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The role of private healthcare sector actors in health service delivery and financing policy processes in low-and middle-income countries: a scoping review

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ABSTRACT

The expansion of the private healthcare sector in some low-income and middle-income countries (LMICs) has raised key questions and debates regarding the governance of this sector, and the role of actors representing the sector in policy processes. Research on the role played by this sector, understood here as private hospitals, pharmacies and insurance companies, remains underdeveloped in the literature. In this paper, we present the results of a scoping review focused on synthesising scholarship on the role of private healthcare sector actors in health policy processes pertaining to health service delivery and financing in LMICs. We explore the role of organisations or groups—for example, individual companies, corporations or interest groups—representing healthcare sector actors, and use a conceptual framework of institutions, ideas, interests and networks to guide our analysis. The screening process resulted in 15 papers identified for data extraction. We found that the literature in this domain is highly interdisciplinary but nascent, with largely descriptive work and undertheorisation of policy process dynamics. Many studies described institutional mechanisms enabling private sector participation in decision-making in generic terms. Some studies reported competing institutional frameworks for particular policy areas (eg, commerce compared with health in the context of medical tourism). Private healthcare actors showed considerable heterogeneity in their organisation. Papers also referred to a range of strategies used by these actors. Finally, policy outcomes described in the cases were highly context specific and dependent on the interaction between institutions, interests, ideas and networks. Overall, our analysis suggests that the role of private healthcare actors in health policy processes in LMICs, particularly emerging industries such as hospitals, holds key insights that will be crucial to understanding and managing their role in expanding health service access.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ The private sector is responsible for an expanding share of healthcare services in many low-income and middle-income countries (LMICs).
⇒ The influence of private healthcare sector actors and their representative organisations in LMICs is not well understood.

WHAT THIS STUDY ADDS

⇒ The literature in this domain is nascent; few papers focused on healthcare actors such as hospitals, clinician entrepreneurs and pharmacies, when compared with the pharmaceutical industry.
⇒ A framework of institutions, ideas, interests and networks was used to understand dynamics of these actors in policy processes.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Private healthcare sector actors are increasingly engaged in efforts to expand universal health coverage.
⇒ Evidence on private healthcare sector actors is urgently needed to understand interests, strategies and policy goals.

INTRODUCTION

Over the last few decades, there has been a steady accumulation of evidence on the important role played by the private sector in health systems in low-income and middle-income countries (LMICs).[1] This evidence base spans multiple dimensions, including the extent of the private sector in health markets,[2] composition in terms of systems of medicine, profit orientation, scope and scale,[3 4] inequities in service utilisation and affordability,[5] quality of services provided[6] and governance of facilities, providers and medical technologies,[7–9] particularly in terms of regulation[10 11] and transparency and accountability.[12] In the context of universal health coverage, governments and other stakeholders are increasingly engaging with questions around the adoption

of holistic approaches that incorporate the private sector in the analysis.[13]

The private healthcare sector comprises one aspect of the private health sector. As described by Montagu *et al*,[14] it pertains specifically to the delivery of healthcare services, such as individual providers, clinics, nursing homes and hospitals, across diverse systems of medicine and levels of formality. The use of private healthcare services varies extensively across contexts, with privatisation of healthcare services growing rapidly in some contexts and declining or static in others.[5 14 15] Additionally, the ownership and management structure of the private healthcare sector in delivery, as well as financing, varies across and within contexts, ranging from simple private companies to publicly traded companies. A growing body of scholarship focused on LMICs is exploring the financialisation of healthcare sectors, including its impact on how care is organised and delivered and on how these dynamics are reshaping power dynamics and policy processes. For example, in Turkey, scholars have shown the political consequences of the growth in commercial players in private healthcare including the establishment of organised interest groups and their growing influence on policy.[16] Similarly, in India, accelerating corporatisation is recasting healthcare sectors as opportunities for economic growth, and creating a new policy ecosystem where, as Chakrabarthi et al. note '(large) organised industry bodies, hospital owners' associations and insurance companies are now significant stakeholders in the organisation of the healthcare sector' (p. 63).[17]

There is also a growing attention to understanding the political economy of health systems in LMICs, that is, as stated by Reich, 'power and resources, how they are distributed and contested in different country and sector contexts, and the resulting implications for development outcomes' (p. 514).[18] Politics is widely understood to impact the health system structure, functioning and resource allocation.[18–21] Political economy analyses are, therefore, critical to developing approaches to health policy that are attentive to power and that finetune the feasibility of policy solutions.[22] Political economy analyses have been crucial in expanding the knowledge base on health systems in LMICs to more rigorously engage with the politics of health policy development, such as the impact of political systems, power held by various international and domestic players in health policy, and the diffusion of ideas.[23]

