# Private health sector engagement in the journey

# towards Universal Health Coverage

## Landscape Analysis – DRAFT

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## Executive summary

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

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

**Our findings indicated a general recognition of private health sector's role in achieving population health goals, but specific policies on private sector engagement and formal dialogue mechanisms remained uncommon.** Regarding **information exchange**, a majority of the countries established systems for collecting information from the private health sector with limited information on private pharmacies, although challenges on implementation were commonly described and levels of reporting varied among reporting systems. In the domain of **regulation**, all countries have administrative and bureaucratic regulation systems to control the entry of new private health providers to ensure minimal standards and training are met in both medical and pharmaceutical services provision, and some also linked specific requirements with financial mechanisms for cooperation. About a third of the countries also have regulation on pricing of medical services and/or medications. Despite the existence of regulation, enforcement appears to be a challenge in most countries. The **financing** domain described mechanisms of strategic purchasing of private health services in leveraging service provision to meet population demands. Contracting was the most common mechanism in financing private health services, while less have experience in voucher scheme financing to reduce financial barriers for disadvantaged populations. As most countries have a public insurance for healthcare, only half provided partial coverage for services

DRAFT

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

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

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## Background

The private health sector has been an important source of health service delivery in low- and middle-income countries (LMICs). Almost all countries have mixed health systems, with service provision from both the public and private sectors. A large proportion of populations across LMICs in different regions obtain services from a wide range of private health sector, including for profit, non-profit, formal, or informal entities of various scales. Although the extent of private service provision and types of services vary by country (Grépin, 2016; Guo *et al.*, 2019), studies found private health service utilization is common for a number of key health services, including treatment for childhood illness and reproductive health services (Campbell *et al.*, 2016; Grépin, 2016).

As countries progress towards universal health coverage (UHC), the private health sector's involvement in provision of health services cannot be overlooked given the significance of private health sector's scale and scope in the health services provision in LMICs. Despite the heterogeneous and complex nature of the private health sector, concerns of the high out-of-pocket payments and the lack of quality control in private health sectors have been major considerations in the goal of universal health coverage (Basu *et al.*, 2012; Guo *et al.*, 2019). Additionally, access to referral services to ensure efficient patient care pathways in LMICs are challenging, particularly with the diverse private health sector (Pittalis, Brugha and Gajewski, 2019). The three dimensions of UHC: ensuring coverage, access, and financial protection, are unattainable without effective governance of the private sector (Morgan, Ensor and Waters, 2016; Clarke *et al.*, 2019; Nabyonga-Orem, Nabukalu and Okuonzi, 2019).

The importance to engage and promote effective partnerships across public and private health sectors has been recognized by policy analysts, governments, and international organizations over the last two decades (Bennett, McPake and Mills, 1997; Mills *et al.*, 2002; The World Bank, 2003; Peters, Mirchandani and Hansen, 2004; Bennett *et al.*, 2005; Lagomarsino, Nachuk and Kundra, 2009; The International Bank for Resconstruction and Development / The World Bank, 2011; Mackintosh *et al.*, 2016). Over the years, various strategies and approaches have been developed for effective public stewardship of mixed health systems to work with the private health sector, ranging from prohibition to encouragement of the private health sector (Peters, Mirchandani and Hansen, 2004; Montagu and Goodman, 2016). While public-private partnerships have been more commonly practiced on specific disease control and vaccine programs (The International Bank for Resconstruction and Development / The World Bank, 2011; M., 2014; Lei *et al.*, 2015), the level of formal engagement with private health sector in the provision of general health services remains unclear.

