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Managing the public–private mix to achieve universal health coverage

Barbara McPake, Kara Hanson

The private sector has a large and growing role in health systems in low-income and middle-income countries. The goal of universal health coverage provides a renewed focus on taking a system perspective in designing policies to manage the private sector. This perspective requires choosing policies that will contribute to the performance of the system as a whole, rather than of any sector individually. Here we draw and extrapolate main messages from the papers in this Series and additional sources to inform policy and research agendas in the context of global and country level efforts to secure universal health coverage in low-income and middle-income countries. Recognising that private providers are highly heterogeneous in terms of their size, objectives, and quality, we explore the types of policy that might respond appropriately to the challenges and opportunities created by four stylised private provider types: the low-quality, underqualified sector that serves poor people in many countries; not-for-profit providers that operate on a range of scales; formally registered small-to-medium private practices; and the corporate commercial hospital sector, which is growing rapidly and about which little is known.

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This is the fourth in a **Series** of four papers about UHC and private health care

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Introduction

The private sector has a large and expanding role in health systems in low-income and middle-income countries. The goal of universal health coverage, as outlined in the Sustainable Development Goals, provides a renewed focus on the need to take a system perspective in designing policies to manage the private sector. Universal coverage systems maximise health outcomes; equitably distribute health-care services that are of good quality and are financially and geographically accessible; ensure that services are delivered efficiently; and are associated with low levels of out-of-pocket burden distributed according to ability to pay. Management of the private sector to achieve this goal requires choosing policies that will contribute to the performance of the system as a whole, rather than of any sector individually.

The papers in this Series have produced important insights into the parts played by the private sector in health systems across the world, and evidence of the effects of some policy responses and interventions. Mackintosh and colleagues[1] argued that a large and dominant formal private sector and a highly commercialised public sector exclude poor people from sources of care that meet minimum quality standards and leave them dependent on poor quality, underqualified private providers, such as drug shops. Health systems with these characteristics are also typified by high levels of out-of-pocket payment, and they also have the highest incidences of causing or sustaining poverty through the burden of health expenditures.[2,3] Conversely, when competent and affordable care is widely available, much of the potential demand for poor quality and informal private providers is diverted, leaving little scope for their survival. Morgan and colleagues[4] presented evidence that the private sector is sometimes able to provide services that are of higher quality and lower cost than the public sector. However, this outcome is variable across provider types; unsubsidised private providers generally provide a limited set of services, and the private sector as a whole neglects important public health services, particularly preventive and promotive care. Such providers on their own will not provide comprehensive universal care, even at a primary care level.

Morgan and colleagues also identified the need to think about interventions and effects at the level of the health system, not focusing on individual providers, and the ways in which public and private sectors are linked. Such links imply that approaches to managing the private sector cannot be taken in isolation from the system as a

Key messages

- The main aim of government policies should be to encourage a public–private mix that ensures widespread availability of good quality, affordable care so that the health system meets the needs of the population as a whole.
- Presented with the option of affordable services of acceptable quality, data suggest that demand for unqualified, low-quality providers that are used mainly by the poor will fall.
- Beyond this insight, the specific mix of public and private providers cannot be specified; it will depend on the characteristics of providers in a particular context, and the capacity of government to regulate and purchase.
- As a system progresses towards universal health coverage, the private sector could be involved as providers of publicly funded services for everyone, or as providers of services beyond those of the basic universal entitlement.
- In these universal systems, governments' role as a regulator will be to ensure that public resources are used for the public's benefit and to protect against predatory behaviour by private providers.
- When there is no political appetite for ensuring that public subsidies are directed to those most in need, or when government capacity is severely limited, there is scope for targeted interventions in the private sector to address quality and encourage provision of specific services to address the most pressing needs.

whole. Montagu and Goodman[5] reasoned that banning the private sector has rarely been successful, except in instances of exceptional control associated with socialist economies; and neither has statutory or professional self-regulation. The findings reviewed by Montagu and Goodman show that although a range of interventions improve private sector quality or access for specific health disorders in specific places, there is limited evidence of their ability to improve the system as a whole and to be scaled up, both geographically and to address a range of health problems. They also highlighted the relative effectiveness of policies that are compatible with the financial incentives of providers, allowing them to pursue their own interests and objectives while at the same time achieving public goals.

