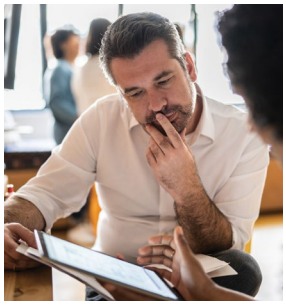

# 18

# The Role of the Private Sector in Delivering Health Benefits Packages: Lessons from Country and Economy Experiences

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## ABSTRACT

To implement universal health coverage, many countries are adopting essential packages of health services (EPHSs), mostly financed and delivered by the public sector, leaving the potential role of the private sector untapped. Many low- and lower-middle-income countries have devised EPHSs but have limited guidance on translating the package into quality, accessible, and affordable services. This chapter explores the role of the private health sector in achieving universal health coverage, identifies key concerns, and presents experience of the Disease Control Priorities 3 Country Translation Project in Afghanistan, Ethiopia, Pakistan, Somalia, Sudan, and the semiautonomous region of Zanzibar.

Key challenges to engaging the private sector include the complexity and heterogeneity of private providers, their operation in isolation of the health system, limitations of population coverage and equity when leaving private providers to their own choices, and higher overall cost of care for privately delivered services. Irrespective of the strategies employed to involve the private sector in delivering EPHSs, it is necessary to identify private providers in terms of their characteristics and contribution and their response to regulatory tools and incentives.

Strategies for regulating private providers include better statutory control to prevent unlicensed practice, self-regulation by professional bodies to maintain standards of practice, and accreditation of large private hospitals and chains. Additionally, purchasing delivery of essential services by engaging private providers can be an effective regulatory approach to modify provider behavior. Despite existing experience, more research is needed to better explore and operationalize the role of the private sector in implementing EPHSs in low- and lower-middle-income countries.

## INTRODUCTION

Private health sector providers are a major actor for provision of health services in low- and lower-middle-income countries. Although private providers operate primarily with commercial and market-oriented motives, enormous scope exists for them to play a key role in the progress toward achieving universal health coverage (UHC) in most countries.

Many countries use essential packages of health services (EPHSs) to progressively implement UHC. Although the public sector mostly delivers such packages, the private sector has a potentially useful, and still untapped, role. Increasingly normative and practical guidance on the development of benefits packages is available to countries (Glassman et al. 2016; WHO 2021). Processes of deliberation for development of benefits packages are maturing, and the need for institutionalization of the process at national and subnational levels is being increasingly asserted (Gopinathan and Ottersen 2017; WHO 2014). According to Glassman and Chalkidou (2012), at least 63 low- and middle-income countries had devised explicit EPHSs, and that number has progressively increased—particularly after the endorsement of UHC as a target in the Sustainable Development Goals.

Limited guidance exists, however, on how to translate a benefits package through effective implementation into quality, accessible, and affordable health care services. Current literature on country experiences provides little information about how to align the objectives and interests of various actors, especially the private health sector, to implement EPHSs and accelerate progress on UHC. The low- and lower-middle-income countries that need to implement such packages have diverse contexts that elude attempts at standardization of implementation approaches—in contrast with the relatively more standard approaches now available for setting UHC packages and increasingly on the deliberative processes of prioritization of health services (Gopinathan and Ottersen 2017; Jansen et al. 2018).

Many low- and lower-middle-income countries currently implementing EPHSs have complex, mixed health systems. Along with a public sector of varying capacity and breadth, those countries often have an extensive and heterogenous private health sector, with varying degrees of governance effectiveness. The mixed structure of their health systems may make it impossible for countries to provide universal access to essential health services without the effective involvement of the private sector, but engaging that sector in the provision of publicly funded packages raises key questions of accountability, quality, efficiency, and governance, which are yet to be appropriately answered (De Wolf and Toebes 2016; Horton and Clark 2016).

This chapter argues that the delivery of services by the private health sector must be broadly understood within the context of the overall health system rather than just by looking at the private providers in isolation (McPake and Hanson 2016). A comprehensive strategy for achieving universal access to health services should strategically review the role of the public and private sectors in service provision so that the two complement each other in achieving health

sector goals. Drawing on existing literature and review of country experiences, this chapter explores the role the private health sector could play in achieving UHC, presents the experiences of countries in engaging that sector, and identifies key areas of concern and how they might be approached systematically while implementing an EPHS.