It is the intersection of these two major trends in health policy and systems research—increasing attention to the private healthcare sector and to political economy—that motivates this paper. Although our aim is not to provide a political economy analysis of the private healthcare sector in LMICs, we believe in the value of situating the discussion on this sector and its policy influence within the broader political economy of health systems in these countries. Policy interest in private healthcare sector engagement in achieving universal health coverage is growing. Although this issue is not new to the followers of global health policy discussions, it has been elevated on the political agenda, especially after the launch of Sustainable Development Goals in 2015. The COVID-19 pandemic has further strengthened this call. Several global policy actors including International Finance Corporation (IFC),[24] WHO,[25] World Bank[26] and the US Agency for International Development,[27] as well as trade associations have demonstrated interest in assisting countries to better engage the private healthcare sector for improving access. These organisations formulate their frameworks from a shared premise: public sector capacity is not sufficient to achieve universal health coverage, and governments are expected to adopt a whole-of-sector approach to health and engage the private healthcare sector.

However, with some exceptions, such as WHO[28] and Montagu *et al*[14], many global accounts of the private healthcare sector overlook the importance of governance and politics in private healthcare sector engagement, which this scoping review aims at addressing. The influence of these private healthcare actors, understood in this paper as healthcare cooperatives and networks, private hospitals and other health facilities, pharmacies, insurance companies and their representative organisations (ie, lobbying organisations, trade groups and other organisations engaged in collective action) in domestic health policy processes in LMICs requires deeper investigation. A sizeable body of work in high-income countries, particularly the USA, has highlighted the pervasive role of private health sector interest groups in multiple aspects of health systems, including the role of interest groups in shaping health reform, regulation of provider behaviours and price negotiations for services and commodities such as pharmaceuticals.[29–32] In the context of some LMICs, critical scholarship has documented the growth of private health sector actors in healthcare delivery and financing, and have situated these trends in the context of paradigmatic shifts towards neoliberalism.[33–35] Research on private healthcare sector actors has also emerged in literature on other domains of health policy processes, such as conflict of interest[36] or in exploring the politics of health sector reform.[37] Further, while research on the healthcare sector has been more limited, a rich literature on other aspects of the wider private health sector has developed, most notably with regard to the manufacturing, distribution and access to pharmaceuticals in LMICs.[38] There remains a strong need to synthesise the role of policy role of actors in the private healthcare sector in LMICs.

For these reasons, it is important to assess the existing literature and synthesise what is known about the policy influence of private healthcare sector actors in LMICs. In this paper, we present the results of a scoping review that is aimed at exploring the available knowledge on the role of a particular set of private healthcare sector actors in health policy processes in LMICs, drawing on a framework of ideas, institutions, interests and networks as key dimensions in policy change.[39] We define actors

in this review as organisations or groups—for example, individual companies, corporations or interest groups. Our scope is not limited to domestic actors given the intractable linkages between domestic and multinational actors. Our scope pertains specifically to the following actors engaged in health service delivery—clinician entrepreneurs, private hospitals and other health facilities, pharmacies, insurance companies and their representative organisations. This review largely focuses on the biomedical and for-profit healthcare sector (with some inclusion of the not-for-profit sector), recognising that private healthcare systems span different systems of medicine, profit orientation and levels of formality.[14]

This scoping review is guided by the following research questions:

1. What is described in the literature regarding the types of private sector healthcare actors that engage in health policy processes in LMICs?
2. What kinds of policy demands do private sector healthcare actors make in these contexts?
3. What is the governance context in which these demands are made? What types of strategies, do these actors pursue, including forming networks and what is their influence?
4. How has scholarship on the role of private healthcare sector actors in policymaking in these countries evolved in terms of output, disciplines and research design?

METHODOLOGY

We used a scoping review to conduct this research. Scoping reviews are a useful approach to understanding or mapping key concepts in a research area, and to clarify definitions and conceptual boundaries of a topic.[40 41] Scoping reviews also help in determining the 'extent, range and nature' of research in a particular area, to summarise findings from this research, and to identify research gaps.[41] This approach is, therefore, well suited to understanding the role of private health sector actors in health policy processes in LMICs.

Our approach to conducting the scoping review drew from steps outlined by Arksey and O'Malley[40]: (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting the data and (5) collating, summarising and reporting data.

Conceptual framework: The data were then analysed according to a framework of ideas, interests, institutions and networks (3I+N), a conceptual model developed by Shearer and colleagues that examines factors explaining policy change.[39] We extend the application of this framework to explore political claims and policy influences, and the interaction of ideas, interests, institutions and networks in shaping policy processes pertaining to health service delivery and financing policy in LMICs. Institutions in this framework follow the conceptualisation of institutions from North as being the 'rules of the game', or the formal and informal norms, structures and processes that influence policy outcomes.[42] Interests are defined as the 'preferences and power embedded in policy actors'[39] and in the framework, focuses on the ability of actors to use their power, resources and capacity to pursue policy change in their interest. Ideas are referred to as 'the content and strength of actors' values and knowledge'[39] and focus on the representation or framing of policy challenges and their solutions by various actors. Finally, networks are defined as '…empirically measurable sets of actors and their relationships' and 'as intentional governance or management structures with an agency to act strategically'[39] and the authors hypothesise that networks are a critical variable in shaping policy change, whereby institutions set the overall context in which networks operate, and that interests and ideas shape, and are shaped by, networks. We expanded on this framework to include a section on policy outcomes in order to understand the resultant impact of these dimensions on policy change.