Together, these insights imply that government policies that support widespread availability of financially accessible and competent providers, whether public or private, have the greatest potential to ensure a public–private mix that services the population as a whole. This approach operationalises the notion of universal health coverage within the realities of pluralistic health systems.

Here we discuss and extrapolate main messages from the papers in the Series and from additional sources to inform policy and research agendas in the context of global and country level efforts to secure universal health coverage in low-income and middle-income countries. The heterogeneity of the private health sector has been emphasised throughout the Series and it follows that policy and research agendas should reflect and respond to that heterogeneity. We explore the types of policy that might be an appropriate response to the challenges and opportunities created by four stylised private provider types on the basis of the three dimensions: objectives (for-profit or non-profit), size of organisation, and quality (proxied by qualified or unqualified front-line staffing).[4] The table shows key dimensions of heterogeneity among private sector providers that are presented in the papers in the Series: the low quality, underqualified sector that serves the poor population in many countries; not-for-profit providers that operate on a range of scales; and formally registered small-to-medium private practices. Additionally, we look at the emerging corporate commercial hospital sector, which is the target of much international investment, but which has been studied very little up to now.[6]

	Unqualified		Qualified	
	For profit	Not for profit	For profit	Not for profit
Small	Low-quality, underqualified providers	Limited presence	Eg, sole practitioner physician practice	Eg, Faith-based clinic
Large	Limited presence	Limited presence	Eg, Corporate hospital chains	Eg, Network of non-governmental organisation providers

Table: **Some key dimensions of heterogeneity among private sector providers**

Methods

As identified in the papers in this Series, system-level evidence about the performance of the private sector is scarce, which makes it difficult to take a purely empirical approach to identifying appropriate policies. No systematic and comparable data are available for the number and type of private health-care providers to enable a cross-country comparative analysis (paper 1, Mackintosh et al); the scientific literature on health-provider performance tends to look at equity, quality, and efficiency outcomes for individual private providers, sometimes compared with public providers, but never looking across the two sectors to enable an assessment of system level outcomes (paper 2, Morgan et al); and although comparatively well studied, the effect of provider level interventions such as training and franchising, does not provide a basis for understanding the system level effects of such interventions (paper 3; Montagu and Goodman). For the present analysis, we took a more exploratory approach, working through available evidence and anecdotes, gathered from our knowledge of the scientific literature, combined with some assertion and speculation that can form the basis for hypotheses to be tested in the future. The importance of such an exploratory approach for the nascent field of health policy and systems research has been recognised in the methodological literature (eg, Sheikh and colleagues).[7]

Low-quality, underqualified providers

Both Mackintosh and colleagues[1] and Morgan and colleagues[4] argue that the strength, scale, and scope of low-quality, underqualified provision are established mainly by the effectiveness of the public sector in its provision of an accessible, affordable, and reasonable quality alternative. Montagu and Goodman[5] suggest that regulation cannot effectively intervene when such providers are the only credible source of care for large populations, even where regulatory capacity is large. In such circumstances, an effectively subsidised health service that is recognised by users as being of adequate quality is needed. This solution can drive out the low-quality element of the private sector in a process of regulation by competition, sometimes referred to as beneficial competition.[8] Such an approach takes advantage of the effects of self-interest and incentives rather than control,[5] and is therefore not reliant on external regulation or professional self-regulation that generally fails to impose rules against popular perceptions of self-interest of both providers and patients.

