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Prohibit, constrain, encourage, or purchase: how should we engage with the private health-care sector?

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The private for-profit sector's prominence in health-care delivery, and concern about its failures to deliver social benefit, has driven a search for interventions to improve the sector's functioning. We review evidence for the effectiveness and limitations of such private sector interventions in low-income and middle-income countries. Few robust assessments are available, but some conclusions are possible. Prohibiting the private sector is very unlikely to succeed, and regulatory approaches face persistent challenges in many low-income and middle-income countries. Attention is therefore turning to interventions that encourage private providers to improve quality and coverage (while advancing their financial interests) such as social marketing, social franchising, vouchers, and contracting. However, evidence about the effect on clinical quality, coverage, equity, and cost-effectiveness is inadequate. Other challenges concern scalability and scope, indicating the limitations of such interventions as a basis for universal health coverage, though interventions can address focused problems on a restricted scale.

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Introduction

A well-functioning health system can be regarded as one that assures quality, delivers services in response not only to health needs but also to private demand, and guarantees provision of care to both rich and poor people. Although in principle a well-functioning health system can encompass both private and public sectors, private providers can function very poorly, with examples of pharmacy monopolies, price-gouging specialists, induced demand for unnecessary diagnostic tests, purveyors of false medicines or fake miracle cures, and large gaps in coverage.[1,2] These systemic failures are driven by poor information, the misuse of market power, a failure to consider or lack of interest in implications for the broader community such as drug resistance, and inequity in the distribution of income and knowledge.

The private sector's prominence in health-care delivery in much of the world, and the common patterns of failure in many areas of private provision, drives many governments, non-governmental organisations (NGOs), private entrepreneurs, and donor agencies to intervene to improve the sector's functioning. The figure summarises the outcomes of these market failures and the four approaches for engaging with private providers to address them: prohibition of private practice; constraint of its operation through regulation; encouragement and subsidy of private sector delivery for specific services; and purchase of services from the private sector.[3] In this paper we discuss the main methods used under each approach. The figure also draws attention to the fact that the design of methods must reflect the heterogeneity of private sector provision in terms of the type of goods and services that are targeted and the type of private provider.

Procedures from all these approaches are commonly applied to different parts of the private sector simultaneously—for example, forbidding private abortion services, restricting who may own and operate hospitals, subsidising and encouraging provision of antenatal vitamins through social marketing, and purchasing laboratory or dialysis services as part of the national health strategy.

We review experience with interventions concerning private for-profit providers in low-income and middle-income countries (LMICs) and assess what is known about their effectiveness and limitations. This paper is based on findings from a systematic review of private sector interventions[4] and our analysis of published and grey literature experiences with private sector health system policy activities in LMICs around the world, collected through many years of work in Asia and Africa. The core concepts have been developed through policy training courses in Asia, Europe, and North America

Key messages

- Engagement with private for-profit providers has taken place on four levels: prohibition, regulation, encouragement and subsidy, and purchase of services
- Despite experience with a rapidly growing number of interventions, robust assessments are few, though some conclusions are possible
- Banning the private sector where demand for services is high and capacity to regulate imperfect is very unlikely to succeed, and use of statutory regulation to constrain private providers is inadequate, especially in low-income countries
- Although some evidence shows that targeted supply-side interventions such as social marketing and vouchers can increase coverage of focused services, less evidence is available for accreditation and contracting, which seek to affect broad areas of service availability and quality
- For all these interventions little is known about their cost-effectiveness and ability to reach poor people