Box 1 Inclusion and exclusion criteria

Inclusion criteria

Time frame: 1990–2023

Concepts: Article engages with the following concepts—private health sector actors and health policy processes and low-income and middle-income countries

Languages: English, French (grey literature only in English)

Sources: Designs included but were not limited to case study research, grounded theory, ethnography and qualitative description. The types of papers included are peer-reviewed journal articles, research reports, conference proceedings and 'grey literature'

Exclusion criteria

Papers that did not provide insight into policy actors, processes and contexts

Papers focused only on public sector actors or working primarily in the public sector (e.g., associations of public sector physicians)

Books and book chapters

Blogs

Scope and article identification: Three authors (VS, VY and BM) deliberated on the research questions motivating this review. We discussed the scope and scale of the industries to be included, types of organisations and potential information sources. We then proceeded to develop a list of inclusion and exclusion criteria for the study (see box 1), followed by a detailed search strategy in order to identify an initial list of articles (see box 2 for list of terms). Given the exploratory nature of our research questions and the nascent stage of research on this topic, we decided to conduct a broad, non-exhaustive search, in an effort to map out and delineate sectors, actors, policy processes and institutional structures in healthcare delivery and financing, in order to lay foundations for future systematic and/or comprehensive reviews on each of these subsectors.

The search terms were used in the following databases, with specific edits made to suit the databases —Medline (Ovid), Web of Science, PAIS and EMBASE. We also

Box 2 Sample search terms used in databases

Private health sector actors

private provider* or private hospital* or private insurance compan* or hospital group* or small hospital association* or pharmac* or doctor* association* or doctor* lobby* or physician* association or physician* lobby

Health policy processes

health* policy or health* policies or health* reform* or decision making or decisionmaking or policy making or policymaking or delivery of healthcare or healthcare delivery or health services or health communication or negotiation or agreement or regulation* or legislation* or health* law* or representation* or health advocacy or lobby* or health* insurance or fraud or corruption or licensing or health accreditation or certification or pricing or health authorization or market entry or public-private partnership* or contracting or privati?ation or franchi?ing or ownership or merger or stakeholder analysis

Low-income and middle-income countries

Filter used

searched the following databases selectively—CAB Global Health, Lilacs, African Index Medicus and Worldwide Political Science Abstracts. We also conducted a selective search through Google Scholar and of key health policy analysis resources, such as a reader on health policy analysis in LMICs published by the Alliance for Health Policy and Systems Research.

Title and abstract screening: We used COVIDENCE to conduct the title and abstract screen. Two independent reviewers (CA and MM) reviewed each title to determine its applicability to the research questions. After screening the titles, two reviewers (CA and MM) reviewed the remaining articles for inclusion in the full-text review, paying special attention to selecting only those articles which engaged in a qualitative description of policy processes as per the abstract. Questions regarding abstracts were discussed among the team (MM, CA and VS) until the point at which a consensus was reached.

Data extraction: The data extraction template was developed through discussion among all the coauthors. The data extraction template was piloted with three articles by CA, MM and VS. Each of the three articles was read by at least two of the reviewers, followed by a series of discussions on each dimension of the template. Using COVIDENCE, data were extracted from papers selected for full-text review by one of three reviewers (CA, MM and MC). Articles that were authored by members of the research team were reviewed by a team member not involved in that particular research. Aspects of the template were modified following these discussions and then applied to the final list of articles.

DATA ANALYSIS

One reviewer (CA, MC, VS and VY) read each paper in COVIDENCE and extracted data as per the template . Team members presented each article during team meetings and discussed questions regarding aspects of the articles to be extracted. One French-language article was reviewed by BM. Charted data were then shared across the full team, and emerging patterns across the papers were discussed. The data were then further analysed by the 3I+N framework through an iterative process of theme development and reviewing the full set of included papers through multiple rounds. The analysis was summarised into four overarching categories—institutions, ideas and interests, with an analysis of networks woven through each of the aforementioned categories, and policy outcomes.

RESULTS

We identified 4341 articles through our search strategy (figure 1). In assessing 218 abstracts, it was determined that the majority did not explicitly address policy processes (specifically that the papers did not provide insight into policy actors, processes and contexts), did not focus on the appropriate actors, were in the wrong geographical setting or did not qualify in terms of type of article (ie, book chapter). Of these articles, we identified 30 articles for data extraction. We excluded an additional 15 articles during the data extraction phase due to their focus on industries or interest groups beyond the scope of the study (ie, food, pharmaceutical companies) resulting in 15 papers in the final analysis (online supplemental file 1). Eleven articles were published in scientific journals, while four articles were published as grey literature.