The figure shows some evidence for this approach by plotting the association between government expenditure on health with a measure of use of unqualified providers for cases of childhood illness. When governments

commit a higher share of GDP to health, the reliance on unqualified providers decreases and, in particular, all countries with health spending of at least 5% of GDP (as advocated by McIntyre and Meheus[9]) have a negligible use of such providers. These findings are consistent with the argument that a publicly financed health service can crowd out the low quality element of the private sector.

Although public (or donor) financing is crucial, several alternative mechanisms exist through which this funding can be channelled to reasonable quality providers. The first is through a directly financed public sector. This approach has been adopted by a few low-income and middle-income countries, including Sri Lanka and Thailand, which have both succeeded in ensuring universal access to a publicly financed and provided health system by crowding out low-quality, under-qualified providers (panel).[1]

Non-profit providers

Non-profit organisations in low-income and middle-income countries are a highly diverse set of providers, ranging from large-scale provider networks run by national non-governmental organisations (NGOs), such as BRAC in Bangladesh; to faith-based providers that can operate as part of diocesan provider networks and be more or less integrated with national health systems (eg, receiving subsidies or allowed to procure drugs and supplies through the government medical supplies system); to organisations largely supported by external funds to provide particular services, often to vulnerable groups such as sex workers or intravenous drug users. Such providers' separation from government can be beneficial for system-level outcomes, perhaps because they are able to better manage performance in terms of equity and quality, or because they allow access to services by groups that would otherwise be politically sensitive. Alternatively, such arrangements can limit benefits—for example, when the service package they provide is not comprehensive, or if particular beliefs preclude them from providing services such as family planning.

These challenges notwithstanding, NGOs have various mechanisms through which they are able to ensure performance, including their own motivation and values, better ability to record and provide incentives for staff performance, and in some settings, greater managerial capacity than government structures.[16] NGOs have sometimes been contracted to provide specific services, such as family planning or reproductive health services,[17] whereas in other settings they have been responsible for providing comprehensive primary care services, although often in only some parts of the country (eg, urban services in Bangladesh,[18] specific parts of the country in Afghanistan,[19,20] and Cambodia[20]).

As with other provider types, the central concern must be the extent to which not-for-profit providers support progress towards universal health coverage. Although not-for-profits explicitly aim to serve the public interest, whether this results in behaviour distinct from for-profits depends on several other factors. For example, in the USA, data suggest that behaviours of the two sectors can be difficult to distinguish.[21,22] Both are exposed to market forces through which survival is contingent on revenue generation and in which goals of surplus generation for

