Private-sector provision of health care in the Asia-Pacific region: A background briefing on current issues and policy responses

Krishna Hort
Nossal Institute for Global Health, University of Melbourne

Abby Bloom
Menzies Centre for Health Policy, University of Sydney
Private-sector provision of health care in the Asia-Pacific region: A background briefing on current issues and policy responses

First draft – June 2013
© 2013 Nossal Institute for Global Health

Corresponding author: Krishna Hort

Address: Nossal Institute for Global Health, University of Melbourne
khort@unimelb.edu.au

Contributors: Abby Bloom, Menzies Centre for Health Policy, University of Sydney

This Working Paper represents the views of its author/s and does not represent any official position of the University of Melbourne, AusAID or the Australian Government.

ABOUT THIS SERIES

This Working Paper is produced by the Nossal Institute for Global Health at the University of Melbourne, Australia.

The Australian Agency for International Development (AusAID) has established four Knowledge Hubs for Health, each addressing different dimensions of the health system: Health Policy and Health Finance; Health Information Systems; Human Resources for Health; and Women’s and Children’s Health.

Based at the Nossal Institute for Global Health, the Health Policy and Health Finance Knowledge Hub aims to support regional, national and international partners to develop effective evidence-informed policy making, particularly in the field of health finance and health systems.

The Working Paper series is not a peer-reviewed journal; papers in this series are works-in-progress. The aim is to stimulate discussion and comment among policy makers and researchers.

The Nossal Institute invites and encourages feedback. We would like to hear both where corrections are needed to published papers and where additional work would be useful. We also would like to hear suggestions for new papers or the investigation of any topics that health planners or policy makers would find helpful. To provide comment or obtain further information about the Working Paper series please contact ni-info@unimelb.edu.au with “Working Papers” as the subject.

For updated Working Papers, the title page includes the date of the latest revision.
SUMMARY

In many countries of the Asia-Pacific region, the private sector provides a significant and increasing proportion of health care. However, the private sector is heterogeneous, consisting of both for-profit and not-for-profit providers, and providing both formal and informal services. The extent of private sector provision also varies considerably among countries.

Government responses to private sector provision have varied from neglect to active promotion and the granting of incentives for private investment. While services from the private sector may contribute to the overall availability of care, they may also contribute to inequality of access and higher out-of-pocket payments. The recent policy focus by most nations in the region on achieving universal coverage will therefore require more attention to the role of the private sector.

Private sector service provision has generated intense debate internationally between those championing the private sector and claiming that it can contribute to achieving public health goals and those maintaining that government, not the private sector, should bear responsibility for services. Nevertheless, international agencies have increasingly recognised the role of the private sector and the need to develop policies and tools to support government engagement with it.

Instead of focusing on the dichotomy of public or private, it may be more productive to view the issue as the management of mixed public-private health systems, with blurred boundaries between the two sectors. In this paper we discuss the stewardship functions of a mixed public-private health system in which the role of government is to appraise, compare, manage and regulate financing and purchasing arrangements with the public and private sector so as to achieve quality and equity goals.
INTRODUCTION

The private sector provides a large proportion of health services in the low- and middle-income countries (LMICs) in the Asia-Pacific region (Patouillard, Goodman et al 2007; Montagu, Anglemyer et al 2011). The role of the private sector includes direct provision of services, in both privately and publicly owned primary, secondary and tertiary facilities, and the manufacture and distribution of medical equipment, supplies and pharmaceuticals (Ahmed, Bloom and Sweeney 2011).

Services provided by the private sector are used by both the poor and the wealthy, with significant use by the poor of some ambulatory services, such as treatment of diarrhoea or acute respiratory infection in children (Montague, Anglemyer et al 2011; Basu, Andrews et al 2012). While in some countries private sector services make health care and medication more accessible to the urban poor and to those living in rural and remote areas, questions have been raised about the quality and costs of private sector care (Patouillard, Goodman et al 2007; Berendes, Heywood et al 2011). Services in the private sector may reduce the burden on state financing, but may also contribute to increased out-of-pocket expenditure and consequently financial hardship for the poor (Lagomarsino, Nachuk and Kundra 2009).