Nature of the private sector

Papers included in this review focused on LMICs, such as South Africa, Nigeria, Tanzania, India, Lao PDR, Brazil, Thailand and Colombia (see figure 2). Sectors represented in the list of articles included the hospital industry, healthcare networks and cooperatives, the insurance industry and retail pharmacies (table 1). The types of organisations and interest groups within each sector were markedly heterogeneous. For example, studies from India noted the presence of multiple hospital industry associations representing specific constituencies (ie, 'corporate' hospitals, specialist hospitals, and 'small' hospitals and nursing homes). Articles also explored health professions engaged in the private sector as professionals owning businesses in the health sector (ie, doctors) or joining to form medical cooperatives, as in the case of Brazil and India.[43] The business sizes of the private sector groups identified in the articles ranged from small, medium to large and also spanned subnational, national and global scales. For example, multinational companies such as those in the case of retail pharmacies[44] or the insurance industry[45] were present in some papers; most, however, dealt with national or subnational industries (figure 3). Finally, some papers described not-for-profit groups as key policy actors, for example, as an independent interest

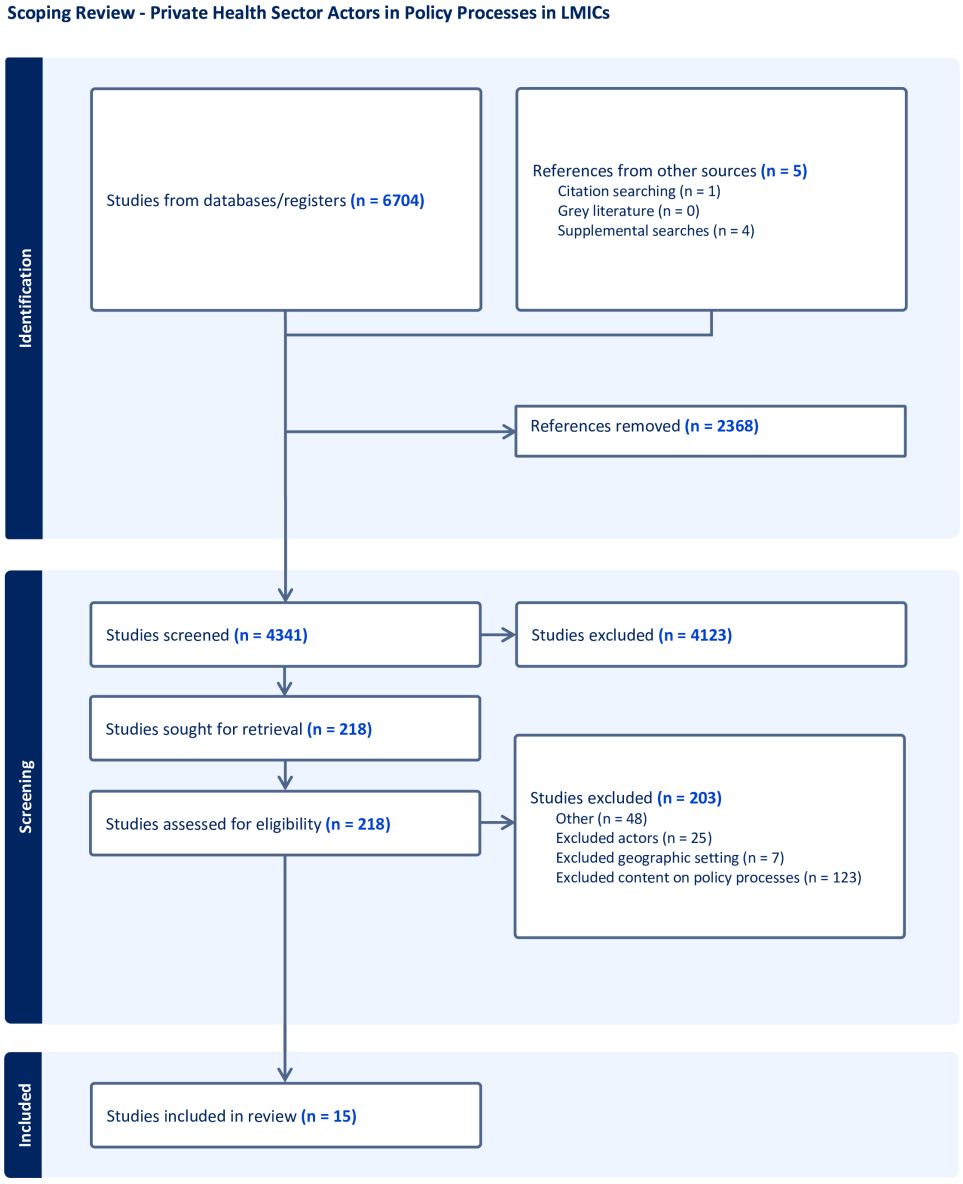

Figure 1 Flow diagram for scoping review. LMICs, low-income and middle-income countries.

group in the landscape of South African insurance firms, or as partners with corporate hospitals in India.

