Original Article

Regulation and participation of the private sector in the pursuit of universal health coverage: Challenges and strategies for health systems

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Abstract

The 1978 Alma Ata Declaration established recommendations for health systems, which significantly impacted low-income countries. These guidelines marked improvements in access to health, coverage and financial equity, especially in Latin American countries. **Objectives:** This paper focuses on the role of the private sector (including for-profit and non-profit organizations) in achieving Universal Health Coverage (UHC). It examines their involvement in the management, service delivery, resource investment and financing of primary health care (PHC) within the sustainable development goals (SDGs). **Methods:** The study covers a review of health systems, emphasizing the influence of private institutions on public health, and evaluates how private sector experiences contribute to system functions and progress towards UHC. **Results:** The findings indicate the crucial role of the private sector in global health systems, notably expanded in several countries. Private actors are essential to improve access and coverage, particularly in countries with low health indicators. The article highlights the importance of primary care physicians understanding these dynamics since their management is vital in implementing public policies for UHC.

Keywords: A private health system, benefits, financing, primary care, primary health care, private health system

Introduction

Following the 1978 Alma Ata Declaration, various ways of interpreting and implementing the proposed measures were proposed. This diversity of interpretations caused some countries to incorporate the concept of Primary Care (PC), "primary care" in a logic of general medicine, focused on vulnerable groups, favouring initial contact with the population. Primary health care emerges as a global and comprehensive concept different from the interpretation of PC. This conceptual expansion involves multisectoral, community and participatory social dimensions of people in developing their health.[1-4]

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The PHC strategy proposed by Alma Ata evolves into a critical factor in international health policy, constituting the expression of the global public policy adopted by states. This multidimensional approach is coupled and presented as public policies with resource exchanges outside the health system and benefits that explore beyond individual health status. Broader and more structural social policies have aimed to seek universal access to health services.[5]

Despite the consensus of a group of authors, the need for greater precision in the concept of PHC in Alma Ata quickly generated criticism from various international organizations.[6] A year after the convention, a health ideology promoted a set of technical packages that prioritized traditional programmatic components, such as maternal and child health and immunizations. This intervention, known as selective primary health care (APSS), sought interventions that had a high impact on outcome

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indicators in the target population. Given the problems of economic development in the world, SPHC spread vigorously in Latin America and Africa during the 1980s.[6-8]

UHC is a definition of countries mediated by the economic development and political conditions of the countries. This is despite the efforts of multilateral organizations. The WHO recognizes the need for private actors to achieve UHC. Through the functions of health systems, this article exposes what factors of private experiences contribute or do not contribute to UHC.

This debate is relevant to PC physicians due to its presence at the intermediate management level. Ignoring these issues would increase the possibility of errors in implementing public policies that address UHC.

Private agents in primary health care

In primary health care, private entities carry out various health-related activities globally, including philanthropic and for-profit initiatives.[9] These actions are initiated by individuals either independently or through organizations. At the same time, there is a growing individual contribution to human resource development, evident in the growing participation in academic support in all countries.

The World Health Organization Advisory Group has defined the private sector to provide a more precise conceptual framework for research, improving operational clarity and effectiveness. This approach allows for a more detailed examination of variables in systems analysis in terms of functions and structures[1].

Functions and objectives of health systems in PC

The 2000 WHO model for health systems analysis distinguishes four essential functions and three main objectives. The primary goal is to improve people's health, while secondary goals include protecting against financial hardship due to disease and ensuring decent health solutions. The fundamental functions are a) the provision of personal and non-personal health services; b) the collection, grouping and allocation of resources for the purchase of said services; c) investments in people, buildings and equipment; and d) the health system of the general rectory.[10]

These functions are integral to all health systems models and interact with objectives in various ways. They are applicable at all levels of care and provide a solid framework for evaluating the private sector's contributions to UHC at the primary health level. A comprehensive literature review created an analysis matrix focused on the elements and factors influencing health system functions.