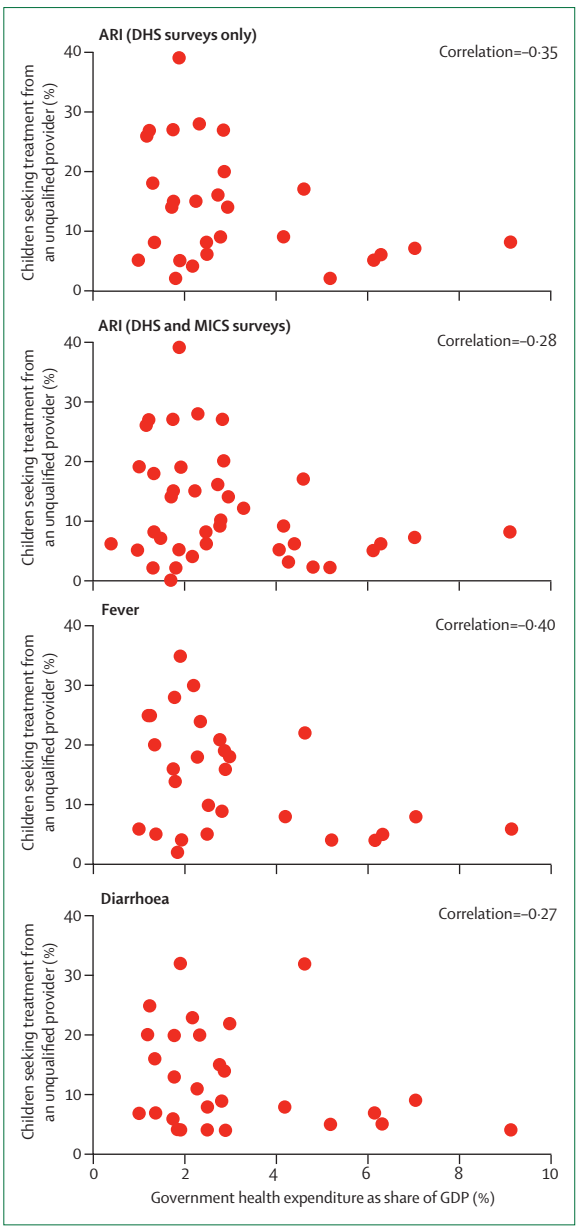

***Figure*: Treatment seeking from unqualified providers for childhood illness versus government health expenditure**
Data for treatment source for diarrhoea and fever come from DHS surveys. UNICEF's Multiple Indicator Cluster Surveys (MICS) ask comparable questions about treatment source for acute respiratory infections, so for this condition, data are shown for DHS alone and for DHS and MICS surveys combined. Data for inappropriate health seeking from Hodgins and colleagues.[9] Data for government health expenditure from Global Health Observatory Data Repository (accessed Dec 26, 2014).

For **BRAC in Bangladesh** see http://www.brac.net

Panel: Crowding out low-quality, under-qualified providers through a directly financed public sector: Sri Lanka and Thailand

As argued by Mackintosh and colleagues,[1] Sri Lanka and Thailand have achieved effective almost universal access to a public health system that is largely recognised as being of adequate quality. For Sri Lanka, Rannan-Eliya and Sikurajapathy[11] make the case that a process similar to regulation by competition has been effective from the early stages of the development of the health sector. By emphasising an accessible network of free clinics and hospitals, the system attracted patients away from traditional and unqualified doctors with the continued effect that in modern times, poor Sri Lankans disdain services from those sources. Already in 1951, 50% of births were attended by skilled birth attendants,[12] a level many Asian countries are yet to achieve. In 2000, the estimate was 92%.[13] In 2008, Rannan-Eliya and Sikurajapathy described the modern public–private mix as dominated by the public sector in inpatient care and by the private sector in outpatient care, a factor that contributes to the relatively low cost of the Sri Lankan health system compared with other countries. Research findings show that the public system is trusted by both rich and poor people for more serious illnesses, and used because it is free. The Sri Lankan population has high levels of use of formal health care, similar to those of the German population (Rannan-Eliya and Sikurajapathy), supporting the argument that there is little gap for the informal, unqualified practitioner to fill, even in the absence of reliable comparative data for this point.

In Thailand, by 2000, 70% of the population were protected against out-of-pocket health expenditure because of the gradual extension of several different public and private insurance mechanisms. Nevertheless, findings of a study in which data were collected in 2000 showed that 55–77% of elderly people in one province in Thailand used drug sellers as their main source of treatment of non-acute disorders.[14] In 2001, insurance coverage was extended to the whole population and consolidated through three public insurance schemes.[15] Levels of out-of-pocket health expenditure and catastrophic health expenditure reduced substantially, especially in the poorest deciles (who are most likely to use low-quality providers).[15]

reinvestment, or for profit distribution, might substantially affect behaviour. Faith-based organisations providing hospital services on a fee-for-service basis when there is little external subsidy are in a similar position; to survive they must charge fees sufficient to cover costs and in many settings this renders them financially inaccessible to sections of the population or liable to cause impoverishment by the collection of fees from those in vulnerable situations. Exemption systems seem to work poorly to reduce either problem, as for example, in the case of Ghana.[23]