Methodological and theoretical/conceptual analysis

Disciplinary and topical foci of the journals in which included papers were published were diverse and spanned public health, public policy, health policy, global health, medicine, gender studies, environmental studies, development studies, ethics, urban-territorial studies and economics. The majority of included articles were research articles (n=11), while four were reports. Many papers involved secondary analysis of existing literature, with the few papers involving primary research, using interview data and occasionally, observation data. However, in a few papers, methods were poorly described. Articles were often descriptive and many lacked a theoretical framework to drive analysis of interactions between the private sector and political authorities in the context of health. Those articles that did include a theoretical framework drew from diverse concepts, such as interest group politics, health sector financialisation and path dependency, reflecting the disciplinary diversity of scholarship on this topic.

Thematic analysis

Institutions

We analysed papers with a focus on the norms, structures and processes influencing policy outcomes in the included papers.

A diverse set of institutional frameworks were described in the included papers, including levels of government (i.e., national vs subnational), units or branches of government involved and processes by which policy was developed or implemented (table 2). The focus of private sector involvement in healthcare across the

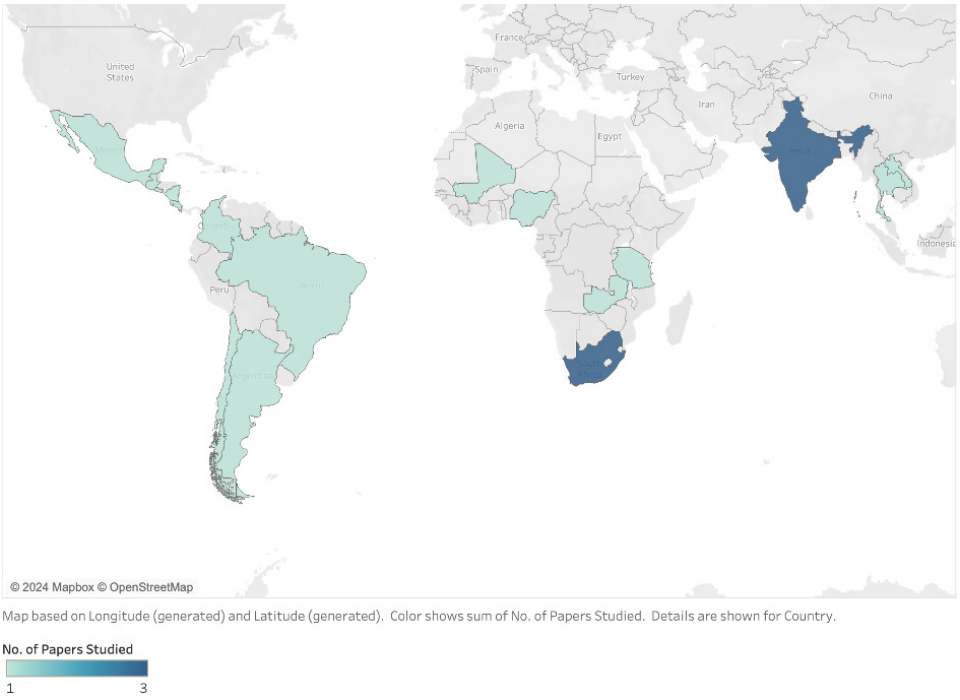

Figure 2 Geographical focus of included studies.

papers was, therefore, diverse and highly context specific. One of the key patterns that emerged from the papers is the stated reliance on the private healthcare sector by government to address gaps in health service delivery and health financing. For example, in Colombia, Prada and Chaves[46] describe the introduction of mandatory health insurance as a major health sector reform which both expanded financial coverage and also strengthened the role of private health insurance companies that were tasked with administering these funds. Similar scenarios across different dimensions of healthcare sectors were observed in India,[17 47] Nigeria[48] and several Central and South American countries.[43–45] Several papers described underlying drivers of the trend towards privatisation as having stemmed from government policy shifts in the 1980s and 1990s away from public investment in healthcare,[17 45 46 48 49] in some cases driven by structural adjustment loan packages from international development and lending agencies due to severely challenging economic conditions in many LMICs in this time period.[45 46]

Another structural pattern concerned the expansion of certain healthcare sectors in countries for the purposes of economic growth. Some papers explored the ways in which certain private sector actors expanded their involvement in healthcare delivery, such as companies engaged in pharmacies or insurance. Papers described how governments sometimes intervene in the healthcare sector to favour the development of the domestic industry or how its reluctance to expand public health infrastructures created market space for private actors.[43–45] For example, in Mexico, the general shift towards privatisation and deregulation combined with low coverage of public health facilities in newly urbanised areas created new market opportunities for private chains of pharmacies.[44] Boosted by the new possibility to get listed on the Mexican Stock Exchange and thus expand their access to capital, these companies rolled out new business models that integrated—and blurred boundaries between—clinical services and drug distribution.[44] Creating conditions more favourable to private actors in order to develop the national economy can be in tension with goals pursued by the Ministry of Health. In Thailand, a focus on medical tourism was driven by the Board of Investment, Tourism Authority of Thailand and Ministry of Commerce, in opposition to the Ministry of Public Health and its goals around narrowing disparities in quality and access between private and public health sectors.[43]