[1] The Advisory Group provides strategic guidance on developing a roadmap for the private health sector and service delivery. The roadmap outlines governance behaviours to align private-sector health service delivery with UHC goals.

Contributions from private agents in the rectorship function

Decisions on the free choice of people

The concept of free choice in healthcare embodies a dichotomy between individual freedoms and public health risks. While it allows people to select their healthcare providers or financiers, it challenges the principle of equal access to care, which could lead to inequalities. This tension affects the foundations of social security and the universality of government health policies. Free choice can disrupt primary and specialized care coordination, endangering patient safety and system efficiency.[11-14]

Studies show different perceptions of free choice in primary health care among different demographic groups, influenced by age, sex and income. These perceptions often reflect a preference for faster access to care, distrust in universal systems, or deficiencies in public health services.[15,16] There is concern about the risk of implementing reforms of free choice models in PC and the difficulty of reversing or mitigating the errors of free choice.[17]

Private management models to improve performance

There is an ongoing dispute about the performance differences between public and private health centres on all continents. In an unresolved field of dispute in the world, a set of articles affirms that there are reforms that aimed to improve the efficiency of PHC resources with private sector tools, for example, the introduction of incentives for competition between centres, a more excellent free choice with private doctors, reorientation of remuneration systems to health results, improvement of indices or indicators of evidence-based activities, use of successful Information and Communications Technology (ICT) infrastructure in the private sphere, among others.

Improving public administration has regulatory complexities that must be presented more clearly in the private sector. However, the PHC model requires describing or moving forward to establish explicit and specific management models of their interests within the other levels of care.[18-20]

Regulation of private actors

Public/private health management models are part of social consensus and agreements; these are reflected through regulations and standards in the countries. Public–private partnerships or integrated benefit systems are a set of heterogeneous realities. For example, private participation in primary-level provision is essential in low- and middle-income countries. On the other hand, the non-regulation of private actors cause the fragmentation of the care system, which translates into a significant increase in health spending and inequalities in access and provision of services to citizens. This applies to low- and middle-income countries, but in high-income countries in Europe with lax regulatory models, the same problems of population fragmentation and inequality exist.[3,13,21,22]

Decisions of rectory against the model

The government's function can guide institutions and society towards developing national policies. Health sector reforms

strongly promoted decentralization.[21] These reforms brought with them new public and private actors. Stewardship decisions weaken the spirit of the PHC model as a political health strategy that improves the health conditions of people in their environment. This weakening is due to the allocation of public resources in favour of new relationship possibilities between the State and private companies. This reveals a pro-market privatizing orientation. An individualistic approach is also seen in the care and financing model, undermining the territorial perspective, community work and comprehensive and multidisciplinary care. It is suggested that groups of private funders had significant influence in the design of regulations that weakened the principles of universality of PHC, favouring the segmentation and stratification of health care.[23-25]

Investment or resource generation function

Governance in PHC human resources

Governance of human resources is crucial for health authorities, focusing on developing a skilled health workforce. This involves ensuring that health personnel possess current and relevant skills through comprehensive training. This training encompasses undergraduate education, a shift towards primary health care (PHC) orientation, collaborative skills, competency profiling, national exams, postgraduate programs and ongoing education.[26,27]

A common characteristic of the health workforce in many low- and middle-income countries is that they tend to be ideal in numbers, and questions are also frequently raised about the quality and adequacy of the services they provide. Workforce governance involves acquiring, deploying and retaining a workforce sufficient in quantity and quality to improve health outcomes as the ultimate goal. A successful health worker policy in PHC requires: sustainable and equitable public–private partnerships, structured approaches to sharing information, better multidisciplinary teams and trained public health teams.[27-29]

A practical problem faced by the governance of human resources in many countries is absenteeism due to justifiable gaps or improper practices by officials. These practices range from the inappropriate use of medical leave to situations of presenteeism at work.[30] For example, studies showed that in African countries, a significant part of health workers was involved in lucrative private activities in parallel to their formal jobs in the system.[31,32]