## TYPOLOGY AND CHARACTERISTICS OF PRIVATE SECTOR PROVIDERS IN MIXED HEALTH SYSTEMS

In many low- and lower-middle-income countries, a key barrier to a policy approach to the private health sector is the inability of policy makers and planners to accurately characterize the sector. That barrier arises because the sector is often heterogenous and provides a broad array of services—from small shops selling medicines to independent practitioners, including unlicensed providers, to large private hospitals and private insurers (Mackintosh et al. 2016). Different types of providers serve different types of populations, provide different kinds of services, and crucially require different kinds of regulatory strategies to better align their activities with the overall goals of the health system (Stallworthy et al. 2014). Strategically leveraging the role of the private health sector should start with an assessment of the sector's diversity, composition, and contribution (Marten et al. 2014; Stallworthy et al. 2014; Tung and Bennett 2014). Although it is challenging to classify private providers in well-defined categories in low- and lower-middle-income countries, this chapter adapts the categories of private providers as defined by McPake and Hanson (2016) (table 18.1).

**Table 18.1** Typology of Private Health Sector Providers in Low- and Lower-Middle-Income Countries

| Category | Description |
|---|---|
| Unqualified and underqualified providers | Sometimes the main providers of health services to poor people, these providers include outlets such as traditional healers, faith healers, unqualified or unlicensed caregivers, and non-formulary-based drugs shops. |
| Not-for-profit providers | This heterogenous group of providers includes large NGOs, faith-based providers, and donor-funded organizations frequently contracted to provide services such as family planning or primary care in specific locations or to reach out to disadvantaged populations. |
| Formally registered small to medium private practices | In some low- and lower-middle-income countries, such practices make up a large proportion of the private health sector. They usually provide fee-for-service clinical interventions; however, they may have questionable quality and cost-effectiveness, and they normally exclude those who cannot pay. Governments may have the option to influence the range and quality of services through strategic purchasing or social franchising for special packages of services.[a] |
| Corporate commercial hospital sector | Although rapidly growing, this sector still plays a minor part in provision of health services in low- and lower-middle-income countries even where it is well developed. The cost of health services provided makes them inaccessible for most households in low- and lower-middle-income countries. Although these hospitals provide good-quality services to the affluent population, they play a limited role in achieving universal access to services because large-scale purchasing cannot be undertaken.[b] |

*Source:* Original table compiled for this publication based on data from multiple sources, including McPake and Hanson 2016.

*Note:* NGOs = nongovernmental organizations.

a. McPake and Hanson 2016; Sundari Ravindran and Fonn 2011; Tangcharoensathien et al. 2015.

b. McPake and Hanson 2016.

## PREVIOUS EVIDENCE ON THE ROLE OF THE PRIVATE SECTOR IN EPHS IMPLEMENTATION

Much of the existing literature on EPHSs focuses on package development, with less information available on country experiences regarding implementation and even less on the role of the private health sector, except in certain areas such as health insurance and commodity supply (PMNCH and SIDA 2019). More pertinent information is available regarding public-private partnerships (PPPs) through outsourcing of publicly financed health services to the private health sector, although that information does not often relate specifically to the delivery of EPHSs (Odendaal et al. 2018; Palmer et al. 2006; Siddiqi, Masud, and Sabri 2006). Previous experience with implementing packages comes mostly from countries in crisis and from postconflict states that receive significant donor funding for health, such as Afghanistan (Newbrander et al. 2014), Cambodia (Bloom et al. 2006), Mozambique, Timor-Leste, and Uganda (Vaux and Visman 2005). The following paragraphs provide two illustrative examples from Afghanistan and Cambodia.

Around the year 2000, Afghanistan had some of the world's worst health indicators and a devastated health system. The public health sector was largely dysfunctional, with services delivered by a multitude of national and international nongovernmental organizations (NGOs). In parallel with the development of the country's basic package of health services (BPHS) in 2003, the Ministry of Public Health (MoPH) decided to contract with NGOs to provide those services (MoPH 2009; Newbrander et al. 2014). Despite concerns that health service delivery was a function of the state, the donors encouraged contracting with well-established NGOs for provision of the BPHS in defined geographic areas (Loevinsohn and Sayed 2008). The NGOs received payment according to budgets they submitted, with full payment depending on achievement of agreed-on goals. The institutionalization of a Grants and Contracts Management Unit within MoPH allowed the ministry to lead the nationwide implementation of the BPHS, which was instrumental in increased access, better access for women, and increased use of services for deliveries (Newbrander et al. 2014).