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

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

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## Scope of the landscape analysis and limitations

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

This approach has several limitations. Not all official country documents from the 18 countries were available online and some country portfolios and program documents available on the web may not be the most recent version. Although efforts were made to identify the most recent official documents through searching the country's government and Ministry of Health website, we were unable to verify if the latest version of the document was accessible. Additionally, this approach enabled the assessment of only documented private health sector engagement implementation from primarily from government and some developmental agencies' perspective, which were public statements of engagement with private sector from the governments' viewpoint. Additionally, these country documents and reports predominantly cover the formally recognized private health sector. As such, informal private health sector functioning outside government's regulatory systems is generally not represented in this landscape analysis. While the documentation review allows identifying the extent of private health sector engagement in government plans and policies, specific in-country context, degree to which such process have been successful in improving access to appropriate services, and programmatic challenges of private health sector engagement in practice is beyond the scope of this document.

## Defining key terms

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

*Private health sector* is defined as all non-state providers of health services, which includes for-profit (both formal and informal) and not-for-profit (NGOs, faith-based organizations, community-based organizations), domestic or international entities (Clarke *et al.*, 2019). As such, the private health sector is heterogeneous and can include providers who are unqualified or underqualified (McPake and Hanson, 2016).

*Service delivery* involves provision of effective, safe, good quality personal and non-personal health care. These services may include primary, secondary, or tertiary care. Service delivery may involve physical interaction between a patient/client and a health care provider, and also includes 'virtual' health services such as digital health and telemedicine (Klinton, 2020).

*Health service providers* may be trained (pharmacists, doctors, nurses, and midwives) or informally trained; may work on their own or in institutions and may provide health care or other health products such as drugs and contraceptive supplies. This document focuses specifically on health service providers who directly interact with service users and supply them with health care services or medicines. Two additional groups of actors have important roles but are not considered here as part of the private health sector: intermediaries or third-party organizations, such as insurance authorities, or civil society organizations; and donors, who play an important role in financing health programs and influencing health policy indirectly (The International Bank for Resconstruction and Development / The World Bank, 2011).

*Governance* is defined as "how societies make and implement collective decisions" (World Health Organization, 2016). While governance is a broad concept, the governance function generally

DRAFT

"characterizes a set of processes (customs, policies or laws) that are formally or informally applied to distribute responsibility or accountability among actors of a given [health] system" (Barbazza and Tello, 2014). Good governance is also described as involving subfunctions that ensures "that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability" (World Health Organization, 2007).

*Private sector engagement (PSE)* refers to "a partnership between the public and private sectors to achieve a specific goal" (World Health Organization, 2018), direct interaction between the state actors and the private sector, as well as private to private collaborations that are properly regulated. In general, there are three broad categories of private sector engagement: including private actors in developing public health policy; development of ownership and contractual arrangement; and influencing behavior of private sector actors.

*Public Private Partnerships (PPPs)* are "a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance" (The World Bank, Asian Development Bank and Inter-American Development Bank, 2014). PPPs encompass a wide variety of arrangements and vary in the scope of services covered in the health care sector. A critical element of PPPs is the sharing of risk between the private party and the government, which depends upon the level of capital committed by the private party, length of partnership, provision for renegotiation, and the structure of payment mechanisms (Independent Evaluation Group, 2016).

*Public-Private Mix (PPM)* "encompasses diverse collaborative strategies such as public-private (between national disease programmes and the private sector), public-public (between national disease programmes and other public sector care providers such as general hospitals, prison or military health services and social security organizations), and private-private (between an NGO or a private hospital and the neighborhood private providers) collaboration" (World Health Organization, 2020). PPM is commonly used for some disease areas such as tuberculosis.

## Methodology

This landscape analysis focuses on top three countries with highest overall utilization of private health providers in each of the six regions of WHO (a total of 18 countries). These countries were identified based on findings from Montagu and Chakraborty (Table 1) (Montagu and Chakraborty, 2020). Data on health system characteristics were obtained by online search of official databases: The World Bank, WHO and Regional Offices websites, International Health Metrics Evaluation. Additional searches were conducted to identify private sector representative bodies by searching the grey literature using keywords: "healthcare federation", "health association", "private health association", or "private medical association". Peer-reviewed literature search was also conducted to supplement the official documents and grey literature search.