Use of the private sector is reported to be increasing, for example, in Indonesia (Heywood and Choi 2010) and in Thailand (Teerawattananon, Tangcharoensathien et al 2003), while the number of private sector facilities is growing, as reported in Vietnam (Hort, Tuan et al 2011) and in Indonesia (Hort, Akhtar et al 2011). Changes in the mix of out-patient cases, such as the increasing burden of non-communicable diseases (NCDs), are likely to lead to new demands on the private sector (Berendes, Heywood et al 2011), while new financing mechanisms such as publicly funded social health insurance, combined with unregulated private sector usage, could result in unsustainable increases in public health expenditure (Ramesh and Wu 2008).

Despite calls for greater regulation and more active stewardship (Berendes, Heywood et al 2011), government policy towards the private sector in LMICs ranges from neglect and disregard to providing incentives and promoting private-sector activities. How best to manage the private sector’s role in health to achieve national goals has stimulated fierce debate in some circles and is increasingly being addressed explicitly by development agencies (Patouillard, Goodman et al 2007; Basu, Andrews et al 2012).

This background briefing provides an overview of some of the key characteristics of the private sector in the Asia-Pacific; reviews responses by governments, international agencies and donors to the private sector’s current and future roles; suggests that the issue may best be addressed by re-framing it in terms of the management of mixed health systems; and identifies the policy issues that need to be addressed. It aims to provide background for policy makers and development partners for further examination of the issues in specific countries. To this end, it is supplemented with three country case studies.

THE PRIVATE SECTOR IN THE ASIA-PACIFIC REGION

The general characteristics of the private sector in the region can be summarised as follows:

(1) The private sector is heterogeneous, comprising a range of different types of providers, operating under a range of funding, purchasing, payment, regulatory and management arrangements. A basic classification is provided by Oxfam (2009):

- **Formal for-profit providers** include multinational and national companies and enterprises as well as private qualified individuals operating a range of large and small health care facilities and pharmacies for commercial gain. These providers are legally registered and recognised by governments.
- **Informal for-profit providers** are unlicensed and unregulated. They are usually small and involve a wide range of individuals and enterprises, including formal and informal traditional healers, birth attendants and ‘injectors’ as well as drug shops and stalls.
- **Not-for-profit providers** include faith-based organisations, charities, social enterprises and other non-government organisations offering a wide range of health services. Activities can be formal or informal, regulated or unregulated. While not motivated by profit,
many organisations attempt to recover costs of services.

In addition, there are public sector workers who also work privately in public sector facilities, in private sector facilities or in their own private practices. This can cause difficulties in defining the private sector, particularly for research purposes, as is discussed in the section on evidence.

(2) In practice, particularly in LMICs, differentiation between public and private providers can be difficult. Several authors refer to an imprecise distinction between public and private providers, as exemplified by ‘dual practice’. In ‘dual practice’, health care workers work in both public facilities as salaried government employees and in private facilities, where they are formal, for-profit, private health care providers.

Bennett, McPake and Mills (1997) note that the private sector comprises a wide range of different providers, in practice the dividing line between public and private can be very unclear, and incentives can be structured in such a way that public institutions behave more like private ones and vice versa.

State hospitals in many countries have been given a degree of financial autonomy that enables them to engage in some activities that are more consistent with private operation: collecting user fees, introducing fee-paying ‘private’ wards and in some countries (Vietnam, China) installing privately funded and operated diagnostic facilities within state facilities (Hort, Tuan et al 2011).

(3) The role and extent of private sector provision vary considerably among countries.

In the Pacific, with some exceptions (notably Papua New Guinea (PNG)), health care is largely financed and provided by the state. The nations of South-East Asia, on the other hand, especially Thailand, Vietnam and the Philippines, are characterised by state finance, social health insurance and a robust mixture of public and private provision, including for-profit providers. In other countries, notably India, Bangladesh and Pakistan, health care funding is overwhelmingly private (upwards of 75-80 per cent). Finally, in countries where extractive industries and resources dominate the economy (notably Mongolia but also PNG and the Philippines), governments have or are negotiating unique arrangements for health care funding and provision by mining and resource companies.

Some authors have suggested that the nations of Asia and the Pacific can be categorised according to the extent of private sector provision in their health system. Montagu and Bloom (2009) have grouped the nations of the Asia-Pacific region into three categories, corresponding to the proportion of services provided by the private sector.

(4) The variation in the proportion of privately provided health care is reflected in variation in the private contribution to health expenditure.