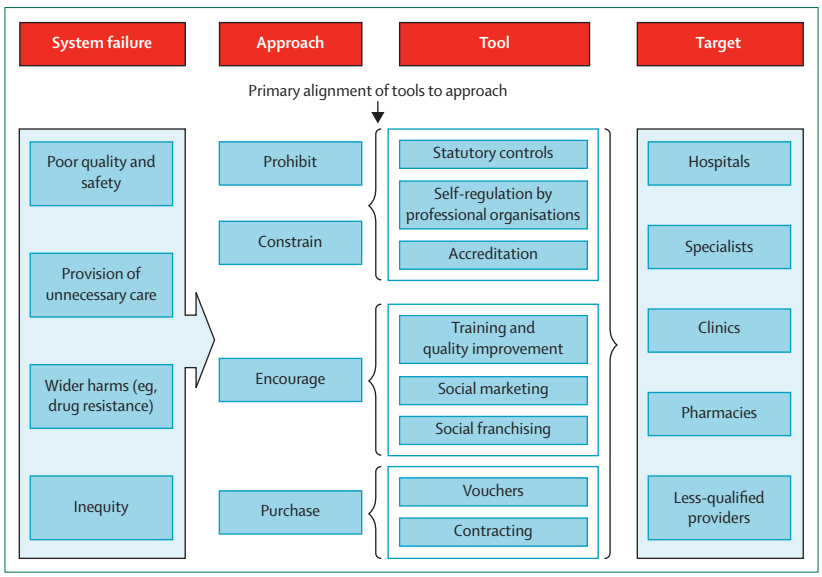

Figure: **Approaches and devices for private sector engagement**

with representatives from universities and health ministries of many countries. Feedback from these policy makers and analysts has further refined our framework for understanding the strategies for private sector engagement.

Approaches

Prohibition

An extreme case of regulation by legal control is a formal ban on some or all forms of private practice. To be effective, any ban requires social support, enforcement capacity, or both. Quite often, neither exists for restricting medical practices in low-income countries, where monitoring challenges mean that prohibitive restrictions are especially difficult to enforce for outpatient services or pharmaceutical sales. By contrast, in many middle-income countries regulatory capacity is sufficient to allow prohibition of some medical practices and an expansion of auditing and enforcement.

Bans on practice by unlicensed providers are often the most visible type of prohibition, but examples of failure are many. In Tanzania, the banning of private providers during the presidency of Julius Nyerere, from independence in 1962 to 1985, forced them to practise undercover and within faith-based organisations but never eliminated private practice.[5] In Cambodia in 2010, the government created a new police force exclusively to impose a ban on private drug sellers. 2 years later no change in practice of these drug sellers was noticed and the force was reputedly allowed to dissolve. Changes in the legal status of abortion services in many countries have forced women to, or away from, informal providers and their unsafe practices, but have had little effect on the overall number of abortions provided.[6]

Examples of successful bans are rare in LMICs; they are documented mainly in strongly controlled socialist economies and reversed rapidly as those economies have opened.[7,8]

Constraint

Although complete prohibition of private health-care providers is rare, some attempt to constrain the activities of private providers is ubiquitous, most commonly through regulation. The term regulation is universally agreed to include statutory rules laid down by government or government-appointed agencies, and also generally considered to include self-regulation implemented by professional bodies. Many commentators emphasise the importance of thinking of regulation more broadly to encompass community accountability, subsidies, contracting arrangements, provider payment systems, and quality improvement or assurance activities.[9–11] Assurance activities in particular are a key part of the hierarchy of so-called responsive regulation, which advocates that regulation should begin with persuasion, dialogue, and voluntary activities, only gradually escalating to mandatory or statutory processes and penalties where required.[12] Although we recognise the importance of this wide range of measures for quality of care, our focus under "Constraint" is more tightly on statutory and self-regulatory constraints, with other strategies to improve private provider performance covered under "Encourage and subsidise" and "Purchase".

Statutory constraints in health care mainly encompass controls on the quality of facilities, human resources, medicines, and equipment, through licensing of pharmacies, clinics, and hospitals and registration of health workers and products.[5,10,13] Other less common constraints aim to counter monopoly power of providers by regulating price, or controlling mergers or collusion. For example, Niger has regulations for wholesale and retail mark-ups for medicines,[14] and in India the government sets ceiling prices for essential drugs.[15] In a few cases regulation is used to address geographical equity: for instance, in Tanzania, legislation restricts registration of new pharmacies in areas where it is deemed there are an adequate number.[5]