However, many not-for-profit organisations in low-income and middle-income countries raise funds externally to support service delivery at no or highly subsidised cost. In principle, a for-profit and a non-profit organisation will use an external subsidy differently. Whereas an organisation with an effective public good objective will use the subsidy to maximise appropriate service delivery, a for-profit organisation will use the subsidy to improve market position and accordingly extract additional revenues through fees.[24] This finding suggests that greater reliance on the presence of additional supportive regulation of subsidised for-profit providers might be necessary. In practice, underlying organisational objectives can be difficult to discern. A stated not-for-profit intention might be a smokescreen for profiteering organisations such as the unscrupulous briefcase NGOs.[25] Registering as a not-for-profit organisation implies a difference in legal status and constrains an organisation from distributing surplus as profit but not from using surplus to pay a higher salary to the organisation's Director and effective owner, to provide just one example of how surplus generation can be directed towards private gain.

In summary, heterogeneity precludes generalisation even within this one category of provider type. Some not-for-profit organisations are subsidised in order to increase access to providers of reasonable quality and hence support universal health coverage. Others have similar roles to those of the other provider types discussed here, especially formally registered, small to medium private practices. At worst, some organisations might abuse receipt of external subsidies to enrich their owners at public expense.

Formally registered, small-to-medium private practices

Small, trained, sole practitioners (doctors or nurses or midwives) probably form a substantial share of the private sector, although comprehensive data are not available at the system level. However, the data presented by Mackintosh and colleagues from the National Sample Survey Organisation enterprise survey in India suggested that these businesses are overwhelmingly in individual ownership at least in that country, which could be the main form of formally registered, small-to-medium private practices.[1] Morgan and colleagues[4] describe patterns of quality, efficiency, and equity associated with different types of private provider. Private providers tend to perform better than the public sector in relation to patient satisfaction but this is often not underpinned by technically better quality care. The private sector has a stronger incentive than the public sector to control costs but not those that can be passed onto patients through recommending courses of treatment that make a marginal, zero, or negative contribution to health outcomes; thus, efficiency implications are inconclusive. Private providers who rely on fees for revenue must exclude those that cannot pay. However, as Morgan and colleagues[4] emphasise, the available evidence fails to address the system-level implications of strengthening this sector, or its implications for universal health coverage, and it is certainly plausible that a stronger fee-for-service based small-to medium private practice sector redistributes scarce resources such as qualified health staff away from those unable to pay such fees.

These small practices, which are formally registered and run by qualified providers, might be good targets for the sorts of mechanisms discussed by Montagu and Goodman,[5] such as franchising and accreditation, which improve quality of care at a small scale in some contexts. But these actions do not operate at the system level and

often focus on a narrow range of services, and are therefore not going to make a major contribution to universal health coverage. Strategic purchasing from these providers (and from the non-profits discussed) that use pooled public sources of funds offers some potential for governments to exert greater influence over both what is provided (range and quality of services) and under what contractual terms (to encourage efficiency and high quality). Strategic purchasing is broader in its scope than contracting, and involves a systematic approach to establishing service entitlements, usually on the grounds of both equity and cost-effectiveness; choosing which providers to purchase from, taking into account both quality and physical distribution; and selecting a mode of contracting including provider payment and other provisions that will encourage efficiency, equity and continuous quality improvement.[26] Examples of strategic purchasing in low-inome and middle-income countries are rare, but include the National Health Security Office in Thailand, which purchases for the universal coverage scheme, showing the capacity and willingness to use its authority to shape the health-care system on behalf of the 70% or so of the population that it covers.[27]

Corporate, commercial providers

The corporate commercial hospital sector has featured little in this Series probably because even in a country like India where its development is more advanced, it still plays a minor part.[1] Nevertheless, there is major investment from international development agencies such as the International Finance Corporation and the UK government's Department for International Development through its investment arm, CDC group, supporting such development, which is premised on its employment and economic growth potential rather than its potential to support universal health coverage. Although the International Finance Corporation is believed to be the largest investor in this sector, data suggest that the UK government alone has invested at least US$2·3 billion overall and US$1·9 billion in the past 8 years. Other development finance institutions including those of France, Germany, and Sweden are also believed to be investing substantially. Most of this investment is directed towards India, Turkey, Brazil, China, Russia, and South Africa.[6]