This is because, in countries without social health insurance, private use of health care is largely privately financed, usually out of pocket, which discriminates against the poor (Montague and Bloom 2009).

Thus, the proportion of total health expenditure from private sources describes private health care provision from a funding perspective. This proportion varies considerably, from below 5 per cent in some Pacific islands up to 90 per cent in Myanmar (Table 1). While the proportion of private expenditure generally matches the extent of private health care provision, there are also some exceptions. For example, Thailand has a low proportion of privately sourced funding, while in China the proportion is relatively high.

In LMICs in the Asia-Pacific, the majority of privately sourced funding is out-of-pocket expenditure, rather than from social or private health insurance, thus exposing households to potentially catastrophic expenditure on health care. Services funded by patients’ out-of-pocket payments (also called direct payments) are by definition regressive, disadvantage the poor (Saksena, Xu et al. 2010) and militate against access and equity goals. Thus the funding model, rather than public or private ownership or provision of the services, is in many instances more significant in determining equitable access (Montagu, Anglemeyer et al. 2011).

(5) The combination of public and private health care provision in LMICs in the region may be considered as constituting what has been termed ‘mixed
One of the main themes of this paper is that the insistence on public versus private is a false dichotomy that disadvantages the countries of the region. First, it misrepresents what are, in reality, blurred boundaries between the public and private sectors. Secondly, the public-private dialectic impedes the design and implementation of pragmatically realistic as well as equitable, appropriate, effective and sustainable health services.

The concept of mixed health systems provides a more practically beneficial view of the issue, by focusing attention on how policies and programs influence public and private sectors, and the interaction between the sectors, in support of national health goals.

TABLE 1. COUNTRIES OF ASIA AND PACIFIC CATEGORISED BY PROPORTION OF PRIVATE PROVISION AND FUNDING OF HEALTH CARE

<table>
<thead>
<tr>
<th>Group</th>
<th>Private Sector Scale and Role</th>
<th>Countries</th>
<th>% Total Health Expenditure from Private Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Private sector provides more than half of all health services. Important for primary care services. Provides some to majority of secondary and tertiary (hospital) care. For-profit private sector much larger than NGOs.</td>
<td>Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand, Vietnam</td>
<td>Myanmar: 90.3 Cambodia: 72.7 Vietnam: 61.3 Indonesia: 48.2 Thailand 24.2</td>
</tr>
<tr>
<td>2</td>
<td>Private sector is small, providing less than half of health services. NGOs and FBOs provide a significant proportion of private sector health care.</td>
<td>Fiji, Kiribati, Marshall Islands, Micronesia, Papua New Guinea, Solomon Islands, Timor Leste, Tonga, Vanuatu</td>
<td>Timor Leste: 29.0 Fiji: 26.4 PNG: 21.0 Vanuatu: 18.1 Kiribati: 15.3 Solomon Islands: 6.2 Marshall Islands: 2.5</td>
</tr>
<tr>
<td>3</td>
<td>Private sector exists in specialty areas (for example, dental care) and within structural arrangements in which government is an active partner.</td>
<td>China, Mongolia</td>
<td>China: 49.9 Mongolia: 14.8</td>
</tr>
</tbody>
</table>

Sources: Montague and Bloom (2009); supplementary data from WHO Global Health Observatory Data Repository (2011)

Notwithstanding the many differences, health care in a majority of low- and middle-income countries is delivered by a mixed health system—defined as a health system in which out-of-pocket payments and market provision of services predominate as a means of financing and providing services in an environment where publicly-financed government health delivery coexists with privately-financed market delivery.

One of the main themes of this paper is that the insistence on public versus private is a false dichotomy that disadvantages the countries of the region. First, it misrepresents what are, in reality, blurred boundaries between the public and private sectors. Secondly, the public-private dialectic impedes the design and implementation of pragmatically realistic as well as equitable, appropriate, effective and sustainable health services.

The concept of mixed health systems provides a more practically beneficial view of the issue, by focusing attention on how policies and programs influence public and private sectors, and the interaction between the sectors, in support of national health goals.
or ‘laissez-faire’ to specific measures that encourage private sector engagement.