Implementation and enforcement of statutory regulations are weak in many African and Asian settings, with some notable exceptions, such as South Africa and the Seychelles.[11,16,17] The regulations are often under-developed and outdated,[11,17] with some countries not having updated their regulatory frameworks for over 40 years.[17] Many governments are not even aware of the scale of the private health-service provision taking place. The operation of unregistered hospitals and clinics is very common;[11] in two Indian states they outnumbered those with formal licences[16] and in Africa only six of 45 countries were reported to have a comprehensive registry of private facilities, with most lists "woefully incomplete and often inaccurate".[17] In some settings, a

high volume of medicines is sold by completely unauthorised outlets, such as the market stalls and itinerant vendors in Niger.[15]

There is ample evidence of endemic regulatory infringement by pharmacies and drug stores that are permitted to sell medicines in many low-income and middle-income countries—eg, dispensing prescription-only medicines without a prescription, stocking unauthorised medicines, dispensing insufficient dosages. For example, in Tamil Nadu, India, 61% of prescription-only medicines were dispensed without a prescription,[18] with the range of such medicines often including antibiotics, steroids, narcotic analgesics, psychotropics, antihypertensives, sedatives, tranquillisers, anti-tuberculosis agents, and abortifacients. A further concern is the quality of medicines, with frequent documentation of both substandard products because of poor manufacture or storage, and deliberately falsified (so-called fake) medicines.[19] Regulation of high-volume, low-cost, pharmaceutical commodities is difficult, and the incentives of pharmacies and retailers make it more so.[7,20] In Colombia, Guatemala, and Mexico, enforcement of prescription laws during the mid-2000s and late-2000s, at the same time as the expansion of pharmaceutical chains, drove a widespread reduction in over-the-counter sales of antibiotics and other prescription-only medicines.[21] This reduction probably reflected both increased regulatory investment and the desire of chains to reduce competition from low-cost, low-quality competitors.[22]

Illegal practices are in some cases a response to demand, with providers who refuse to acquiesce to client requests quickly losing custom to those who will. Inspections are often rare, with some facilities not inspected for over a decade,[16,17] and revocation of hospital licences almost unheard of in many settings.[16,23] One reason could be inadequate capacity of inspection and judiciary agencies, which often do not have the resources for inspections and face severe shortages of staff,[16] who in some case are not even regularly paid.[17] This situation is complicated by overlapping mandates for regulation, which generally encompass national and local public bodies, and require coordination with police and judicial offices to enforce penalties.[16,17] Poor implementation can also indicate lack of incentives for front-line inspectors and their imperfect access to information, and capture of regulatory staff who come to identify with specific interest groups or providers and who could even own infringing retailers or facilities.[11,13,20] For example, in India the conditions for registration of facilities were substantially weakened as a result of challenge by doctors' groups.[16]

Regulators in some settings accept that enforcing standards could increase the cost of provision beyond what can be afforded by poor communities.[24,25] For example, the employment of a pharmacist or even a lower level pharmacy cadre would not be viable for a business in rural Kenya. One possible consequence is a gap between the *de jure* regulation in the country's laws and the de-facto level of regulation that inspectors aim to enforce.[20] The resulting divergence between regulations and common practice provides extensive opportunities for corruption, for example in the form of routine bribe payments to avoid inspection visits or adverse reports.[25]

Little assessment has been done of the introduction or improvement of regulations, with the exception of a few randomised controlled trials in pharmacies.[8,26,27] This gap partly reflects the challenges of conducting controlled assessments of legal changes. However, the use of other approaches such as case studies and qualitative methods for rigorous investigation of regulatory implementation is also rare,[16,25,28] and no evidence about the cost-effectiveness of regulatory strategies exists.

Despite widespread evidence of poor implementation of statutory constraints, in most settings regulation seems to have had some effect on the ordering of private sector provision, and in preventing degeneration into a completely ungoverned free market. For example, in many (though not all) settings most providers will have some form of health qualification, and the sale of medicines is often constrained to specific types of outlets.[29] However, in view of the widespread failures of implementation of statutory regulation, in recent years increasing emphasis has been placed on the benefits of consumer-based regulation, and compulsory and voluntary self-regulation schemes.