Experience in India suggests that the sector is underpinned by a viable business model, in serving both richer Indians and an international market for which its low cost base gives it an advantage.[28] The sophistication of these customers in assessing quality and the marketing advantage provided by international accreditation especially in attracting international patients, supports the maintenance of some quality standards.[29,30] At least some of the most skilled professional staff employed in the corporate hospital sector have been recruited from abroad, and some hospitals invest in the training of health professionals implying that there might not be a major deprivation effect on other parts of the health sector of such scarce resources.[28]

However, the price of corporate hospital services ensures that they are not accessible to poor Indians, or even Indians of moderate means. One study[31] measured prices for renal dialysis as equating to nearly seven times the average per person GDP on an annual basis, premised on large profit margins of up to 100%. Although some researchers have suggested that a stronger health insurance system in India would extend access to such hospitals,[30,32] it is unrealistic to suggest that universal access to services priced at this level can be achieved at feasible levels of national health expenditure. Another study[33] has suggested that despite high quality standards for patients of such hospitals, irresponsible waste disposal poses a hazard for the surrounding population.[34] Thus, the corporate private sector in India provides an opportunity for a small section of the Indian population to access good quality services but cannot offer much support to universal health coverage and might undermine public health in some respects.

One case study of the International Finance Corporation investment in a private hospital in Lesotho, South Africa, underlines the difficulty of affordability of this type of hospital development at the national level for a middle-income population.[35] The hospital, which opened in 2011, replaced the public national referral hospital but generates recurrent costs three times higher than previously and consumes more than half of the total government health budget. Like the Indian case, total costs are inflated by high profit margins (25%).[35] The affordability problem poses important challenges for universal health coverage. Resources are diverted from more accessible and cost-effective primary care, ensuring that the effective coverage of public primary care services is reduced—whether because services become unavailable altogether or because fewer facilities can provide services of a basically adequate quality standard. Costs have escalated (from 34% of the total health budget in 2007 to 51% in 2013) partly because more people have chosen to access care at the hospital rather than in primary care. This situation creates a vicious circle to the extent that resources then continue to be diverted from their alternative uses in the primary care system.

As is the case for the other issues we have sought to address in this paper, the evidence is patchy and inadequate. This in itself questions levels of investment by publicly supported international agencies such as the International Finance Corporation and CDC group who should ensure that their attempts to drive economic development do not undermine countries' investments in universal health coverage or public health in general, by investing in the evidence base that would guide their investments.

What evidence is needed to inform policy debates?

As Morgan and colleagues[4] point out, improving the evidence base to allow an understanding of how different kinds of private providers support or detract from country efforts to achieve universal health coverage is challenging. Researchers cannot control and experiment with the presence or absence of different kinds of providers at a national level and so face difficulties in establishing a counterfactual (ie, the scenario that would obtain if the public-private mix were different) against which measured experience can be compared. Although country level comparison provides the most credible basis on which to base analysis, there are important problems in reaching clear conclusions on the basis of such comparison. Country contexts differ in relation to social, political, economic, demographic, historical, and economic drivers of health sector performance. These differences shape the nature of the private sector and the implications of that nature for health outcomes. Disentangling the web of inter-relationships to conclude as to how countries' approaches to managing the roles of their private sectors in their health systems have supported or undermined universal health coverage might be more art than science, informed by empirical evidence of health system characteristics, performance and trends, and by judgments about logical processes and associations.

Empirical evidence of the characteristics, performance, and trends of health systems is more limited than it needs to be. Large gaps exist in descriptive information about health systems. Simple descriptors such as number of institutions, beds and their ownership, volume of inpatient stays and outpatient consultations, and their distribution across institution types are not routinely available, and when obtained are not internationally comparable because of inconsistent definitions and collection methods.