For example, in Indonesia, where 50 per cent of hospitals are privately managed, the Ministry of Health has not developed a specific policy for the private sector and provides little incentive or guidance for private sector investment or services. While Indonesia does have a policy restricting private practice locations to two for any doctor with a state facility appointment, this regulation is largely ignored (Hort, Akhtar et al 2011).

On the other hand, Vietnam, where only 7 per cent of hospitals are privately owned, has policies specifically encouraging private sector investment to achieve a target of 10 per cent of total hospital beds within the private sector by 2020. Incentives include tax relief and provision of free land for the construction of new private hospitals. Dual practice is not as common or as regulated in Vietnam as in Indonesia: doctors are required only to seek permission from the director of the state facility in which they are employed (Hort, Tuan et al 2011).

Some governments have sought to encourage private sector engagement for public health goals, including formal and informal contractual arrangements. More recently, countries in the region have encouraged the private sector to fill gaps in state health care provision and funding. Vietnam and India are examples where governments have instituted official policies to encourage greater private sector participation in health programs for the general public, and where different private sector business models have developed.

The Cambodian government, with international donor support, contracted with non-government organisations for health care services and health care financing in a number of areas (Box 1). The Papua New Guinea government has funded church health services for many years to deliver primary care without formal contracts (Box 2). India provides an example of social franchising for private eye care (Box 3).

A commitment to universal coverage is likely to impact on the public-private mix. The introduction of national health insurance schemes and progress towards universal health coverage are likely to change the balance of financing for health care and potentially the public-private mix. If successful, and inclusive of the poor and workers in the informal sector, these schemes will shift health care funding away from out-of-pocket payments towards increased state funding, and from fee-for-service to more strategic purchasing arrangements (WHO 2010c) within a broader and participatory planning, social health insurance and regulatory framework (World Bank 2007).

**BOX 1. CONTRACTING NGOS FOR HEALTH SERVICES IN CAMBODIA**

Contracting NGOs to provide health services led to increased utilisation and decreased out-of-pocket payments in poor rural districts.

Since the early 1990s, Cambodia’s health system has changed rapidly, experiencing decentralisation, privatisation and increased private financing. Differences between the rural and urban health sectors are pronounced: medical human resources are skewed towards large cities and towns, with fewer and lower quality staff in rural areas. The private sector is the main source of care in rural areas (Grundy, Khut et al 2009). Deliberate engagement with the private sector was to be a cornerstone of Cambodia’s 2000 Primary Health Care Plan and would entail collaboration with other government sectors and with the private sector (ADB 2007).

From 1999 to 2003, supported by the Asian Development Bank, the Ministry of Health conducted an experiment to compare the effective and equitable delivery of a standard package of primary care services by private versus public providers in nine health districts. International NGOs successfully bid for contracts to provide health services at fixed per capita prices. The contracts specified maternal and child health utilisation and outcome targets. The contracted entities were empowered to collect user fees to subsidise performance-based monetary incentives for staff. Incremental management fees were provided by the Asian Development Bank, and all other funds were provided by the Ministry of Health. In three districts, NGOs ‘contracted in’ using continued overleaf
BOX 2. PRIMARY HEALTH CARE IN PAPUA NEW GUINEA

In Papua New Guinea, long-term relationships between government and church health services support the provision of primary health care.

PNG has a largely rural population, 87 per cent living in rural and remote areas and presenting challenges to the provision of health services. Health service providers affiliated with churches operate an estimated one-half of all rural primary health facilities (Ascroft, Sweeney et al 2011). Churches also run numerous nurse and community health worker training centres (Hauck, Mandie-Filer and Bolger 2005). The government and a small number of corporate and other organisations operate the balance.

Both church-run and government-run facilities must adhere to a single set of standard treatment guidelines, and staff in both types of facilities participate in the same in-service training. Both church and government operators must supply data to the government National Health Information System (Health Sector Monitoring and Review Group 2003).

The Churches Medical Council (CMC) forms the national body that is the intermediary with the government. Approximately 82 registered church agencies from 14 different Christian denominations exist in PNG, and 24 are recognised by and receive funding from the national Department of Health through the CMC, earmarked for health services.

There is apparently no signed, formal contract between the government and the CMC setting out the rights and responsibilities of each. According to Matheson, Howse et al (2009), although numerous memoranda of understanding and memoranda of agreement have been reached over time, the explicit commitment of the CMC to work with government is evidenced in national and provincial policy documents, and by the ongoing nature of the arrangement.