Consumer-based regulation can allow consumers to sue providers for adverse experiences and outcomes. In India, a Consumer Protection Act was passed in 1986, to be enforced through dedicated consumer courts.[30] Most studies report high awareness of the legislation by providers, and many complaints have been lodged by consumers.[31] However, the process can be lengthy and costly for consumers,[32] one argument being that outcomes are weighted in favour of defendants, with doctors sometimes receiving the benefit of the doubt.[16]

Self-regulation by professional organisations is common, but also problematic in LMICs.[16] The delegation of regulatory responsibilities to professional groups is based on the rationale that these groups are well placed to assess performance, and that government costs can be reduced and enforcement improved. However, the organisations are often poorly resourced, and not well placed to control providers.[10] They also tend to place more emphasis on providing leadership and protection to the medical community, with minimum disciplining of members.[16]

Accreditation, which is the most widespread form of voluntary self-regulation among hospitals, is well established throughout Europe and North America, where it provides a process for combined external and peer assessment of facility standards and quality processes.[33] Accreditation standards are commonly set as targets among many hospitals, and revised regularly

to account for widely shared improvements in quality norms. The use of peer assessors from other institutions also facilitates sharing of lessons between facilities.

Accreditation is increasingly common in middle-income countries, where it is often a condition for reimbursement under national health insurance (eg, Thailand, Kenya, Malaysia, Philippines).[34] This conditionality of insurance payments is effective at modifying provider practices in a positive way and, as a result, programmes have often been started after the introduction or expansion of national or social health insurance.[35] The evidence on the effect of accreditation is mixed; some studies find positive effects on clinical quality and patient outcomes whereas others find no effect.[36] However, accreditation works well only if most hospitals in a country take part, and that happens only when participation is linked to reimbursements. Therefore, accreditation in low-income countries is a challenging, and perhaps impossible, proposition.[37] Additionally, accreditation is expensive, and this cost must be borne by participating hospitals, and ultimately their clients. For facilities at the high end of the market, accreditation with global agencies is a good investment. For facilities serving local populations in LMICs or contracted by the public sector, the cost of accreditation can be hard to pass on to patients or purchasers.

Other approaches to providing public information about provider quality include scorecards, surgical outcome comparisons, and know-your-rights campaigns, which are common in countries in the Organisation for Economic Co-operation and Development. These approaches are only now being tested in small ways in LMICs, as in India where the White Ribbon Alliance has piloted a phone-based system for new mothers to assess their delivery providers.[38]

Encouragement and subsidise

Many governments and NGOs provide positive incentives to encourage the private sector to increase access to key health-care interventions or to improve quality. This support is most commonly done by offering training to private providers, social marketing of commodities, recruiting private providers into a social franchise network, providing targeted tax incentives to encourage investments or reduce end-user prices, or offering subsidies to potential clients. The number of these initiatives has increased substantially over the past two decades, often supported by donor funding.

These strategies aim to reduce reliance on the consumer's imperfect quality assessment and increase the control of quality through supply-side incentives and requirements. The services concerned can include those with benefits for the wider community such as the treatment of infectious diseases, but many do not, justified rather by the need to address inequities in provision. Such expansion in provision can also reduce monopoly power, thus putting downward pressure on prices.

To encourage the use of standard treatment guidelines, the inclusion of private providers in free or subsidised publicly funded training programmes has become increasingly common.[11,39] This arrangement is premised on the assumption that the main reasons for inadequate care relate to the inadequate knowledge of private providers, which can be addressed through short, focused training sessions. Examples are 2–3 days of training for shopkeepers on appropriate provision of antimalarial medicines in Kenya,[40] short trainings on appropriate management of tuberculosis by private practitioners in India,[41] or 35 days on dispensing and treatment practices for staff in drug shops in Tanzania.[42] Training has often been combined with other strategies, such as community information, prepackaging of medicines, strengthened supervision, or feedback and negotiation sessions (eg, the INFECTOM approach).[20,42–45]

However, extensive evidence of a sizeable know–do gap among private providers remains. For example, whereas only 20% of pharmacists in Vietnam said they would sell antibiotics for a child with a viral upper respiratory tract infection, 83% did so when they were assessed by mystery shoppers.[46] This gap has led many people to question the use of training in isolation, and advocate interventions that draw on techniques and forms of business organisation common in the commercial sector.