In 1999, Cambodia contracted out management of public sector primary care facilities to NGOs in five randomly selected districts (Bloom et al. 2006; Odendaal et al. 2018). The contracts specified targets for maternal and child health service improvement. The program increased the availability of 24-hour service, reduced provider absence, and increased supervisory visits. It involved increased public health funding and led to offsetting reductions in private expenditure as residents in treated districts switched from unlicensed drug sellers and traditional healers to government clinics. Concurrently, the Asian Development Bank piloted two models of contracting for health services: (1) *contracting out*, whereby contractors had full

responsibility for delivery of all district health services in accordance with the Health Coverage Plan; and (2) *contracting in*, whereby contractors managed only district health care services, with the remaining staff consisting of Ministry of Health civil servants. An evaluation found that contracting to NGOs was feasible, cost-effective, high performing, and equitable, and that it effectively targeted and benefited the poor (ADB 2004).

## FEASIBILITY OF ENGAGING THE PRIVATE SECTOR IN EPHS IMPLEMENTATION: COUNTRY AND ECONOMY EXPERIENCES

More recently, the Disease Control Priorities 3 (DCP3) Country Translation Project reviewed the experiences of Afghanistan, Ethiopia, Pakistan, Somalia, Sudan, and Zanzibar in setting and implementing EPHSs using the DCP3 evidence and model packages (Jamison et al. 2018). All six countries and economies have a mix of public and private providers. Formally registered providers operating as individuals or small to medium facilities seem to provide the bulk of services in the private sector, especially in urban areas. Despite its importance, the private health sector does not play a major role in EPHS delivery. As mentioned, Afghanistan is an outlier, with most of its basic and essential benefits packages delivered mainly by NGOs through outsourcing of services. Notwithstanding its short-term benefits, outsourcing is unlikely to be sustainable because of the unpredictability and increasing scarcity of external aid for health (Sabri et al. 2007).

All six countries and economies have a wide range of private health care providers—from large tertiary hospitals and qualified practitioners to unqualified providers. In all countries and economies, policy and regulatory frameworks exist to varying degrees to govern the private health sector, but no country systematically uses that sector in the delivery of EPHSs. Even in countries with social health insurance programs, such as Pakistan and Sudan, benefits packages in those programs are not linked with the EPHS.

All have policy frameworks that support PPPs, with contracting used as the predominant mechanism for engaging the private health sector. PPPs are being used in Afghanistan, Pakistan, and Somalia to enhance delivery of services. The countries and economies show only limited use of social marketing and franchising in delivery of the benefits packages, except for services such as family planning in Pakistan and family planning and nutrition in Afghanistan; but Zanzibar is actively considering such elements. All have substantial out-of-pocket expenditure as a percent of total health expenditure—except Zanzibar, where it is less than 20 percent. Table 18.2 summarizes the feasibility of engaging the private sector in EPHS implementation and presents information on related health financing and service use indicators in the six cases.

**Table 18.2** Status of Private Health Sector Arrangements and Feasibility of Engagement in EPHS Implementation, Selected Countries and Economies