Ascroft, Sweeney et al (2011) conclude that even in the absence of legal contracts, the church-run health system has become so intertwined with the government system that church-run facilities are typically seen to belong to the government system. The PNG study illustrates the common circumstance where faith-based organisations have long-standing and valued roles in national health systems that have evolved their relationship over time, yet the relationship between the organisation and government remains informal in key aspects. By contrast, any new such arrangement would be deemed a formal contracting situation and subject to very prescriptive agreements, which might have unintended consequences that inhibit rather than aid progress towards national health goals.
The search for different and more effective ways to respond to the growing influence of the private sector has initiated a debate between different donor partners and other international agencies about an appropriate strategic response.

**Debate**

The position of Oxfam and other respected experts on health systems in LMICs represents one of the prevailing views. Hanson, Gilson et al (2008) argue, ‘There is no alternative to strengthening the public role in the health system’. According to Oxfam (2006), ‘If the state is broken, the market does not solve the problem ... Market-led solutions have often undermined the provision of essential services and have had a negative impact on the poorest and most vulnerable communities.’

An alternative perspective is represented by Smith, Feachem et al (2008), who argue that the public and private sectors have different weaknesses and strengths and a considered amalgamation of the two sectors can produce beneficial outcomes:

**The reality is that in most low-income countries, most people receive most of their care from the broadly defined private sector ... Many countries, and the donors that have supported them, have tried to address these challenges through an implicit policy of creating a public sector monopoly,**

---

**BOX 3. SOCIAL FRANCHISING FOR EYE HEALTH IN INDIA**

India has a large, national government-funded health system, yet most Indians lack access to health services due to location and/or cost and historically have used private health care providers. The proportion of all services provided by the private sector, over 60 per cent in some estimates (Radwan 2005), has grown rapidly in response to recent increases in demand and the government’s financial constraints.

The national health policy contains objectives for eye care, but government-funded programs do not reach villages. Many households depend on one or both parents’ capacity to earn income, often in a trade that requires nearly perfect eyesight. For example, many women augment their husbands’ meagre wages by piecework embroidery, which is dependent on visual acuity. Loss of vision through presbyopia is readily and relatively cheaply corrected with mass-produced standard eyeglasses.

VisionSpring’s mission is ‘to reduce poverty and generate opportunity in the developing world through the sale of affordable eyeglasses’ (VisionSpring undated). VisionSpring uses a social entrepreneurship model commonly called ‘social franchise’, which is in turn a variant of ‘micro-franchise’.

VisionSpring’s ‘Business in a Bag’ provides entrepreneurs with both a sales kit containing all the products and materials needed to market and sell eyeglasses and training in the basics of eye care and managing their new business. Each ‘vision entrepreneur’ receives continuing technical, marketing and business support from VisionSpring staff. Villagers purchase VisionSpring eyeglasses directly from vision entrepreneurs. The model is designed to enable both the vision entrepreneurs (usually women) and their suppliers to operate at a profit virtually immediately. Vision entrepreneurs’ earnings are reported to be approximately twice the local wage rates (Clemminck and Kadakia, 2007).

The social enterprise and grassroots nature of VisionSpring’s activities means it does not often engage directly with government, and when it does, this tends to occur within the context of village activities, such as a government van picking up people treated and referred by VisionSpring’s entrepreneurs. VisionSpring demonstrates the potential of the social enterprise model as an alternative route to engage non-state providers in providing services to the general public, within a broad government policy framework.
ignoring the large and growing private sector gorilla in the room. Some countries are now exploring pluralistic models that partner with the private sector to serve public policy goals. These models should be encouraged and supported. Improving health care for the world’s poor means harnessing everyone’s capacity, not just that of governments.

Furthermore, Smith, Feachem et al (2008) argue that many LMICs are already engaging the private sector in order to improve health outcomes. For this reason, they say it is crucial to ensure that public-private partnerships are effective and equitable.

These debates continue, with evaluative and meta-analysis studies beginning to emerge, providing evidence both for and against private sector provision of health care. A series of studies conducted by the Results for Development group with funding from the Rockefeller Foundation (Lagomarsino, Nachuk and Kundra 2009) was recently criticised as reflecting ‘Rockefeller Foundation’s ideological bias against single payer universal coverage public health care systems’ by Schultan and Unger (2011).