Papers also focused on relationships between the policy environment which private sector actors were situated within and the policy impact of these actors. In Brazil, for example, private health sector interests were 'already quite entrenched with strong organised interests during the drafting of the Constitution', bolstering the ability for sectors such as the private health insurance industry to enjoy tax exemptions and monopoly creation (p. 1812).[43] In Nigeria, individuals advocating for the introduction of health maintenance organization (HMO) into the Nigerian system, as well as the insurance industry, played a key role in promoting an HMO-based system for private healthcare in the 1990s.[48] A paper that focused on managed care in Latin America discussed the 'silent process of policymaking' involving these companies and their involvement in health sector reforms (p. 1245)[45]. These examples stand in contrast to Thailand, where 'sustained investments in public health infrastructure and deliberate efforts to check the influence of the

Table 1 Descriptive information regarding articles included in the scoping review

Industry	Articles included in the scoping review
Healthcare networks and medical cooperatives (for-profit and not-for-profit)	[52]Macq et al. 2008 Public purchasers contracting external primary care providers in Central America for better responsiveness, efficiency of healthcare and public governance: Issues and challenges
Hospitals and clinics (large, midsize and small hospitals, nursing homes, clinician entrepreneurs)	[17]Chakravarthi et al. 2023, Corporatisation in private hospitals sector in India—a case study from Maharashtra. [53]Mishra et al. 2021, A Draconian Law: Examining the Navigation of Coalition Politics and Policy Reform by Health Provider Associations in Karnataka, India [47]Reddy and Mary 2013, Rajiv Aarogyasri Community Health Insurance Scheme in Andhra Pradesh, India: a comprehensive analytic view of private public partnership model [56]Berger and Hassim 2010, Regulating Private Power in Health.
Health insurers and administrators (for-profit commercial insurance, managed care organisations, not-for-profit insurers/ medical aids)	VandenHeever 1998[54], Private Sector Health Reform in South Africa [48]Onoka et al. 2015, Towards universal coverage: a policy analysis of the development of the National Health Insurance Scheme in Nigeria [45]Iriart et al. 2001, Managed care in Latin America: the new common sense in health policy reform. [51]Gilson et al. 1999, The Dynamics of Policy Change: Healthcare Financing in South Africa, 1994–1999.
Private pharmacies	Box 2: Sample search terms used in,Mori et al.[50] 2013, Reforms: a quest for efficiency or an opportunity for vested interests? a case study of pharmaceutical policy reforms in Tanzania [44]Salinas Arreortua and Rojas 2021, Financialisation of the Pharmaceutical Industry and its Impact on Urban Peripheries in the Metropolitan Area of the Valley of Mexico [49]Stenson et al. 1997, Pharmaceutical regulation in context: the case of Lao People's Democratic Republic. [55]Maïga et al. 2010, Processus et enjeux de la réglementation des prix des médicaments essentiels dans le secteur pharmaceutique privé au Mali
Multiple sectors represented	[46]Prada and Chaves 2019, Health system structure and transformations in Colombia between 1990 and 2013: a sociohistorical study. Critical Public Health Harris and Libardi Maia 2021,[43] Universal healthcare does not look the same everywhere: Divergent experiences with the private sector in Brazil and Thailand

private sector have constrained the power of the private sector and led to more robust and equitable reforms under UHC' (p. 1810).[43] For example, participatory governance platforms in Thailand, such as the National Health Assembly, have helped make various influences on health policy processes, including the private sector, more visible and have also elevated voices in civil society and other sectors.

Across the selected articles, the institutional mechanisms enabling private sector participation or consultation in decision-making, such as standing or temporary committees or contract negotiation, were largely not described, or described in generic terms (ie, 'lobbying' or 'bargaining'). A few articles that did describe these mechanisms were limited in their analysis of the power dynamics manifesting in these mechanisms.[50 51] In some instances, private industries or groups representing private healthcare sector actors, such as groups representing hospitals were made members of committees to regulate industry behaviour or to propose solutions for reform[43 50 51] or were involved in directly drafting policy.