| | Afghanistan | Ethiopia | Pakistan | Somalia | Sudan | Zanzibar |
|---|---|---|---|---|---|---|
| **Types of private providers and Private Health Sector policy framework** | | | | | | |
| Types of PHS providers and their contribution to delivery of services | • HBPs are provided by NGOs through contracting out to some not-for-profit hospitals.<br>• Unqualified and underqualified providers practice mainly in rural areas.<br>• Limited corporate commercial hospital sector exists. | • Formally registered providers, corporate commercial sector, and some practitioners of traditional medicine | • Private providers include qualified GPs, secondary and tertiary hospitals, and unqualified or underqualified providers.<br>• Some private hospitals are empaneled and implement national health insurance packages. | • NGOs are the largest service providers.<br>• Large numbers of unqualified providers, faith-based healers practice.<br>• Small to medium secondary and tertiary hospitals exist mainly in urban areas. | • Many qualified small to medium private facilities exist.<br>• Corporate sector is present in cities.<br>• Faith healers, herbal medicine sellers, and traditional healers also provide services.<br>• Many health facilities are run by charities and not-for-profits. | • Most providers are registered, licensed, and monitored.<br>• Some unqualified practitioners work as traditional healers.<br>• Private health facilities empaneled with national health insurance program implement benefits packages. |
| PHS policy framework | • National policy on PHS exists.<br>• MoPH has PHS oversight authority. | • Policy and legal framework for PHS exists and is enforced by regulatory agency.<br>• Licensing and registration system is present for providers. | • Various policies include the PHS.<br>• Common regulatory framework for public and PHS facilities and providers is implemented by licensing and registration bodies. | • No specific policy exists for the PHS; a general law governs commercial sector.<br>• National health sector strategy recognizes PHS, but no regulatory authority exists. | • No national policy framework or regulatory body exists for PHS.<br>• Registration and licensing systems exist under different boards or bodies. | • Policy exists, but no legal framework exists for PHS.<br>• Private Hospital Advisory Board and professional bodies register facilities and providers. |
| Current level of relationship/ partnership between the public and PHS | • Ministry of Finance manages PPP policy on health.<br>• NGOs provide BPHS and EPHS countrywide via a contracting out model. | • Policy on engaging PHS for service delivery in cities exists.<br>• PHS provides some services included in EPHS but is not obliged to do so.<br>• Some pilot and small-scale PPPs are in place, and a PHS engagement unit exists in MoH. | • Some provinces and programs have PPP policies for service delivery and facility manaagement through contracting with NGOs.<br>• Contracts are not always done through open competition or tied to results-based investments. | • Strategy exists for contracting service delivery to NGOs and private hospitals.<br>• All NGOs are required to deliver EPHS regardless of who contracts them.<br>• MoH has limited capacity to manage contracts. | • No policy exists for PHS engagement, but federal MoH is currently developing one. | • MoH has policy on PHS engagement for service delivery and some programs, and NGOs have PPP policies for health.<br>• Private Hospital Advisory Board acts as the link between MoH and the private sector. |

*table continues next page*

**Table 18.2** Status of Private Health Sector Arrangements and Feasibility of Engagement in EPHS Implementation, Selected Countries (continued)

| | Afghanistan | Ethiopia | Pakistan | Somalia | Sudan | Zanzibar |
|---|---|---|---|---|---|---|
| **Types of private providers and Private Health Sector policy framework** | | | | | | |
| **Financial and service contribution of the PHS to the delivery of services** | | | | | | |
| Private expenditure as % of THE (year) | 75 (2009)<br>77 (2019) | — | 46.7[a] | — | 70.3[b] | — |
| Out-of-pocket payment as % of THE | 77[c] | — | 56.48[a] | 47 | 66.95[b] | 16 |
| Prepaid plans and social security as % of THE | .. | — | 0.9[a] | 2 | 6.43 (SHI as % of THE)<br>24.62 (SHI as % of GGHE)[b] | — |
| PHS as % of annual total outpatient visits | n.a. | — | 75–80 (mainly curative services) | 60 (services provided by the PHS) | n.a. | 47 (services by PHS mainly curative) |
| PHS as % of inpatient episodes or hospital visits (year) | n.a. | — | n.a. (bed density in PHS <3/10,000; in public sector 6/10,000) | — | n.a. | — |
| **Policies and interventions used or piloted to engage the PHS in delivering health services and/or HBPs** | | | | | | |
| Outsourcing/ contracting out | • Delivery of BPHS and EPHS | • None | • Provinces contract out for delivery of primary and secondary services.<br>• Provincial HBPs exist, but role of contracting not defined. | • Private for-profit sector provides more services not included in EPHS, particularly in curative and rehab care. | • NHIF contracts with private facilities to deliver listed services.<br>• FMoH and NHIF codeveloped newly defined EPHS, which will be linked. | NHIF, Jubilee, and Strategies insurance company contract with private facilities to deliver services. |
| Social marketing or franchising | • Limited vertical projects on family planning, iodized salt, oral rehydration solution (ORS), iron, and folic acid | • Some | • Mainly in family planning through donor funding. | • Not included in the health benefits package. | • Benefits package includes role of social marketing and franchising. | n.a. |