To assess the most recent status of private health sector engagement in each country, three types of documents were specifically searched using WHO and Regional Offices database, government, and Ministry of Health

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

*Table 1 List of countries included in the landscape analysis*

DRAFT

(MOH) websites: 1) national policies, national

health strategy, or national health plan, 2) specific health program strategies, plans, or guidelines (e.g. immunization, malaria control and treatment) published by the government, and 3) health system reviews and private sector assessments of each country conducted by WHO or USAID. A peer-reviewed literature search was conducted using Medline database to identify relevant studies conducted between 2010 and 2020. Only articles available in English were reviewed and the most recent documents were used for the analysis.

We used the World Bank/International Finance Corporation's private health sector engagement assessment framework to analyse the patterns and extent of private health sector engagement across five domains: policy and dialogue, information exchange, regulation, financing, and public production (modified as engagement in vertical services provision) (The International Bank for Resconstruction and Development / The World Bank, 2011). The overall assessment framework and the indicators are listed in Appendix 1. When applicable, relevant examples from high-income countries (HIC) are described in the corresponding section. Information from HICs were obtained from health system reviews, similar to the methods described above for LMICs.

Table legend:
Green – documentation / policy exists, yellow – weak evidence, red – no regulation / system exists, grey – no relevant information found, white – no document found to obtain the information.
"-" – Information cannot be translated.

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## Policy and Dialogue

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

*Table 2: Overview of po*

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

Most countries in the analysis have identified the importance of involving the private health sector in their national health plans or policies. While the extent of private health sector being mentioned differed by the countries, almost all of the 18 countries (2 countries could not be determined) included private health sector in specific objectives in their national health plans. Almost half of the countries also

**Example from Uganda**

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

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

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

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

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engaged the private health sector in the development of such objectives and outlined the role of private health sector in achieving their national health goals. However, only a few countries have further established a formal partnership framework in the health sector to facilitate sector-wide implementation. Of the 18 countries, only Uganda, Nigeria, and Philippines have a designated policy to public-private partnership in the health sector (not including specific disease-focused program). Among the three countries, Uganda has the longest history of interest in public-private partnerships (PPP) in health since 1995 and established a PPP working group which operated under the Health Policy Advisory Committee to implement and monitor the national strategic plans (Government of Uganda, 2012). Besides the country's non-sector specific PPP Act, in 2012, Uganda's Ministry of Health has established a health-sector specific PPP policy that modified and adapted the PPP Act to the health sector and described the areas that the Ministry of Health would work with the private sector (O'Hanlon, Nakyanzi and Musembi, 2017). Nigeria's PPP policy in health articulated various aspects of PPP, including financing for different forms of PPP for health, provision of care in PPP, as well as crafted the regulatory framework, but the challenge of forming effective partnership remains (Okafor, 2016). Although the PPP policy in health provided the general framework, implementation of forming effective partnerships requires continual strong coordination of different stakeholders in the health sector and has not been documented in most countries.

## Information Exchange

| Country | National Health Information System that includes private providers | National Health Information system that includes private pharmacies |
|---|---|---|
| Uganda | | |
| Nigeria | | |
| Eswatini | | |
| Egypt | | |
| Pakistan | | |
| Jordan | | |
| Albania | | |
| Kyrgyzstan | | |
| Armenia | | |
| Mexico | | |
| Suriname | | |
| Dominican Republic | | |
| India | | |
| Indonesia | | |
| Bangladesh | | |
| Cambodia | | |
| Lao PDR | | |
| Philippines | | |

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

Note: No data was available on information flow from government to private health sector

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

Despite the recognition of the importance to engage private health sector in national health plans and policies, countries varied in their level of information exchange with private health sector. About two-thirds of the countries have national health information systems that collect routine information from both public

DRAFT

and private health providers and countries mandate private health providers to report health information. However, there was a wide range of level and completion of reporting from private health providers among these countries. To improve compliance and the ability to regulate reporting, some countries linked submission of facility reports with license renewal for private health facilities and required submission of missing reports prior to renewal of the health facility license. However, incentives for compliance from the private sector is uncommon, unlike some high-income countries such as the example from New Zealand (World Health Organization, 2014; Payne *et al.*, 2019).