The involvement of private healthcare actors served two potentially contradictory goals—on the one hand, involvement of these actors allowed for more participation in regulatory process; on the other hand, involvement of these actors could result in regulatory capture—as arguably observed in Tanzania with regulation of pharmacies[50]—and/or stifle more equity-oriented policy. Similarly, in Colombia, "private health insurance companies have replaced public insurers and accumulated

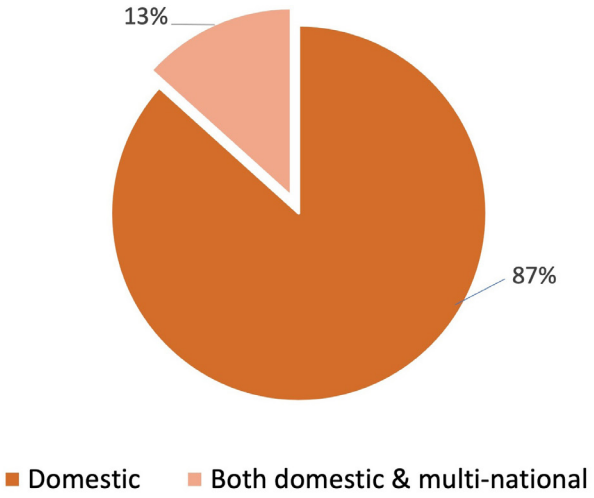

Figure 3 Scope of industries represented in included studies - domestic v. multinational.

economic, scientific and political capital that allows them to influence decision-making in the legislative and executive arenas" (p. 318).[46]

Some papers described the critical importance of networks in facilitating informal institutional practices, such as favourable contract terms or engagement in ownership of businesses in the sector.[43 48 51 52] For example, in a paper describing public–private partnerships in primary care in four Central American countries,[52] authors refer to networks in Nicaragua and Guatemala where current and former ministers and civil servants attempted to influence/become involved in the contractual process. This was similarly observed in Nigeria, where "politicians (including senators), banks and wealthy individuals" became involved in HMOs due to financial opportunities (p. 1110).[48]

Finally, several papers noted the hugely complex task for governments in regulating private actors or in initiating regulatory reforms in these sectors.[46 47 49 50 53] In Lao PDR, for example, the growth of private pharmacies occurred rapidly in the late 1980s during the period of economic reform, but without adequate regulation.[49] In Colombia, similarly, regulatory mechanisms to oversee the private healthcare sector, particularly the insurance industry, did not keep pace with the growth of the sector; as a result, the inability to resolve policy disputes between the government and private sector resulted in greater involvement of the courts in adjudication.[46] Papers focused on India addressed the role of private healthcare sector actors in resisting regulation of the private sector, an increasingly complex policy domain given the reliance on the private sector in achieving goals around universal health coverage.[17 47 53] For example, in the state of Karnataka, India, efforts to institute more robust regulation of the private sector in terms of patient rights and standardisation of costs were met with fierce opposition from a coalition of physicians and hospital owners.[53] In Andhra Pradesh, India, a coalition of hospital associations pressured the government into increasing tariffs for a state-financed insurance programme by 30%.[47] Finally, in Tanzania, the 'regulatory capture' of the primary regulator for pharmacies was openly stated by participants, with a respondent noting that a key function of the regulatory body was to protect the interests of pharmacists.[50]

Interests

The papers included in this review present private healthcare sector actors and their wide range of interests in domestic policy processes. Actors described in the papers were diverse, including specific companies (domestic and multinational), formal interest groups and multiorganisational coalitions or networks. The level of organisation differs across healthcare sectors.

Organisations of private healthcare actors vary in type and size. That said, some interest groups represented a variety of constituents within a single association (e.g., hospital associations representing for-profit and not-for-profit interests) while in other cases, distinct interest groups represented mostly specific interests (for-profit, corporate hospitals compared with single-doctor clinics). Multinational interest groups were key players in the case of pharmacies in Mexico and in insurance reform in South Africa and Latin America. Multinational companies were also noted in these articles to engage in processes of mergers with domestic companies to solidify their position within domestic markets.

The interests represented by actors reflected private sector actors' goals of maximising or safeguarding benefits to their constituents/owners. In the cases where actors' interests and the interests of the government in power aligned—or were not in opposition—policy domains

Table 2 Institutional frameworks guiding engagement of private healthcare sector actors

Involvement of private sector actors in policy processes to address access gaps (Salinas Arreortua and Rojas 2021[44]; Harris and Libardi Maia 2022[43]; Reddy and Mary 2013[47]; Onoka *et al* 2014[48] Chakravarthi *et al* 2023[17]; Stenson, B; Tomson, G; Syhakhang, L 1997[49])
Involvement of private healthcare sector actors in drafting institutional frameworks for private sector engagement (Harris and Libardi Maia 2022[43]; Reddy and Mary 2013[47]; Mishra, Elias, and Sriram 2021[53])
Involvement and participation of private healthcare sector actors in policy mechanisms (Maïga, Maïga, and Maïga 2010[55]; Mishra, Elias, and Sriram 2021[53]; Harris and Libardi Maia 2022[43]; Onoka *et al* 2014[48] Gilson *et al* 2018[23])
Networks and relationships facilitating favourable contracts, informal payments (Macq *et al* 2008[52]; Harris and Libardi Maia 2022[43]; Onoka *et al* 2014[48])
Conflicting policy or legislative goals within governments and between levels of government. (Harris and Libardi Maia 2022[43]; Onoka *et al* 2014[48])
Economic policy regarding entry of multinational companies into domestic markets. Iriart *et al* 2001[45]; Salinas Arreortua and Rojas 2021[44]
Contracts with public sector bodies (ministries, state-owned companies). Harris and Libardi Maia 2022[43]; Macq *et al* 2008[52]; Gilson *et al* 2018[23]; Iriart *et al* 2001[45]

