World Health Organization

SIXTY-THIRD WORLD HEALTH ASSEMBLY **A63/25**
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Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services

Report by the Secretariat

1. In most countries health-care delivery involves both public provision and a range of entrepreneurial initiatives, usually referred to as "private sector" or "private provision". These terms cover many realities from faith-based and other nongovernmental non-profit organizations to individual health-care entrepreneurs and private for-profit firms and corporations. Private provision is a substantial and growing sector that is capturing an increasing share of the health market across the world. The changing pattern of health-care provision presents new challenges to governments, but in ways that may differ considerably in each specific context.

2. In low-income countries, private provision dominates outpatient (ambulatory) care, whereas public provision dominates hospital and in-patient services. In most low-income countries in sub-Saharan Africa and Asia, small-scale private for-profit and private not-for-profit providers have become, or are becoming, the main source of ambulatory care. Payments to these providers are largely unregulated and on an out-of-pocket fee-for-service basis.

3. Although individual entrepreneurship is also prevalent in middle-income countries, large private firms, including multinational corporations, are capturing a growing share of the direct-service provision market, particularly the high-income segment, and increasingly are competing for contracts with public and social security systems. In Latin America and middle-income countries elsewhere, this is leading to social segmentation with private insurance-based health care for the affluent; social insurance for those in formal employment; and public direct provision for the poor.

4. Many high-income countries rely on extensive networks of private providers for ambulatory, hospital and in-patient care, but also have a long history of engagement with private providers that has led to a high level of regulation.

LESSONS FROM REGULATION IN HIGH-INCOME INDUSTRIALIZED COUNTRIES

5. Most high-income industrialized countries regulate capacity, prices, quality, levels of service and citizens' entitlements. Their regulatory capacity has been built up over decades along with the accelerated move towards universal coverage through public or social security-based financing. Self-regulation of provider behaviour has been replaced by systems in which the State and leading actors in

society increasingly co-regulate access to care, provider behaviour, and quality and efficiency through a range of regulatory mechanisms.

6. The scale, character and calibre of the entrepreneurial initiatives that characterized the health sector of high-income countries in the 1990s led to considerable institutional restructuring and innovation in the provision of care. The power and autonomy of professional and corporate groups are substantial; at times, these features can have a negative impact on coverage and costs. Nevertheless, the groups concerned operate in a more competitive environment than was previously the case, making them more amenable to negotiated regulation. On the whole, it has been possible to boost entrepreneurial innovation by relying on negotiated contractual arrangements, rather than by making use of privatization.

7. The choice of optimal regulatory strategies in any national context remains a focus of debate concerning the degree of interventionism, the weight of public interest in State regulation, the choice of regulatory mechanisms, the role of various actors and sectors in regulating health-care provision, and the balance between different kinds of regulation. Effective regulation requires social consensus, rules, adherence and a range of tools and approaches that may include financial incentives and disincentives, accreditation, licensing, contracting, and complaint-handling.

8. There is ample evidence, however, that building trust and consensus about health-system goals is a necessary precondition for effective regulation, and that this activity requires a capacity for policy dialogue on the part of institutions and leaders, together with the involvement of a range of constituencies such as professional associations, corporate providers, unions, academia, civil society organizations, user representatives and government institutions.

9. Experience with harnessing entrepreneurial provision of care shows that regulatory frameworks and strategies can include entrepreneurial dynamism without surrender of responsibility for public policy aimed at achieving an efficient health-care service. Progress towards better outcomes, more health equity and universal access is not automatic, rather it requires a combination of commitment to the principles and values of primary health care, inclusive leadership, increased reliance on public financing and consistent long-term efforts to build up institutional capacities for regulation.

STEERING AND REGULATING HEALTH-CARE PROVISION IN LOW- AND MIDDLE-INCOME COUNTRIES

10. Provision of primary care, and to a lesser extent, hospital and in-patient care, in low- and middle-income countries, while dominated or extensively shaped by private provision and finance, is usually poorly regulated.