**Health Information Service in New Zealand**

- Following the first ministerial strategy for health information in 1991, the New Zealand Health Information service was established in 1992. The information service included three major components:
  i. National Health Index (NHI) – a unique patient identifier
  ii. National Minimum Data Set (NMDS) – national data on public and private hospital discharges.
  iii. National Statistics
- The well-developed information technology systems, the highly computerized General Practitioner (GP) practices and the widespread use of electronic medical records are all in favor of the success of the information system. In an effort to support the GPs in purchasing computers and complying to the electronic claiming procedures, the government offered NZ$ 5000 to the GPs in 1998. This increased the utilization of computerized billing and appointment systems and had reached 100% by 2008.

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

Level of reporting also differed between types of information systems. For instance, the private sector in Jordan reported only to notifiable disease of epidemic prone nature, but not to other communicable and noncommunicable diseases (Cairo: WHO Regional Office for the Eastern Mediterranean, 2019), while majority of private providers in Swaziland reported to the health management information systems and less reported to the immediate disease notification system (Bennett *et al.*, 2017). Furthermore, systems and regulations for routine private sector reporting remained lacking in a few countries (Sychareun *et al.*, 2014; Bhattacharyya *et al.*, 2016; World Health Organization, 2017), resulting in informal and unsystematic data sharing, as well as a lack of integration in the public health information system (Bhattacharyya *et al.*, 2016). In Suriname, the national health sector plan in 2011-2018 described the objective "to strengthen the national health information system to generate, analyze, and utilize reliable information from public and private sources" (Suriname Ministry of Health, 2011). While it was unclear if the plan has been fully implemented, national surveillance of reported diseases acquired cooperation of private clinics and specific services such as vaccination coverage was reported by private clinics.

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

It is important to recognize that countries may have multiple disease specific surveillance and monitoring systems besides national health information system and notifiable disease reporting, such as TB, malaria, and HIV. Some of these parallel disease-specific monitoring platforms may result in fragmentation due to differences in reporting forms and systems. Common barriers of private health providers reporting to national health information systems include being cumbersome process, lack of incentives, and lack of training

**HMIS in Cambodia**

- The Ministry of Health of Cambodia launched a web-based reporting and access, Health Management Information System (HMIS) in 2010. Providers from the public and the private sector who had internet access were able to enter data directly, whereas those without internet connections submitted returns on paper.
- The attributes of HMIS that contributed to a reporting rate close to 100% were:
  a. Single system for all routine health data
  b. Standardization of the set of forms across all levels
  c. Retaining the design from the past
  d. Reliability in completeness and timeliness of data
  e. Computerization for most health facilities
- The validity and reliability on the HMIS data are both high and is reported to be within 5% of the results of household surveys.
- The data from HMIS is used for routine reviews, provincial planning and budgeting

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

DRAFT

provided to private sector staff in the reporting systems (Buchner *et al.*, 2019; Tan *et al.*, 2019; Wandera *et al.*, 2019). While efforts have been made to reform health information systems towards web-based platform and collection of individual-level data to facilitate data integration across many LMICs, a comprehensive review of progress and compliance to the information standards across different health information systems by private sector should be explored.

## Regulation

| Country | Standardized registration and regulation of private providers | Standardized registration and regulation of private pharmacies | Regulation on Service pricing | Regulation on Drug Pricing | Enforcement of Regulation |
|---|---|---|---|---|---|
| Uganda | | | | | |
| Nigeria | | | | | |
| Eswantini | | | | | |
| Egypt | | | | | |
| Pakistan | | | | | |
| Jordan | | | | | |
| Albania | | | | | |
| Kyrgyzstan | | | | | |
| Armenia | | | | | |
| Mexico | | | | | |
| Suriname | | | | | |
| Dominican Republic | | | | | |
| India | | | | | |
| Indonesia | | | | | |
| Bangladesh | | | | | |
| Cambodia | | | | | |
| Lao PDR | | | | | |
| Philippines | | | | | |