*table continues next page*

**Table 18.2** Status of Private Health Sector Arrangements and Feasibility of Engagement in EPHS Implementation, Selected Countries (continued)

| | Afghanistan | Ethiopia | Pakistan | Somalia | Sudan | Zanzibar |
|---|---|---|---|---|---|---|
| **Types of private providers and Private Health Sector policy framework** | | | | | | |
| Social (health) insurance | n.a. | • No | • Sehat Sahulat program (health insurance program) covers selected inpatient tertiary and secondary services. | • Not included in the health benefits package. | • SHI covers > 82 %[d] population with own list of services and medicines. | n.a. |
| Demand-side interventions (vouchers or cash transfers) | • Pilot projects for RMNCH services in two provinces | • No | • Limited and mainly from NGOs, mostly through direct donor financing. | • Not included in the health benefits package. | • With support from World Bank and European Union, cash transfers have been provided intermittently in some areas. | n.a. |

*Source:* Original table developed for this publication.

*Note:* BPHS = basic package of health services; EPHS = essential package of health services; FMoH = Federal Ministry of Health; GGHE = general government health expenditure; GPs = general practitioners; HBPs = health benefits packages; MoH = Ministry of Healthe; MoPH = Ministry of Public Health; NGOs = nongovernmental organizations; NHIF = National Health Insurance Fund; PHS = private health sector; PPP = public-private partnership; SHI = social health insurance; THE = total health expenditure; .. = negligible; n.a. = not applicable; — = not available.

a. National Health Accounts 2017–18.

b. Sudan System of Health Accounts 2018.

c. National Health Accounts 2019.

d. National Health Insurance Annual Report 2021.

The chapters on India and Nigeria in this volume provide examples of explicitly addressing the role of the private sector in providing defined services in a package, including simultaneous efforts to improve private sector regulation and strategically increase the sector's role in achieving universal access to essential health services.

India's regulatory framework governing the private sector, encompassing both quality control and pricing of services, is identified as weak. However, India's 2017 National Health Policy provides a clear vision for private sector engagement (chapter 10 in this volume). That policy advocates transitioning from input-based financing to output-based purchasing for secondary and tertiary services. India's Pradhan Mantri Jan Arogya Yojana program provides tax-financed noncontributary care to 40 percent of the population by purchasing services from empaneled public and private facilities for secondary and tertiary care. Furthermore, the refined and expanded health benefits package incorporates certain regulatory measures for specific hospital types (for example, public or tertiary hospitals) to mitigate fraud and ensure the delivery of services at the appropriate level.

For the Nigerian context, chapter 9 of this volume proposes enhanced resource management through strategic purchasing and highlights that the new National Health Insurance Authority Act 2022 provides a firm statutory basis for robust oversight and regulation of providers such as through health management organizations. The chapter also suggests a potential role for the private sector in pooling health funding through quasi-public or private entities as one potential way of aligning donor funding with national health priorities. Although recognizing the potential role of the private sector, the chapter advocates for stringent regulation considering the expected expansion of private sector involvement following the 2022 act.

## KEY CHALLENGES TO ENGAGING THE PRIVATE HEALTH SECTOR: IMPLICATIONS FOR EPHS IMPLEMENTATION

Engaging the private sector in providing high-quality services as part of EPHS implementation comes with multiple challenges:

- First, understanding the complexity and heterogeneity of private providers is a prerequisite for devising a clear role for those providers in implementing the benefits package.
- Second, private health providers are part of complex mixed health systems and need to complement the public sector without operating in isolation. Box 18.1 elaborates various roles that the private sector plays in mixed health systems (Mackintosh et al. 2016).
- Third, equity and population coverage become challenges when the private health sector is left to its own choices. Without any public subsidy, the private health sector generally provides only a limited set of services and neglects crucial public health services. Private providers therefore are not geared to provide universal coverage of needed services even at the primary level without clear financing mechanisms, additional incentives, and performance monitoring (McPake and Hanson 2016).
- Fourth, challenges related to quality and performance exist. It is often asserted that people use health services from the private sector because of better perceived quality compared to the public sector (WHO 2012); however, perceived quality is often confused with technical quality and patient outcomes. In many cases, overall services are of low quality in both the public and the private sector (Morgan, Ensor, and Waters 2016).
- The final challenge relates to system inefficiency. Private health services may add to the overall costs of care through, for example, overuse of diagnostics and services and overuse of expensive medications leading to waste of resources and other system inefficiencies such as antibiotic resistance. For routine and simple ailments, the public sector is more efficient by limiting overuse of resources and treatments and by providing preventive and public health services (Morgan, Ensor, and Waters 2016).