Commodity social marketing applies commercial marketing techniques to create demand for products that have high public health value. The promoted commodities are distributed, usually at a subsidised price, through for-profit retail outlets such as pharmacies, shops, drug sellers, and even bars. Social marketing is the most common large-scale private sector intervention model in LMICs, with well over 100 programmes in recent years in more than 70 countries. Family planning commodities were the most frequently socially marketed products throughout the 1970s, 1980s, and 1990s, and vitamins, nutritional supplements, antimalarial drugs, and insecticide-treated mosquito nets have also become common in the past 20 years. For example, social marketing of condoms began as part of family planning efforts, and was substantially expanded in response to the HIV/AIDS pandemic. More recently, artemisinin-based combination therapies have been promoted for the treatment of malaria in the private sector through the Affordable Medicines Facility—malaria (AMFm) which subsidised these medicines at a supranational level.[46]

Many examples of social marketing programmes operate at large and often national scales, and evidence shows that they can increase use of targeted products, including condoms, oral contraceptives, insecticide-treated mosquito nets, oral rehydration therapy, and antimalarial drugs.[32,46–48] In some situations, social marketing is expected to shape the market by establishing new products, changing consumer habits, and stimulating private sector supply, potentially making an unsubsidised market more feasible in future.

By contrast, some have concerns that promotion of own-branded products by a social marketing agency might crowd-out purely private sector alternatives, possibly making the market less viable should the social marketing agency withdraw.[49] In the market for insecticide-treated mosquito nets in Tanzania, this concern led to a switch from a traditional social marketing model to a manufacturers' model, in which the social marketing agency promoted a set of approved products from local manufacturers, but in most programmes the promotion of own-brands has persisted. Other debates have continued about the relative cost-effectiveness and equity effect of social marketing in comparison with alternative commodity delivery strategies such as free public provision and community health worker services.[32,50]

Social marketing focuses on public health commodities that can generally be delivered to end-users with little or no accompanying service by a health-care professional.[51] By contrast, social franchising has been used for enhancing delivery of more complex services, provided principally in clinics or small hospitals. Social franchises "attempt to use franchising methods to achieve social rather than financial goals",[52] by linking pre-existing private health practitioners in a network to provide socially beneficial services under a common brand.[53] Franchises can be stand-alone, in which the franchisee exclusively provides franchised products and services, or fractional, in which the franchisee provides a package of services under both the franchise and unfranchised product lines.[54] Although the franchisor is often an NGO, there are a growing number of government and for-profit social franchises.[55] Franchisees can pay a fee to the franchisor, but aspects of the franchise package such as training and marketing are often funded solely (ie, subsidised) by the franchisor.

Social franchises have been documented in more than 20 countries and their numbers have increased rapidly, doubling every 4 years since 1994, with over 90 tracked by Social Franchising for Health (SF4health)[55,56] The range of services provided through franchised clinics has also increased, with over half of existing programmes supporting multiple services, most commonly including family planning, reproductive health, safe deliveries, and diagnosis and treatment of HIV/AIDS, tuberculosis, malaria, pneumonia, and paediatric diarrhoea. An estimated 15 000–20 000 individual clinics in Asia, Africa, and Latin America now operate as part of social franchise networks.[53]

A key goal of these networks is to provide improved quality of care. Improvements in user satisfaction and perceptions of quality have been documented in most, though not all, franchises studied, but the effect on objectively measured clinical quality of service delivery has been hardly ever demonstrated.[56,57] Social franchising has been shown to increase client volume at franchised clinics, and occasionally has increased overall use at the community level.[56] Key concerns raised about social franchising models include the difficulty of controlling clinical quality, especially for more complex services, and the equity impact, with most evidence showing that franchised clinics tend to serve clients with high socioeconomic status relative to clients of non-franchised clinics or the general population.[56]