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

**Care Quality Commission (CQC) – United Kingdom**

- The Care Quality Commission (CQC) was established in 2009 to replace the previously fragmented licensing standards in United Kingdom.
- The CQC regulates the performance of National Health Service (NHS) as well as the private providers and assists the Department of Health in monitoring the quality of services through registration, annual inspection, monitoring complaints, patient satisfaction surveys and enforcement. Reports on the performance of health providers in these inspections are readily available for public view in their website.
- All health and social care providers in the NHS and the private sector are assessed by a common set of regulations that applies across the nation. The CQC is entrusted with enforcement powers like fines, public warnings, suspension or cancellation of registration and prosecution that are enforced if the requirements are not met.

*Sources: Seán Boyle: United Kingdom (England): Health system review. Health Systems in Transition, 2011; 13(1):1–486; Review of CQC's impact on quality and improvement in health and social care*

The domain of regulation focuses on a government's ability to design and implement rules and approaches to ensure a minimal standard and availability of health services. Across the 18 countries, all countries have a standardized registration and regulation process of private health providers (except Eswatini – no relevant documentation was found) and pharmacies (except Mexico – no mention of pharmacy regulation) to control market entry. The responsibilities of health providers regulation are generally carried out by the national or provincial Ministry of Health or Ministry of Trade in each country. Such responsibilities generally include ensuring the licensing and registration of the private health sector. Despite the perceived importance of the regulatory domain and the intended function, the level of regulation and enforcement varied widely across countries and major challenges have been reported particularly

in lower-income countries with higher rural populations. Medicines in Jordan are highly regulated, in terms of quality assurance, registration, import and export, as well as pricing. On the other hand, unlicensed drug stores remained highly prevalent and often operated near to public health facilities in rural Uganda. A mapping study reported 76% of the private drug shops were unlicensed in more than 200 surveyed villages in eastern rural Uganda, and the barriers to licensing reported being the cost of license and lack of qualifications to apply (Buchner *et al.*, 2019).

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

While licensing and registration are commonly applied regulatory approach, price regulation can also be applied to attain better health coverage, service quality, as well as financial protection and health outcomes through the creation of economic signals and incentives to influence behavior (Barber, Lorenzoni and Ong, 2019). However, economic regulation of the private health sector has not been usually practiced across the countries: less than a third of the countries reviewed has laws or policies to set maximum fees for health services provided by the private sector. Most of these countries that regulate pricing of private health services also have regulations on drug pricing, although different regulation body and mechanisms are applied for medicines. Additionally, Pakistan has developed its first ever drug price policy in 2015 to improve the availability and affordability of medicines (Saeed *et al.*, 2019), while the Philippines government has recently sought public consultation on updating a tentative list of Maximum Retail Price for drugs and medicines (Department of Health, 2019). However, despite the legal mechanism on drug price control, there was report of illegitimate price hikes of five times increase by pharmaceutical companies in Pakistan over 3 months in 2016 and companies used various tactics to avoid regulatory authorities (Saleem *et al.*, 2016), underlining the challenging situations in enforcing regulations.

**Regulation of private health facilities in Jordan**

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

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

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

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

Besides the administrative and bureaucratic controls by government that have traditionally been perceived as the main regulatory strategy, regulatory strategies in health markets are diverse and may not be solely enforced by the state. Other regulatory strategies include market supply-oriented approaches, consumer/citizen-oriented approaches, and collaboration-oriented approaches (Bloom, Henson and Peters, 2014). The authors suggested that multi-pronged approach would be required amid the increasingly complex health products and services markets in LMICs and may not be addressed by governments alone (Bloom, Henson and Peters, 2014). However, limited evaluations have provided strong evidence for different approaches of government regulation, training, and coordination of private for-profit providers in LMIC, as suggested by a recent systematic review (Wiysonge *et al.*, 2016). Despite the limited studies, the review found training providers for improving quality of care demonstrated moderate evidence. However, management improvement was rarely described as an approach in the review of private health sector regulation in these 18 countries and other regulatory approaches beyond administrative and bureaucratic functions may be further explored, including the use of price regulation in health care and pharmaceuticals.