**Lack of Evidence**

This debate has led to calls for more evidence and more systematic analysis of the evidence, as reflected in recent systematic reviews (Basu, Andrews and Kishore 2012; Montagu, Anglemyer et al 2011; Berendes, Heywood et al 2011; Patouillard, Goodman et al 2007). However, each of the reviews has examined different aspects of the private sector and come to different conclusions.

Patouillard, Goodman et al (2007) focused on whether interventions to engage the private sector in health services increased utilisation and quality of care for the poor. They limited their analysis to the for-profit private sector, but examined a variety of services, including provision of insecticide-treated bed nets and pre-packaging of drugs. They identified 52 studies and concluded that there was evidence that some interventions (notably social marketing, vouchers and pre-packaged drugs) increased utilisation by the poor, but that for many interventions there was insufficient evidence. In particular, most studies did not compare investment in the public sector to provide the same services.

Berendes, Heywood et al (2011) examined aspects of quality (including responsiveness and technical quality) of ambulatory health care services provided by public and private sectors in LMICs. They defined the private sector to include both formal and informal providers, but restricted it to the allopathic medical system, and identified 80 studies in which public and private provision could be compared in the same country. They concluded that meta-analysis of the studies demonstrated better responsiveness and availability of drugs in the private sector, but no significant differences in patient satisfaction or technical quality. But in view of the significant use of the private sector, they advocated for quality improvement programs to extend their coverage beyond the public sector.

Montagu, Anglemyer et al (2011) focused their review and meta-analysis on clinical outcomes from treatment in public and private sectors in LMICs. They adopted a broad definition of the private sector (where gains or losses accrue to the provider) and were able to identify only 21 studies that compared clinical outcomes between public and private provision, all of these in middle-income countries; no studies were found in low-income countries. No significant differences were found on meta-analysis of mortality rates (although evidence quality was rated as low), and, among other outcomes, there was modest evidence of poorer outcomes from TB treatment in the private sector. Interestingly, their conclusion seems to extend beyond these findings (Montague, Anglemyer et al 2011):

> The quality of privately provided clinical services appears to be broadly equivalent or better than government-provided services in middle-income countries. In areas where government-based clinics or hospitals do not exist, or are insufficient to provide care for the population in need, governments should consider both legal and fiscal support for the development of private facilities, and contracting of services from private facilities as an acceptable alternative to public provision.

Finally, Basu, Andrews et al (2012) undertook a more recent systematic review of the evidence comparing public and private service performance against six ‘themes’ identified from the World Health Report of 2000. They did not specify their definition of the private sector, but identified 59 empirical studies and 13 meta-
analyses. While the number of studies for each theme was quite small, the authors found evidence in the private sector of higher responsiveness, poorer adherence to standard treatment regimes and some over-treatment and higher costs of drugs and some treatments. They noted that some claims for the benefits of the private sector may have been overstated in the literature and concluded that the review did not support claims that the private sector is more efficient, accountable or medically effective than the public sector.

While there may have been some ideological bias in the interpretation of findings, the reviews do agree on the lack of strong evidence on which to judge the relative effectiveness of public or private sector service provision. In particular, several emphasise a lack of rigorous studies that compared outcomes (Montagu, Anglemyer et al 2011) or included a counterfactual in order to compare sectors (Patouillard, Goodman et al 2007).

Berendes, Heywood et al (2011) note that the overall quality of care in both public and private sectors is low, so that differences may not be very material, and that it is possible that public and private sectors operated in different conditions, with high workloads, lack of resources and low salaries contributing to poorer quality in the public sector.

Basu, Andrews et al (2012) take this idea further by identifying contextual differences between public and private that ‘limit the ability of existing work to compare fairly the public and private sector for differing disease categories and in differing social and economic contexts of healthcare delivery’.

They also identified what they referred to as the competitive dynamics operating between public and private sectors, whereby the private sector could ‘crowd out’ resources for the public sector, by encouraging transfer of personnel and resources from public to private, and, in public-private partnerships, encouraging diversion of public money towards the private sector without similar increases in the public sector.

Different definitions of the private sector also make a difference, as Basu and Andrews et al (2012) point out. When the non-formal sector was included, a World Bank study noted higher usage of the private than the public sector; but when the non-formal sector was excluded, the findings were reversed.