Purchase

The purchasing of some private goods and services is common throughout all public health systems and in most instances is not controversial. Few would suggest that government health services manufacture their own beds, bricks, or water filters, or their own antibiotics, sterile gloves, or mosquito nets. More complex purchasing commitments, often described with the umbrella term contracting, can be more controversial. Nevertheless, contracting for narrowly defined service components is commonplace. Examples include contracts for dialysis centres in South Africa and the Philippines, and laboratory or pharmaceutical distribution services in Tanzania, Zambia, and Mali. Contracts have also contained a range of financing, construction, and operations models for expansion of hospital infrastructure (and sometimes the provision of clinical services) in Brazil, Mexico, Lesotho, Thailand, and many other countries.[58–60] No systematic evidence from LMICs exists for the quality of contracted private relative to public facilities,[61,62] whereas the evidence from wealthy countries is insufficient and contradictory.[63,64]

Contracting arrangements are sometimes fiscally pragmatic, leveraging private funds for initial infrastructure investments to expand capacity faster than government funds alone allow. In other instances, contracting arrangements are a recognition that private expertise can fill a specialised need better than government can (eg, dialysis or pharmaceutical logistics management), or allow more rapid expansion of service provision. For example, many countries contract NGOs for the provision of family planning and reproductive health services to augment what government clinics alone can provide. Such contracts can be especially favoured where there is an attempt to avoid controversy or serve stigmatised patients, such as sex workers or drug users who might have reasons to be cautious in government facilities.

For more about **data tracked by SF4health** see http://SF4health.org

Contracting for all primary-care provision in a defined geographical area has also been implemented, most commonly in fragile and post-conflict states. Such contracts have been studied extensively in Cambodia, Rwanda, and Afghanistan.[65–69] Although these contract bids were open to for-profit providers, in the end all large-scale contracts of this sort were delivered through non-profit providers. The system of contracting out can, but not always, deliver both effective services and cost-effectiveness, and it has nearly always been used as a

temporary solution to assuring public service provision.[70] As soon as stability is assured, governments have shown a strong preference for resumption of traditional primary care that is owned and operated by government. The experience of Cambodia illustrates this system well, where contracting was introduced at the instigation of the Asian Development Bank, and showed many successes, but was rapidly dismantled once the bank requirements were completed and government capacity had grown.[71]

In addition to directly contracting private services, governments can also indirectly purchase services by providing vouchers to users, which can also facilitate targeting subsidies at a particular group such as poor people. In a typical voucher programme, donor or government funds are given to a targeted population for specific goods or services in the form of a paper or electronic voucher that can be used at previously approved public or private providers, who are subsequently reimbursed. A variant of this approach is to base eligibility of users on possession of identification indicating their poverty status, such as the use of the Below Poverty Line card in India.[72] In some cases voucher payment initiatives have been added to established clinic social franchises. Vouchers have been used for family planning services, vaccinations, treatment of sexually transmitted infections, deliveries, antenatal care, and vitamins, and to increase uptake of insecticide-treated mosquito nets. An advantage is that the funds can be targeted to low-income or high-risk individuals in specific geographical areas. One suggestion is that quality of care will also be increased as providers strive to be included in the voucher programme, and in some programmes to compete for the custom of voucher recipients.

Since 1995, the number of voucher programmes has increased rapidly, building on the well-documented experience of the Instituto Centroamericano de la Salud in Nicaragua where targeted payments for treatment of sexually transmitted infections have been in place for 15 years.[73–76] Another well-documented example is the provision of vouchers to women attending public sector antenatal clinics in Tanzania to cover part of the cost of the purchase of insecticide-treated mosquito nets from private retailers.[77–81] Since 2008, 19 voucher programmes are reported in LMICs.[82]

Available evidence shows that vouchers have been associated with increased use of targeted health services.[83–85] Evidence that they can be associated with improvements in quality of care and effective targeting to specific populations is modest, and the effect on population-level health outcomes is inconclusive.[83–85] No clear evidence is available for the cost-effectiveness of vouchers as a method of subsidising health services. Concerns include the potential for fraud around voucher reimbursement, and the costs of identifying accurately both recipients and providers of suitable quality.[82,86,87]

Discussion and conclusions

In many LMICs such as China, Cambodia, Paraguay, Senegal, Nigeria, and Ghana, health expenditure is increasing at more than 10% a year.[88] Although the situation in each country is different, they share a challenge common to almost all developing countries—namely, the best way to interact with private providers to create a well functioning health system.