11. Low- and middle-income countries' health costs are largely financed through unpooled, private (often informal) out-of-pocket expenditure, which limits the ability of health authorities to shape health-systems performance. In such countries a significant number of people tend either to be excluded from access to care because of inability to pay, or to be faced with crippling personal expenditures. The countries concerned tend to rely more on unregulated or poorly regulated private providers, while their public providers often adopt behaviour and practices similar to those of unregulated private providers.

12. The resulting commercialization of health-care provision is growing rapidly, and is both demand-driven and supply-driven, with a dynamism that is often in stark contrast with public

provision. That commercialization is not only the result of an increased market share for unregulated private for-profit providers, but also of the growing commercialization of health-care provision in public facilities.

13. In low- and middle-income countries financial barriers and lack of social protection exclude large parts of the population from access to care. Users are poorly informed of their needs and unable to judge many aspects of quality and cost; they are thereby vulnerable to over-charging and/or lowering of quality (and thus unsafe care), and to cost escalation that may even exclude those able to pay.

14. Harnessing entrepreneurial dynamism for the renewal of primary health care will require many governments to make significant progress in the three areas of strategic intelligence, financial leverage, and institutional capacity for regulation and policy dialogue.

15. The debate about the purported advantages and drawbacks of the reliance on public, private not-for-profit and private for-profit providers has suffered from a distinct lack of factual documentation and evidence. There is a need for better empirical information, over a range of contexts, on the characteristics, extent, growth and consequences of unregulated commercial care provision. Such information should cover short- and long-term impact on safety, access, quality of care, health outcomes, health equity and social outcomes as well as the level of trust in health systems and health authorities. An improved evidence base would also allow for a more productive exchange of experience between countries on best practices regarding constructive engagement with and regulation of different types of health-care providers.

16. The capacity of governments to work productively with, regulate and oversee health-care providers is to a large extent constrained by the way health care is financed. Countries that spend more through government or social insurance mechanisms generally achieve better and more equitable health results than those that rely more on out-of-pocket spending at the point of service; those that combine higher public spending with a universalist commitment to access and to low or zero charges at point of use do particularly well, achieving comparatively high levels of access and limiting excessive expenditures.

17. In many low- and middle-income countries reduced institutional capacity constrains constructive engagement with the wide range of actors involved in health-care provision. The trend towards understaffing and underfunding of regulatory institutions, often a consequence of past disinvestment, needs to be reversed. The contribution of civil society organizations for regulating provider behaviour, such as consumer protection organizations, is often insufficiently recognized, thus opportunities to build the social consensus necessary for effective regulation are often missed. Regulatory institutions often lack staff with the skills and self-confidence required to move to a more negotiated type of regulation. Governments need to re-invest in long-term efforts to build up their regulatory capacities; such efforts merit far greater support by the global health community.

18. WHO aims to consolidate experience, document best practice and facilitate exchange and joint learning about ways to strengthen government capacity for constructive engagement and effective oversight of the full range of health-care providers.

19. The Secretariat is collaborating with Member States and various other institutions to determine the relative roles of various types of private for-profit, private not-for-profit and public institutions and individual professionals and the consequences for equity, effectiveness, safety and efficiency. There is

a particular focus on the implications of current trends for the promotion of universal coverage and people-centred primary care, two of the core policy directions for the renewal of primary health care.

20. The Secretariat is also seeking to identify innovative approaches to contracting, franchising, provider payment, performance management, co-regulation with non-state actors and other regulatory mechanisms and techniques; to promote best practice models for building institutional capacity for oversight and regulation of the whole range of health-care providers, and to facilitate exchange of experience and joint learning between countries.