DRAFT

## Financing

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

*Table 5. Summary of financing in the 18 countries*

**Philhealth coverage in Philippines**

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

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

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

One of the mechanisms to improve the effectiveness of public funds is the use of contracts to pay private health care providers. Most of the 18 countries have experience in service contracting with private health sector in certain regions or in providing services in specific health conditions. Countries use contracting with private health providers for a variety of purposes. In Pakistan, the management of basic health units was contracted out to non-governmental organizations under the People's Primary Healthcare initiative to improve health services provision and increase of primary health care utilization (Khan and Puthussery, 2019); while in Mexico and Suriname, the public sector contracts with private providers for specific high-demand interventions, or to provide services in remote locations (OECD, 2017).

The time-limited contracting mechanism also allows governments to negotiate and specify pre-conditions for private providers to engage in a contract, such as the requirement to obtain accreditation to ensure service quality. Such mechanism can enhance regulatory function described in the previous section.

Although contracting can assert influence on private health providers, the supply side approach may not improve service use among the underserved populations. Voucher schemes can incentivize providers to improve their service quality and access by disadvantaged populations. The demand side approach is often used to improve equity for specific type of services such as reproductive health program and maternal and child health programs (Sidney *et al.*, 2012; Murray *et al.*, 2014), with the assumption that affordability being the barrier to access the service. Recently, voucher scheme has also be applied to the treatment of chronic health conditions such as diabetes mellitus and hypertension (the Philippines) (Obermann, Jowett and Kwon, 2018). A third of the countries reviewed have experience with the Ministry of Health engaged in one or more voucher programs. A recent evaluation of the voucher program in Pakistan found the program helped expand contraceptive access and choice among the populations in need (Ali *et al.*, 2019).

**Universal Medical Care in Canada**

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

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

Wide-scale financial risk protection cannot be achieved without high population coverage for a core set of health services by pooled financing. Despite 15 out of the 18 countries reviewed have established public health insurance schemes, nearly two-thirds of them have limited population coverage (<50%), some of which only covered specific sectors or groups of the population. However, a few other countries have rapidly expanded their population coverage in recent years: Indonesia introduced the national insurance program (JKN) in 2014, and enrolled 75% of the Indonesian population by 2018 (Agustina *et al.*, 2019); Lao People's Democratic Republic Ministry of Health launched a tax-based national health insurance in 2016 and rolled out to cover over 90% of the population by the end of 2017 (World Health Organization Regional Office for the Western Pacific, 2018); the Philippines expanded population coverage to more than 90% since 2013 through subsidizing premiums for senior citizens and the poorest population (Haw, Uy and Ho, 2019).

Majority of the publicly financed health insurance cover the use of public sector health services only, with eight countries also cover some private health care facilities. Many of these national health insurances that reimburses private facility include primary health care services (75%). However, unlike the national health insurance in some high-income countries where the full cost of services is covered (e.g. Canada and a number of European countries), the coverage of private health services is often partial and patients have to cover the co-payment out-of-pocket. Five countries' national health insurance provide coverage for pharmaceuticals to provide some financial protection on medicines, although growth in medicine prices can be a major driver of increasing co-payments (Vogler *et al.*, 2019). Most of the countries have limited information on offering financial incentives to providers.

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## Engagement in Vertical Services Provision

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

*Table 6. Summary of Vertical Services Provision in the 18 countries*

Public-private engagement in vertical services provision symbolizes a collaborative effort between the sectors in working towards specific public health goals. As many LMICs established disease specific programs for diseases of national importance, a number of these programs engaged with private health providers as they are often the first point of contact for these diseases or prevention service. Such engagement requires functioning supporting systems in place to make progress towards disease control targets. To assess the level of public-private engagement in these programs, four sub-domains were assessed: i) Functioning referral system - the requirement of private providers to notify patients to a common information system, ii) Distribution of public goods – utilization of private providers to distribute government funded goods that are free for care seekers, iii) Training of private providers – efforts taken by the vertical programs to strengthen the capacity of private providers, and iv) Established Partnership – a formal arrangement between the public and the private sector.