Overall, the evidence of systematic reviews is not strong enough to determine the relative effectiveness or efficiency of private compared to public sector service provision, but does suggest that the context, particularly regulatory and financing policy, is important in determining the performance of the two sectors.

**Responses by International Agencies**

Faced with the continuing significant role of private health care in many countries, many international agencies have acknowledged the need to include the private sector in their health policies.

In April 2008, when a summit on public-private partnerships in health was held with the participation of virtually all major multilateral and bilateral donors (Wilton Park 2008), there was almost universal consensus that the private sector had to be engaged proactively if LMICs were to meet national health goals. The conference stimulated initiatives among donor organisations that had not previously promoted engagement with the private sector or funding for programs involving the private sector.

By 2009 the development assistance programs of several countries represented at the conference, including the Netherlands and Australia, had begun to examine the opportunities to engage the private sector, including the for-profit part.

In 2010, the World Health Assembly passed a resolution encouraging nations to harness the private health sector in the interest of achieving national health goals. The resulting resolution succinctly states WHO’s intent: ‘Strengthening the capacity of governments to constructively engage the private sector in providing essential healthcare services’ (WHO 2010b).

The World Bank publication, *Private Participation in Health Services* (Harding and Preker 2003), provides the most comprehensive analysis to emerge concerning the rationale and opportunities for engaging the private sector in meeting national health goals.

The Department for International Development (DFID) of the UK government supports public-private partnerships, and, through an NGO, is promoting awareness of them, including upcoming tenders, with project snapshots on the web. In launching DFID’s
private sector division in late 2010, the secretary of state for international development stated (DFID 2011):

> It is my intention to recast DFID as a government department that understands the private sector, that has at its disposal the right tools to deliver and that is equipped to support a vibrant, resilient and growing business sector in the poorest countries.

The review of Australian aid released in July 2011 specifically identified for the first time the strategic goals of AusAID’s program as both ‘[i]nvesting in … private sector development’ and ‘improving the quality of governance’ (AusAID 2012). Australian development assistance has for many years been delivered in part through private not-for-profit organisations (NGOs), but the recent review also included the for-profit private sector.

AusAID’s recent health strategy also refers specifically to the private sector, noting: ‘Donors and national governments also need to better engage with the non-state sector to ensure affordable and accessible health services’ (AusAID 2011). The strategy includes the following reference to the private sector in regard to the second pillar, ‘Closing the funding gap to provide essential health services for all’ (AusAID 2011):

> Australia will therefore support partner countries to target their health resources more effectively and will advocate for increased and equitable allocation of partner government resources for health. This may include making better use of the non-state sector (such as private providers, faith-based organisations and other non-government organisations) in delivering services [italics added].

### Resources to Support Private Sector Engagement

Resources have been produced to guide and support governments in engaging the private sector on public health goals. Two recent papers explore the means by which governments may engage with non-state providers. In the first, Ahmed, Bloom et al (2011) summarise the main mechanisms.

More recently a comprehensive model of private sector actors and approaches to engage and interact with the private sector was compiled as part of a project dedicated to strengthening health systems in concert with non-state providers (Abt Associates 2011). The report, which examined partnerships between public and private sectors for HIV/AIDS services, is equally applicable across the entire health spectrum.

Results for Development hosts a website, the Center for Health Market Innovations, which, at last count, listed 1200 examples of private sector engagement in health care (Results for Development 2012). The World Bank Toolkit provides a step-by-step guide to how governments can engage the private sector (World Bank 2011).

In recent years most donor agencies operating in the Asia-Pacific region have endorsed and funded activities involving non-state providers. Their aim is to extend coverage and access to all socio-economic groups, including the poor. For example, WHO’s Strategic Agenda (2010-15) for Papua New Guinea states: ‘WHO will also help the Government to provide constructive oversight of non-state health providers to foster their positive contribution to achieving universal access to quality health services’ (WHO 2010a).

### Effective Stewardship

In addition to the potential benefits of engaging the private sector, there are also potential problems. Nishtar (2010) succinctly summarises the features of mixed health systems that hinder their achieving equity and other national health goals: (1) insufficient state funding for health; (2) a regulatory environment that enables the private sector to deliver social services without an appropriate regulatory framework; and (3) lack of transparency in governance. These three factors interact and ‘compromise the quality of public services and defeat the equity objective in several ways’ (Nishtar 2010).