21. The Executive Board discussed an earlier version of this report at its 124th session in January 2009 and requested the Secretariat to prepare a new draft resolution.[1] In May 2009, the Sixty-second World Health Assembly decided to postpone the provisional agenda item on WHO's role and responsibilities in health research to the Sixty-third World Health Assembly.[2]

ACTION BY THE HEALTH ASSEMBLY

22. The Health Assembly is invited to consider the following draft resolution:

> The Sixty-third World Health Assembly,[3]
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> Having considered the report on strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services;[4]
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> Recognizing the variety of private providers, from faith-based and other nongovernmental non-profit organizations and individual health-care entrepreneurs, both formal and informal, to private for-profit firms and corporations, and the evidence that they play a significant and growing role in health-care delivery across the world;
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> Noting that governments across the world are faced with the challenge of constructive engagement with the complex range of health-care providers, in ways that vary considerably according to context;
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> Noting that the cost and quality of the care provided and the effect on health and social outcomes may vary considerably and that there are serious reasons for concern in environments where regulation is poor or absent, yet as a whole the documentation and evidence base in this regard is weak;
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> Recognizing that governments that have the institutional capacity to govern the broad range of health-care providers can play a constructive role in providing essential health services;

[1] See document EB124/2009/REC/2, summary record of the tenth meeting.

[2] See document WHA62/2009/REC/3, summary record of the first meeting of the General Committee, section 1; and document WHA62/2009/REC/2, verbatim record of the second plenary meeting, section 2.

[3] See document A63/25 Add.1 for the financial and administrative implications for the Secretariat of this resolution.

[4] Document A63/25.

Concerned about evidence that in many countries effective engagement, oversight and regulation of the various private health-care providers may be constrained by imperfect strategic intelligence, limited financial influence and weak institutional capacity;

Aware that building trust and constructive policy dialogue are vital for successful engagement, oversight and regulation;

Noting that the renewal of primary health care provides a policy framework in which to set benchmarks for strengthened government capacity for constructive engagement with, and oversight of, both public and private health-care providers,

1. URGES Member States:

(1) to gather, by means that include improved information systems and stronger policy dialogue processes, the strategic intelligence required for: objectively assessing the positive and negative aspects of health-care delivery by private not-for-profit and private for-profit providers; identifying appropriate strategies for productive engagement; and developing regulatory frameworks that ensure universal access with social protection and the reorientation of service delivery towards people-centred primary care;

(2) to map and assess the capacity and the performance of the government departments and other bodies concerned with oversight and regulation of both public and private health-care provision, including: professional councils; institutional purchasers of health services, such as public funders and state health insurance agencies, and accreditation bodies;

(3) to investigate the potential contribution to the regulation of health-care provision of non-health-sector governmental and nongovernmental entities, including health-consumer protection agencies and patient groups, and, as appropriate, set up mechanisms to maximize the value of those contributions;

(4) to build and strengthen for the long term the institutional capacity of these regulatory bodies, through adequate and sustained funding, staffing, and support;

(5) to pursue opportunities for intercountry exchange of experience with different strategies for engagement, oversight and regulation of the full range of health-care providers;

2. REQUESTS the Director-General:

(1) to provide technical assistance to Member States, upon request, in their efforts to strengthen the capacity of health ministries and other regulatory agencies in order to improve engagement with, and oversight and regulation of, the full range of public and private health-care providers;

(2) to convene technical consultations, set the research agenda and facilitate intercountry exchange of experience in order to obtain better shared understanding and documentation of the consequences, positive and negative, of the growing diversity of health-care providers, ensuring that particular attention is given to contexts of poor

regulation and to consequences in terms of health, health equity, and health systems development;

(3) also to convene technical consultations, set the research agenda and facilitate intercountry exchange of experience in order to obtain a better shared understanding of the potential of various strategies to build up the institutional capacity for regulation, oversight and harnessing entrepreneurial dynamism and sound cooperation among various types of health-care providers;

(4) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the progress made with the implementation of this resolution.

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