Nachuk, and Kundra 2019; Stallworthy et al. 2014). They include the following commonly cited interventions:

- Interventions that reduce health market fragmentation include franchising, professional associations, provider networks, and integrated delivery models (such as hub-and-spoke models) (Aiyenigba et al. 2016).
- Interventions that change the incentives of private providers to monitor the quality of care delivered. For example, accreditation or licensing through professional associations, franchises, and any demand-side financing payment scheme (e.g., insurance, vouchers, pay-for-performance mechanisms) coupled with purchasing mechanisms to improve quality (Balabanova et al. 2008).
- Models that provide subsidies for specific interventions or populations, such as subsidized public and private insurance and vouchers, that can increase both demand and supply for effective interventions (Montagu and Goodman 2016).
- Interventions that increase patient demand for effective care, for example, social marketing, leveraging rural cooperatives and other existing community structures, and trusted knowledge brokers (citizen report cards, citizen complaint lines, consumer associations) (Lagomarsino, Nachuk, and Kundra 2019).
- Technological innovations such as telemedicine, mobile diagnostic devices, and health care kiosks—many pioneered by private social entrepreneurs—that provide more efficient, higher-quality and more consistent care to hard-to-reach populations (Lagomarsino, Nachuk, and Kundra 2019).

Most of these private sector service delivery solutions and innovative models are already being piloted or scaled up in many LMICs. Social marketing and social franchising are probably the most common service delivery models (Morgan, Ensor, and Waters 2016). Both techniques rely on onboarding large networks of health care providers to expand coverage and to leverage economies of scale to enhance access to care. For example, Population Services International (PSI) franchised over 14,000 existing clinics in Pakistan to ensure high-quality maternal, child, and family planning services, which it monitors with anonymous clients, and facilitates through ongoing standardized training (Thurston et al. 2015). Clinics that meet standards receive the PSI-sponsored Greenstar logo, and this branding assures consumers of the clinic's quality. Greenstar has been successful in expanding access and is currently distributing an estimated 30 percent of all contraceptives in Pakistan (Thurston et al. 2015; Dimovska et al. 2008).

Governments and donors have important roles to play in facilitating the systematic documentation and monitoring and evaluation of innovative private programs, while also supporting networks of implementers of similar programs and health innovation accelerators, so common challenges and best practices can be identified, curated, and jointly addressed (Spreng 2011).

SECTION 8

CONCLUSION

Given the complexity of health markets in many HICs and LMICs, governments should consider how they can become better stewards of these markets. Aspects of health markets that contribute to key goals should be nurtured, and those that detract should be mitigated through regulation (Kumaranayake and Lake 2002).

As a result of the heterogeneity of the private sector, different stewardship mechanisms, governance behaviors, and recommended actions—including building data intelligence, developing strategic policy direction and blueprint, strengthening stakeholder platforms for dialogue, and catalyzing innovative service delivery models—would have to be prioritized for different groups. Countries will need to focus on developing different regulatory mechanisms, behaviors, and actions relative to the maturity of their health systems and on the role of the private sector that is fit for purpose in a reimagined PHC ecology.

It is expected that the work on private sector governance should also strengthen governance in the public sector to collectively deliver on the realization of UHC and PHC transformation (Advisory Group on the Governance of the Private Sector for UHC 2019).

This discussion paper offers a useful footing upon which the World Bank can orient and engage clients interested in private health sector engagement in the context of a renewed PHC delivery model, and support the related investment and lending activities to advance PHC reforms at the country and state levels.

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As World Bank Group Health, Nutrition, and Population (HNP) General Practice undertakes a strategy refresh anchored in a reimagined primary health care (PHC) agenda as the foundation for achieving universal health coverage (UHC), a knowledge product that examines the potential role of the private sector in transforming PHC delivery and shaping health markets is timely and relevant.

As PHC is being repositioned in the global health care ecology, the discussion paper provides a comprehensive review of promising private sector PHC service delivery models, and highlights recommended actions that can steward the contributions of public and private health actors toward achieving UHC goals.

The private sector plays a significant role in health care provision globally, and the opportunity to harness the private sector to reorient PHC delivery is driving a renewed interest in scalable private sector delivery models to advance UHC. Although essential information on private sector models is limited, a review of the available evidence of private sector interventions (such as franchising, contracting, accreditation, and regulation), has been conducted to understand lessons and transitions emerging to inform how governments can potentially develop more effective private sector interventions that are aligned with their UHC goals.

Using established typologies, the paper defines the role of the private sector relative to the different country policy objectives on private sector engagement, relevant health market failures being addressed, private sector constructs in mixed health systems, and the level of development of the country in terms of income levels.

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This series is produced by the Health, Nutrition, and Population Global Practice of the World Bank. The papers in this series aim to provide a vehicle for publishing preliminary results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual author/s whose name appears on the paper. Enquiries about the series and submissions should be made directly to the Editor Martin Lutalo (mlutalo@worldbank.org) or HNP Advisory Service (askhnp@worldbank.org, tel 202 473-2256).

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