Scientific literature on low-income and middle-income countries is highly dependent on demographic and health surveys, which are routinely undertaken in a large number of countries by a reasonably consistent method. These allow comparisons of patterns of recourse to categories of provider type for basic maternal and child health interventions. Their main limitation is absence of data for use of the health system for rarer health events (the sample is not powered to explore these events), sub-national patterns (data are representative only at the national level), and adult health disorders. This shortcoming has caused some to question whether patterns of public–private mix that are regularly described on the basis of DHS data can be relied on to describe the health sector as a whole.[36] An attempt to improve this situation was made in the form of the World Health Survey, undertaken between 2002 and 2004 in 65 countries in Africa, the Americas, Europe, eastern Mediterranean, and south-east Asia, covering more than 300 000 individuals.[37] Unfortunately, data from an exercise done more than a decade ago are now of little relevance, and the effort has not been repeated.

Organization for Economic Cooperation and Development (OECD) countries have somewhat better data than are available for low-income and middle-income countries, but gaps in key areas that would inform an understanding of the implications of public–private mix differences are still missing. Data at the level of the individual episode of care are scarce. Consequently, a comparative study[38] of public–private mix across OECD countries relied on qualitative rather than quantified differences between countries to assess primary care; the indicator for outpatient services applied was predominant mode for primary care (private solo practice, private group practice, private clinic, or public centre) and second mode for primary care, and other levels of the system were treated similarly; and proportions of beds rather than episodes in public, non-profit and for-profit hospitals.

Even with more comprehensive data collection, important sectors of health-care provision would probably evade monitoring. The informal sector is by its nature resistant to being pinned down, divided, and counted. The small-to-medium private practice sector is characterised by impermanence and instability,[39] making a snapshot from any distance in time an unreliable guide to present realities. The private sector generally has been difficult to gather data from in exercises such as National Health Accounts,[40] suggesting that international comparisons will continue to be affected by unknown biases caused by missing data, even in the presence of enhanced efforts to get health system data at the global level.

Despite these difficulties, greater efforts to obtain comparable data about the characteristics of whole health systems and measures of universal health coverage relevant outcomes such as episodes of care by sector at the population level would provide high returns in view of the huge gaps in the evidence.

What is the role of government in pluralistic health systems?

Universal health coverage requires public finance. The cost of even a basic health system exceeds the ability to pay of large proportions of the populations of all countries and most of the populations of low-income countries. This situation implies that government, or another agency with the duty to serve the public interest (in cases such as conflict affected states this might be the UN or a bilateral development agency), provides the stewardship of the system. The stewardship role is that of ensuring that public resources intended for the public interest, serve that interest.

Elsewhere in this paper, we have suggested that ensuring the availability of a core health system, publicly subsidised, reasonably effective, and accessible to most of the population, has a crucial role in the management of

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the rest of the system through regulation by competition. Effective strategic purchasing, meaning the application of funds to ensure efficiency, adequate quality, and fair distribution of services to the population whether through public or private providers, is essential. The health financing capacities of all countries are stretched between the demands of population coverage, service coverage, and out-of-pocket cost minimisation, implying that any failure to achieve efficiency, including the payment of unnecessarily high prices, can be reflected only in quantitative or qualitative gaps in services and coverage.

With that clarity about the role of government (or their proxy) and public finance, there are two potential roles for private sector providers. First, private providers (for-profit or not-for-profit) might be the chosen delivery mode for the publicly financed, universally accessible, basic health system, as they are in the UK where private general practitioners provide the universal primary care system, or in Bangladesh, where that role is increasingly delegated to non-governmental organisations. In other countries, such as Denmark and Sri Lanka, that part is equally effectively played by publicly owned institutions. This structure suggests that it is the public stewardship function that matters, not the ownership of the providing organisations.