In a series of papers, Lagomarsino, Nachuk and Kundra (2009) conclude that governments need to take a more active role as stewards of health systems, with a focus on three areas:

- regulatory policies that monitor quality effectively and mitigate the worst health market failures;
- financing policies that minimise out-of-pocket payments and increase access by pooling risks across populations, with subsidies for the poor;
- purchasing policies that create incentives for quality and for delivering high impact interventions and
services to the poor.

In reference specifically to mixed health systems, regulation is considered vital, because, the authors assert, it is the essential protection against market failure. They identify ‘funds pooling’ and ‘risk pooling’ as important features, the latter to shield individuals and families from catastrophic health care costs and foster use of services that improve health outcomes (Lagomarsino, Nachuk and Kundra 2009). These strategies have subsequently largely been incorporated into the universal health care strategy (WHO 2010c).

Effective regulation requires governments to take on the role of ‘steward’ of the whole health system and to establish effective governance arrangements. According to the WHO and others, effective health system governance (stewardship or leadership) requires a mix of regulation and encouragement, incentives, persuasion and involvement of informed patients and the public (civil society), with innovation as a central feature (Bhattacharyya, McGahan et al 2008; Kickbusch and Gleicher, 2012).

An important aspect of stewardship of the whole system is the need to consider the interaction between public and private sectors, something that can be overlooked by a focus on one sector. As Basu, Andrews et al (2012) comment:

A critical challenge in years to come is how to address competitive dynamics between private and public realms, so that public sector facilities are not stripped of resources that are given to the private sector as subsidies, and so that the ability of public clinics and hospitals to retain skilled healthcare workers is not compromised, especially as both types of systems attempt to coexist in the healthcare delivery environment of low- and middle-income countries.

While governance and regulation in health systems have received considerable attention in the high-income countries, these crucial aspects have been neglected in the systems of LMICs. Bloom, Champion et al (2009) draw attention to the different institutional context of LMICs, where institutions have not had the long period of development and maturation that has occurred in most high-income countries. They emphasise the importance of trust between providers and clients, and advocate regulatory strategies that build on and strengthen existing informal relationships of trust between providers and clients, such as ‘co-regulation’ that involves the providers in self-regulation.

The increasing role of the private sector in the health systems of LMICs will require building the capacity of LMIC governments to take on the stewardship role, including increasing their effectiveness in regulation and governance. Whether services are publicly or privately provided, their effectiveness depends on whether they have been well designed, are suitable for the socio-economic and political context and are managed within an appropriate regulatory framework with clear and effective governance arrangements.

**CONCLUSION**

The private sector is playing a significant role in many health systems in LMICs in the Asia-Pacific region, albeit with considerable heterogeneity and variation among countries. However, in many of these countries, the increased role of the private sector is associated with the development of particular characteristics in the health system, such as porous and blurred boundaries between public and private sectors, high levels of out-of-pocket expenditure, low government investment in health and weak regulation.

This constellation of characteristics has been referred to as the ‘mixed health systems’ syndrome and can result in significant obstacles to achieving public health goals such as equity, efficiency and quality of care. Ongoing epidemiological changes (the increase in NCDs) and new policy initiatives (notably the introduction of publicly funded national health insurance) could further exacerbate these problems. However, effective policy responses by governments and development partners have been hindered by ideological debates and different interpretations of the fairly scanty evidence.

This paper suggests that policy makers shift their focus from the dichotomy of public and private, to view the issue as one of the management of mixed public-private health systems. This view would suggest that what is needed is more attention to the government’s role as steward of the whole health system and more consideration to financing, regulation and oversight of the interaction of public and private sectors, to enable achievement of public health goals.
REFERENCES


Private-sector provision of health care in the Asia-Pacific region: A background briefing on current issues and policy responses

NosIns.WP17.SNonStateHospitals.pdf. (Accessed 12 January 2013)


The Nossal Institute invites and encourages feedback. To provide comment, to get further information about the Working Paper series, or to download this publication please visit our Health Policy and Health Finance Knowledge Hub website: www.ni.unimelb.edu.au/hphf-hub or email us at: ni-info@unimelb.edu.au

The Knowledge Hubs for Health are a strategic partnership initiative funded by the Australian Agency for International Development.