**Box 18.1**

### Categories of Mixed Health Systems in Low- and Lower-Middle-Income Countries and the Role of the Private Sector

Countries like India and Nigeria have health systems characterized by dominant private provision in primary and secondary care accompanied by high out-of-pocket expenditure. They also have low public expenditure on health. Fees and other charges in the public sector create an additional access barrier encouraging people to turn to private services, which include low-quality and unlicensed providers.

Countries and economies such as Ghana, Malawi, Nepal, and the semiautonomous region of Zanzibar show a stratified private health system with high out-of-pocket expenditure driven by private hospitals and clinics for the more well-off and extensive use by the poor of medicine-selling private shops. The public sector is characterized by varying levels of reliance on fees, which acts as a barrier to access, especially for the poor.

Countries such as Argentina and South Africa have a high-cost private health sector used predominantly by affluent patients, largely financed by private health insurance. The poor generally rely on the public sector, where there is little reliance on service charges.

In Sri Lanka and Thailand, the private sector complements a universalist public sector. Well-funded, high-quality public health systems limit the private sector to a complementary role. That role keeps out-of-pocket costs in check because they mainly relate to use of private services.

Transitioning systems, as in China, have a small private health sector. Such systems traditionally have high private expenditure because of a commercialized public sector, but ongoing reforms are causing that expenditure to fall.

*Source:* Mackintosh et al. 2016.

## DISCUSSION

There is no denying the importance of engaging private health providers in the implementation of UHC packages in the context of low- and lower-middle-income countries. The rather limited evidence, however, makes it less clear how to do so. Using country experiences, the following paragraphs summarize the associated challenges and opportunities as well as possible options for governments to consider when implementing EPHSs in partnership with the private health sector.

Characterizing private providers is essential for understanding their composition, characteristics, and contribution to the overall provision of health care and in determining how the private sector will behave and respond to regulatory tools, incentives and disincentives, and market supply and demand dynamics. In systems with an inadequate or low-quality public sector, engaging the private sector in EPHS delivery seems a realistic option, at least in the short to medium term, for rapidly improving access to essential health services and enhanced financial protection (Ensor et al. 2002; Montagu and Goodman 2016). Private sector engagement has its challenges related to governance issues, such as dual practice of health providers

(WHO 2012); poor quality of care; regulatory compliance; and the limited number of private service providers, which creates a barrier to rapid increase of access to services.

A key takeaway is that, although private providers have an important role to play in such contexts, they are not a panacea to the problem of limited and poor-quality health care services or access to services (Mackintosh et al. 2016; Montagu and Goodman 2016). For instance, the current evidence is mixed about whether financial protection will be provided when services are offered by the private sector as part of a publicly funded benefits package (Ensor et al. 2002; WHO 2012). Although the private sector may play a significant role in the delivery of the publicly financed EPHS, concurrent improvement in the quality of public sector health care delivery in strategic and planned ways is imperative. Whatever strategies countries use to involve the private sector in the delivery of UHC packages, it is necessary to pay attention to the issues of performance and quality. In purchasing interventions from the private sector, countries will need various regulatory tools such as credentialing, accreditation, and use of key performance indicators, along with regular monitoring and enforcement (Montagu and Goodman 2016).

There can be several strategies used for regulating private providers, such as better statutory control to prevent unlicensed practice, self-regulation by professional bodies to maintain professional standards of practice, and accreditation, especially of large private hospitals and chains. Additionally, purchasing delivery of essential services by engaging private providers can serve as an effective regulatory approach to modify provider behavior.