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

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## Trends and private health sector engagement towards universal health coverage

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

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

The need to gather information from private health sector was realized but many countries documented challenges in information exchange between the public and private sectors. Despite the mandate for private sector to report health information to specific government body using designated systems, level of implementation differed widely not only between countries and specific private health sectors, but also among different reporting systems and types of health information within a country. These discrepancies in reporting weaken the ability to build accountability and understanding to foster engagement with private health sectors. Furthermore, limited access to accurate information about private health service utilization can limit other domains of private sector engagement, particularly in regulation and financing mechanisms. As pricing and payment systems rely on accurate information on service utilization and costs, information systems can be an important barrier to implementing payment mechanisms to providers (Barber, Lorenzoni and Ong, 2019). **Important lessons to improve information exchange between the public and private sectors may be shared across programs, countries, and regions, a process which can be guided and facilitated by WHO.**

**The role of regulation has predominantly focused on the administrative and bureaucratic process of registration and licensing in LMICs.** Besides having legal mandates to control the entry of private health service providers and setting minimal standards for such providers to operate, other mechanisms may be applied to enhance enforcement and improve compliance of maintaining quality of services. For instance, a number of countries linked their financing mechanisms with some regulatory functions, such as the requirement to obtain accreditation in ensuring minimal service quality to have the ability for contracting with the government, and the incentive to improve their services to attract consumers through the voucher scheme mechanism. In addition to formal private health providers, informal private providers are an important source of health care in a number of LMICs, which act outside the regulatory framework. In recent years, governments began to recognize the importance of informal private providers and the need to organize training and formal registration for these providers (Mbonye *et al.*, 2015; Liu *et al.*, 2016). **Connecting regulation and financing enables extending the regulatory role beyond the traditional administrative function to market supply-oriented approaches and collaboration-oriented approaches, and co-production of service and regulations across key stakeholders. WHO may collate countries' experience and development of best practice, and create knowledge sharing on different mechanisms and pathways to connect regulation and financing domains by LMICs to strengthen governance.**

DRAFT

The implementation of regulation along with financing mechanisms may also facilitate regulatory mechanisms to improve performance. In Philippines, the focus of including the private health sector with the Primary Care Benefits was used to incentivize the delivery and utilization of services at primary level, encouraging primary care providers and drug outlets to participate once accredited (Obermann, Jowett and Kwon, 2018). It is important to note that implementation of these multi-faceted regulations requires institutional collaboration across Ministry of health, service regulatory agency and national insurance agency. Effective governance of mixed health systems requires not only cooperation and collaboration between the public and private sectors, but also among different health and financing agencies. **As the public financing coverage rapidly expanded, ensuring the quality of services by both public and private providers and the extent of service coverage are important aspects in the governance of health service provision.**

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

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

DRAFT

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DRAFT

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

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| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indonesia** | LMIC | SEARO | 2.99 | 37.34 | 7.25 | PERSI (Indonesia Hospital Association) | 60 | 31711 | NA | NA | 30643 |
| **Bangladesh** | LMIC | SEARO | 2.27 | 71.89 | 490.29 | Bangladesh Private Medical Practitioners Association (BPMPA) | 57.2 | NA | NA | NA | 123800 |
| | | | | | | | | | | | |
| **Cambodia** | LMIC | WPRO | 5.92 | 58.56 | 161.68 | - | 33 | NA | 8488 | NA | 2156 |
| **Lao PDR** | LMIC | WPRO | 2.53 | 46.44 | NA | - | 14.6 | 894 | 222 | NA | 2132 |
| **Philippines** | LMIC | WPRO | 4.45 | 53.94 | 244.02 | - | 32.20 | NA | NA | NA | NA |

DRAFT