Integration and synergy of private resources

Private for-profit and non-profit agents contribute to health coverage in low- and middle-income countries. Primary health care comprises international cooperation agencies, foundations, churches and alternative medicine practitioners, among other providers.[33] This synergy and interrelationship must be clear and operational in response, a sign of this interrelation of everyday actions due to the COVID-19 pandemic. In countries with better-developed health systems, the evidence indicates that integrating and synergy of existing public and private resources is essential. For example, it is necessary to integrate the actor's private companies in the surveillance of Non-Communicable Diseases (NCD) and the official report of communicable diseases (CD). The barriers identified are infrastructure, technical capacity and knowledge, among other matters.[34]

Studies suggest that middle- and high-income countries have a better assessment of attributes such as technology and physician training, and deficient attributes such as convenience and speed is recurrent in satisfaction surveys to measure public and private providers, respectively. For example, the Chinese government has increasingly engaged and interacted with the private sector to initiate public–private partnerships (PPPs) to improve the healthcare system's capacity. However, Chinese residents appear to be more accustomed to public healthcare, as it has been the dominant healthcare provider in China for a long time.[35,36]

Financing Function

Incentives in PHC purchase models

Regarding collection actions in low- and middle-income countries, more information needs to refer to countries not subject to humanitarian cooperation and international aid. In order to improve the conditions of technical and administrative efficiency, preventive care should be encouraged through financing, and the action of integrated services based on a population rather than an individual approach should be promoted. The above may require new capabilities and legislation to enable strategic purchases based on PHC principles. Thus, it is possible to collaborate with the private sector in integrated models. He provided certain conditions for purchasing mechanisms, such as strengthening this function with common strategic frameworks, using technology for predictive analytics, minimizing stock-outs, and maximizing people's access to supplies.[37-40]

Financing of private providers with public funds

Financing private providers with public funds in primary health care (PHC) is practiced in various countries and modes. High-income nations like Australia, the Netherlands, and low-income countries often use non-profit organizations to extend coverage. In low-income regions, studies highlight concerns about indirect costs versus direct user benefits, yet data indicates a rise in service provision despite reduced government funding.

The debate includes the use of care vouchers, with studies showing no decrease in public service utilization due to voucher use, suggesting they promote dual use of public and private healthcare. Decisions on publicly expanding PC services through market mechanisms should be tailored to each health system's context and objectives.[41-44]

Out-of-pocket spending in PHC

There needs to be more methodology in estimating out-of-pocket spending in PHC. Little is known about the drivers of out-of-pocket spending in primary health care. In many low-income countries, out-of-pocket household payments are the most crucial source of financing for health. Direct payments for health care have

detrimental effects on the allocation of family income available for basic needs such as food, shelter, clothing, education and public services, among others.

In low- and middle-income countries where national health insurance was implemented, out-of-pocket spending on PC decreased. No empirical studies were found regarding the contribution of private agents that reduced out-of-pocket spending or some other impact.[36,45-47]

Service provision function

The role of the private sector in the integration of the provision

The WHO asserts that UHC hinges on health systems focused on primary health care, involving three elements: integrated health services, multisectoral policy and community empowerment.[48] As health system stewards, governments must ensure the private sector's regulated integration to prevent adverse impacts and market failures.[49]

UHC models should incorporate care providers into networks, especially where private PC predominates. Experiences in Europe and other countries demonstrate UHC's effectiveness with varying degrees of private sector involvement, achieving high patient satisfaction. These cases provide regulatory frameworks for other nations transitioning to UHC.[50-52]

In models merging public and private healthcare, prioritizing the quality of services and establishing measurement standards are essential. In many countries, including Iran, Turkey, the United States, the Netherlands, Australia and the United Kingdom, the private sector supplements healthcare outside regular hours, driven by specific policies and financial incentives or due to a lack of government providers in lower-income countries.[53]

The research underscores the necessity of integrating public and private resources in healthcare, a need highlighted during the COVID-19 pandemic response. It suggests leveraging the private sector in areas needing more public primary health care, whether in resources, geographic coverage, or technical capacity.[48,53-55]

The private sector in the PHC coverage strategy

The public–private association could provide a good opportunity in PC to facilitate access to services for the population in areas where the state has weak coverage. However, studies indicate that success is proportional to developing a set of factors, such as relationships between partners, clear rules (especially those of sustainable financing), a patient-centred approach and the flexibility to share objectives. Common and uncommon, in other words, the development of a constant mechanism of mutual commitment, which involves the capacity of the public sector to regulate, monitor and control the quality of the services provided by the private sector and its possibility of integration into the health system.