Use of large-scale purchasing interventions has occurred mainly in postconflict situations. Although such purchasing may offer a useful strategy to quickly increase access to services, its long-term sustainability is questionable especially as donor interest fades over time (Ensor et al. 2002; Sabri et al. 2007). In Lebanon, the key challenges to contracting were found to be a weak enabling environment, weak clinical governance, and poor marketing and promotion of the package (Hemadeh, Hammoud, and Kdouh 2019). The Arab Republic of Egypt used PPPs to deliver services for its BPHS for child and maternal care, primary care, and laboratory services, directly managed by a Family Health Fund. Pakistan contracted with private providers to improve access to services in remote areas or to improve the functionality of existing public sector facilities (WHO 2012). However, the evidence for whether such efforts improve access and quality of services is mixed even for small portions of services (Odendaal et al. 2018).

Evidence for financial protection is also not clear. In Argentina and Nigeria, adequacy of funds has presented a problem: only a limited set of services could be provided, and financial sustainability of purchasing interventions has been questionable. In addition, most contracting initiatives in many low- and lower-middle-income countries have not had a pro-poor focus, which suggests inadequate focus on equity (WHO 2012). Therefore, given the evidence so far, it is not clear that large-scale purchasing represents an effective, efficient, or sustainable strategy to provide the larger number of services included in an EPHS.

One view is that a package can act as a tool or instrument for systematizing and aligning the interests of private providers with the overall goals of the health system. In turn, the package can be leveraged as a coordination tool for organizing the health care system and its components, such as financing, purchasing, provider payments, and the organization of service delivery, conceptualizing the role of the private sector within that framework. The explicit nature of the package also facilitates negotiation and conditions of contracts between providers and the government (Giedion, Bitrán, and Tristao 2014).

Although incentives to providers do not always explicitly align with EPHSs, in some countries evidence shows that purchasing strategies are used to ensure quality and efficiency in delivery of the packages. For instance, in Argentina, resources are linked to prioritized services and the outcomes obtained by the providers. By contrast, in Mexico, where resources to providers are not linked with the services in the EPHS, providers have limited incentives to provide services included in the package (Giedion, Bitrán, and Tristao 2014).

Given the urgency to meet the UHC goals, how can governments navigate the challenges of implementing EPHS and progressively achieving UHC while dealing with the uncertainty inherent in working with large, heterogenous, insufficiently documented, and poorly regulated private health sector providers? First, policy makers need to characterize and understand the public health sector in terms of service mix, health expenditure, distribution of services, and its interactions with the public sector as a prerequisite to involving it in EPHS implementation. Second, they must pay attention to supply-side factors—especially the availability of health providers of various categories because that availability can limit their role in rapid expansion of service delivery. Third, countries should conduct a systematic preassessment of private providers and facilities to identify any shortfalls in the infrastructure and personnel needed to provide services included in the EPHS (PMNCH and SIDA 2019). Delivery of EPHSs will not be realized unless countries address the gaps in their health systems (WHO 2021). Fourth, investment and capacity building will also be needed to develop high-quality monitoring and enforcement systems. Finally, increasing overall health expenditure is a must for effective engagement of the private sector in EPHS implementation.

Conflict, political instability, and underinvestment have devastated the health systems in three of the six countries assessed. They face unique challenges of coordinating and dealing with the fragmented aid system as well as with large numbers of NGOs supported by donors that have different approaches to planning, financing, implementing, monitoring, and evaluation. Their governance systems have either collapsed or become severely weakened, and financing health care largely depends on foreign aid. Nevertheless, opportunities exist to rebuild their health systems, including their choice of models for service delivery (for example, the adoption of public financing and private provision). Recent experience in the reviewed countries and economies shows a greater receptiveness of policy makers to positive change than one would encounter in transforming rigid and unyielding health systems, as seen in many low- and lower-middle-income countries.

## CONCLUSION

In those systems with an inadequate or low-quality public sector, and in which the private health sector currently provides a substantial proportion of services, designing and implementing EPHSs without involving the private health sector is unrealistic at least in the short term. Such systems are the most likely to benefit from involving the private health sector in the institution and reliable delivery of EPHSs. With private sector involvement, countries may rapidly improve access to essential services and financial protection.

Despite the inevitability of private health sector involvement in UHC, countries need to consider the challenges that surround private health sector engagement before formulating a coherent strategy on such engagement. Better exploring the role of the private health sector in EPHS implementation will require more research, with some of the recommended options operationalized by developing a guide for engaging the private health sector, which can be adapted to the local context, and by piloting EPHS implementation at small subnational administrative levels (for example, by conducting a cluster-randomized trial in a district, assessing impact, and providing recommendations for scaling up implementation).

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