To address this problem, policy makers can draw on several decades of experience with private sector intervention. Unfortunately, much of this experience remains imperfectly documented, with a notable scarcity of robust assessments, which to some extent indicates neglect of this area of research; it also points to the inherent challenges of studying interventions that often require research methods less well accepted than the randomised trials that are the gold standard for much health research.

However, some conclusions are possible from the experience so far. First, we know that some approaches will not work, at least in isolation. Clearly, prohibiting the operation of the private sector, where demand for services is high and capacity to regulate imperfect, is doomed to failure. Furthermore, the ability to constrain private providers through statutory control is inadequate, especially in low-income countries. Self-regulation cannot be relied on to fill the gap because in most settings professional organisations function more like trade unions than effective regulators. We also know that even after training there is often a substantial gap between knowledge and practice.[39,89] That is not to say that regulation and training have no value; training could be an important first step when provider knowledge is highly imperfect, and in many settings regulation prevents a complete free-for-all of so-called quack practitioners and peddlers of fake drugs. Strong regulatory capacity should be the medium-term and long-term priority for low-income countries. In the near term, however, attention is increasingly turning to interventions that encourage private providers to improve the quality and coverage of their care, while advancing their own financial interests.

These approaches include social marketing, social franchising, accreditation, vouchers, and contracting. Evidence shows that social marketing and vouchers can increase coverage of targeted services and commodities, though there are clear limits to the types of interventions that social marketing can deliver, since it is unsuitable for even mildly complex services. By contrast, robust evidence on the effect of social franchising, accreditation, and contracts is less available; despite some positive outcomes, we do not have strong evidence that they can improve technical quality of care and coverage at the community level. For all these interventions, the evidence of their ability to reach poorer groups is weak,[90] and little is known about their cost-effectiveness.

With all interventions in the "Encourage and subsidise" category, key challenges are likely to be the expansion of them in both scale and scope. For example, the intensive nature of support and monitoring of facilities required for social franchising is likely to make rapid geographical scale-up very difficult. Vouchers might work well for a targeted set of services, but would be hard to use for provision of health services more generally. Sustainability is also a concern, since strategies such as social marketing, social franchising, and vouchers require substantial continued subsidy, and are almost entirely funded by extranational donors and implemented through NGOs. Donor preferences for these methods stem from their focused nature, the effectiveness of targeting to prioritised health services or particular populations, and the efficiency gains resulting from funding work outside large, often inefficient, and reputedly ineffective or corrupt, national bureaucracies.

These concerns point to the limitations of the "Encourage and subsidise" methods as a basis for large-scale public–private engagement, and the provision of universal health coverage. Rather they can be thought to function more as band-aids or at best bandages—potentially effective at addressing a focused problem on a restricted scale, but in no way a solution to the systemic, broad-based challenges of the whole health system. Broader-based solutions potentially exist in the form of a combination of accreditation, contracting, and regulation. Though unlikely to be implementable in low-income settings, they are becoming increasingly feasible as incomes and capacity rise in middle-income countries, and collective financing and purchasing can be used to effectively steer private sector development.

The private sector is increasingly hard to ignore, and the costs of ignoring it could be very high in public health terms. A range of devices exists for engagement, and experience with them has rapidly developed in recent years. The choice of appropriate approach will vary substantially, dependent on the health system failures being addressed, the nature of the health-care product or service, the type of provider, and the level of development of the country both in terms of income levels and health system organisation.

Contributors

Both authors contributed equally to the conception, development, and writing of this article.

Declaration of interests

Both authors have previously been contracted by Population Services International, an NGO focused on supporting social benefit through private provision of goods and services in developing countries. DM has given talks to, and received honoraria from, other NGOs engaged in private health-care provision.

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