As summarized in Table 1, after an exhaustive review of the literature, a The analysis matrix focused on the elements and factors that influence health.

Table 1: Matrix of factors to observe for the analysis

Functions	Areas of research
Rectorship Function	The free choice of people
	Private Management Models to Improve Performance
	Regulation of private actors
	Stewardship decisions against the PHC model
Investment Function	Governance in PHC Human Resources
	Integration and synergy of private resources
Financing Function	Incentives in PHC Purchasing Models
	Financing of private providers with public funds
	Out-of-pocket spending in PHC
Service Provision Function	The role of the private sector in the comprehensiveness of the provision
	Private sector in the PHC coverage strategy
	The quality of the services
	Segmentation and exclusion of the population

Source: own elaboration

Governments need to consider long-term plans and sustainable policies to start these types of partnerships and learn from the experience of other countries. The governing competence for the design of health guidelines must contain a central axis to improve the general results of population health. Regarding improving coverage through private participation, studies show different results related to the regulatory capacity, integration and institutional level of health systems.[56-58]

Also, the evidence centres a dispute on the risks and benefits of private sector participation in health systems; this controversy often lacks evidence and tends to polarize into arguments for and against private sector participation, particularly on private for-profit providers. The role of the private sector and its impact on PC are often at the centre of these debates. For example, studies characterize the private sector as a driver of innovation, excellent quality and efficiency in providing access to the population. On the other hand, studies indicate that the private sector undermines PC by stressing the health markets (prone to failure), which are generally not corrected without state regulation, and encourage individualization, contrary to the PC model—Health.[48,59-63]

Segmentation and exclusion of the population

Segmentation of coverage, financing and fragmentation of care has hindered the implementation of a universal PHC. The ability to expand free choice in PHC has increased the average number of visits, particularly among those wealthier groups with fewer healthcare needs. It has made integrated care for those with complex needs more difficult.[13,17,64,65]

The quality of services

The studies indicate that the successful provision (private or public), although it has historical roots, will depend to a great extent on the established regulatory frameworks.

In Europe, public and private models provide people with equity, access and quality care. At the same time, there is a consensus within the European health systems about better performance

of the private ones in providing dental and pharmacy services. These services and products are the most standards among providers and, therefore, the easiest for both buyers and citizens to compare based on cost and accessibility.[50,66]

However, in South America, studies empirically corroborated inequalities in quality experiences at the first level of care, suggesting the better performance of the public system in various PHC functions.[3,23,67-69]

Conclusions

An operational definition incorporating private sector participation within health systems necessitates regulation aligned with the systems' aims and definitions. The literature needs a comprehensive framework, leading to regulatory gaps and weaknesses.

Countries aspiring for UHC should examine historical interactions with the private sector, recognizing its roles in resource generation, financing and healthcare provision. Nonetheless, overseeing and guiding health systems remains an inalienable responsibility of national governments.

Public funding is pivotal for achieving UHC, requiring efficient allocation to priority areas and populations to guarantee equitable access to quality healthcare and financial protection for all citizens. Utilizing all domestic resources is fundamental in the pursuit of UHC.

The private sector emerges as a significant component in achieving UHC, but its involvement entails risks that must be meticulously managed. As health system stewards, governments are responsible for regulating private sector participation to prevent detrimental practices and market failures. This governance includes maintaining checks and balances to align private sector contributions with the broader goals of UHC and public health.

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Conflicts of interest

There are no conflicts of interest.

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