The second role that private providers can have is to provide additional, beyond basic, health care for those who can afford to pay for it. The threshold for including interventions that are less cost-effective in the universal basic service will rise as public capacity to cover costs increases. Above that cutoff point, health systems of all levels of resource endowment can either prohibit private provision or allow provision on the basis of individual willingness to pay or voluntary insurance. Almost all systems adopt the latter position, leaving considerable room for the private sector to offer additional services, additional accessibility, or additional amenity through supplementary insurance or out-of-pocket payment. This arrangement does raise equity and solidarity concerns, and falls short of ideals of equal access to potentially life-saving intervention. Nevertheless, there is scope for additional accessibility and amenity to attract some patients away from publicly subsidised services to privately financed ones, allowing universally accessible services to expand in accessibility or amenity terms, or to include progressively less cost-effective interventions. This scope seems to make a significant contribution to the sustainability of Sri Lanka's model.

The crucial role for governments (or their proxies) is therefore the stewardship role over public finance, whether it finances public or private providers to deliver care. Success in delivering accessible basic health care is more often absent than present in low-income and middle-income countries. Some authors have argued that capacities required of government for contracting private providers are similar to, if not more demanding than, those for managing public provision,[41] and the same is likely to be true of effective management of subsidised care provision by non-governmental organisations. The notion of government capacity is itself complex[42,43] and inclusive of a broad set of ideas, including technical competencies, as the term is often understood, but also the more controversial terrain of political incentives. Universal health coverage, effective regulation by competition, and consequent management of the private sector contribution all rely on a political will to ensure that coverage of basic health care reaches the poorest groups. Any universal health coverage-directed health reform, such as the 2010 US Affordable Care Act or the 2002 Thai universal health scheme, is contingent on complex calculations of its political cost and return within the country's political system, which if politicians get wrong can cost them their positions and the country its health system gains.

The less crucial but nonetheless important role for government (or their proxies) is to regulate the provision of private sector care that constitutes the additional care beyond the publicly financed and universally accessible system. First, regulation is needed to ensure that public resources are not misdirected to private users. If publicly and privately financed care is not carefully separated, there are risks that those who pay privately also secure privileged access to public health subsidies. Second, regulation is needed to ensure that users of private services are not exploited by provision of unnecessary or unsafe care, excessive claims of benefit, or excessive charges. Although complex, this challenge is not of the same order as trying to prevent provision of some service (however dangerous) to willing and often determined customers whose realistic alternative is no care at all. Regulation of the market, for example to prevent the emergence of monopolistic provision, is one regulatory strategy to minimise the exploitation of consumers.

Finally, when there is no political appetite for ensuring that public subsidies are directed to those most in need, or when government capacity is severely limited, there is potential for the types of intervention proposed by Montagu and Goodman[5] to encourage the provision of specific services, probably with donor funding, to address some of the most pressing needs. However, the limitations of such an approach need to be recognised; these interventions do not provide access to comprehensive basic care and rarely reach a substantial share of the population. It is not possible to work around government to achieve universal health coverage.

Conclusion

Extreme positions about the role of the private sector in health systems are frequently informed by comprehensive assumptions about the nature of the private sector, and they do not take into account the strong degree of interlinkage between the public and private sectors in the health system. These complexities mean that simple solutions cannot have sustained, widespread effects. Achievement of universal health coverage requires

pooled, mainly public financing, but can be compatible with various roles for private health providers, under effective public stewardship. Success in stewardship of the health system through the transition to universal health coverage in pluralistic health systems will require policies that recognise the links between the public and private sectors and that work at the system level to improve performance throughout.

As well as policy, political commitment will be needed to ensure that public services are accessible to poor people and that resources are directed towards the most cost-effective services. Politicians in several contexts have discovered that supporting universal health coverage is an effective strategy to gain popular support, for example in Indonesia where the 2014 election of President Joko Widodo was secured in part by promising national roll out of the free health care policy he introduced as Governor of Jakarta.[44] Marrying such political momentum with sound technical strategies to manage pluralistic health systems similar to that of Indonesia would deliver transformative global health gains.

Contributors

BM and KH came up with the idea for the report, drafted sections, commented on, and edited successive drafts, and approved the final version.

Declaration of interests

We declare no competing interests.

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