Box 3 Interest group strategies

Unspecified lobbying, representation or leverage with government (Mishra et al 20[57]21; Gilson *et al*[51]; Reddy and Mary 2013[47]; Stenson et al[49]; Maïga et al 2010[55])
Direct involvement in drafting or developing policy (Onoka et al 2013[50]; Gilson et al[51])
Protest and strikes (Harris and Libardi Maia 2022[43]; Mishra et al 2021[53])
Lawsuits and adjudication by the courts (Barnard 2002; Berger 2010[56])
Evidence generation (Maïga et al 2010[55]; Van Den Heever 1998[54])
Access to senior decision-makers (Mishra et al [53]; Macq *et al* 2008[52]; Gilson *et al* 1999[51]; Chakravarthi *et al* 2023[17])
Constituent mobilisation and framing to the public (i.e., WhatsApp, misinformation) (Mishra, Elias, and Sriram 2021[53]; Maïga, Maïga, and Maïga 2010[55])
'Informal' practices (collusion, favoritism, bribery) (Gilson *et al* 1999[51])
Formal negotiations (Salinas Arreortua and Rojas 2021[44], Chakravarthi *et al*[17], Gilson *et al*[51], Maïga, Maïga, and Maïga 2010[55])
Facilitating international or domestic travel for decision-makers (Gilson *et al* 1999[51])
Developing networks with other stakeholders (Chakravarthi *et al* 2023[17], Gilson *et al* 1999[51])

often concerned service delivery or financial protection challenges where governments stated a perceived necessity for private sector engagement for service expansion or for stated needs in quality improvement.[47] In some cases, constituencies had divergent interests on particular policy issues, resulting in opposing coalitions.[48 51 54] For example, in South Africa, the insurance or medical schemes sector was divided between the Representative Association of Medical Schemes, which represented largely non-profit firms offering employer-based and voluntary schemes, and the Concerned Medical Schemes Group, which represented commercial life assurance schemes.[51 54]

The papers refer to a range of strategies that interest groups use to pursue their interests (box 3). Some papers reference 'lobbying', 'political leverage' or 'pressure tactics' but often do not provide details regarding what these strategies entail.[47 49 51 53 55] A few papers did delve into the rationale and approach taken to advocacy by interest groups. In these papers, the strategic use of complementary advocacy tools in terms of opening or closing windows for policy action was evident. For example, in the case of policy processes to amend the Karnataka Private Medical Establishments Act (2016), 'outsider' approaches to lobbying, such as strikes, facilitated 'insider' approaches, such as closed-door meetings with high-ranking political leaders.[53] For example, in South Africa, the insurance industry implemented 'a dual strategy' by both directly participating in committees engaged in policy development, while also using the access generated by their financial power to informally lobbying decision-makers.[51]

The nature of power wielded by various interest groups in the papers suggested potential differences in the types of strategies undertaken by these organisations. For example, better resourced organisations representing the hospital industry in India appeared to leverage the membership strength of doctors' associations in order to capitalise on strike and protest action to secure direct access to policymakers.[53] The papers also indicate that some interest groups that are better resourced, represent wealthier constituencies or leverage more sources of power tended to use highly effective strategies. Iriart *et al* note that reform processes involving managed care in Latin America tended to be 'silent' involving primarily policy elites involved in particular subsectors, and limiting a 'societal perspective on reform'.[45] Resources were also involved in the generation of research or evidence. In South Africa, a coalition of insurance companies commissioned research from a firm to generate evidence regarding the policy issue; the paper proceeds to note that the commissioned firm had been involved in controversy in previous research and was discredited by the department involved in this policy process.[54] Finally, the courts were also used in South Africa by the Hospital Association of South Africa to block the development and publication of a national reference price list for health services.[56] Some papers further stressed the relational nature of power in these cases, describing the power of other actors, coalitions and subsystems and the ways that this influenced the positions and behaviours of other interest groups and processes more broadly.[46 51 53]

A few papers described the evolution in sources of power for particular interest groups.[45 46 48] For example, in Nigeria, HMOs grew in their ability to manage a variety of stakeholders, and even attracted international funding from the IFC.[48] The networks in which interest groups were situated appeared to influence their access to decision-makers and their influence on policy—both formally and informally.[45 57] For example, Iriart *et al* describe the composition of boards of directors for managed care companies and describe how the board of one Argentinian company included highly placed US officials in addition to domestic and international business persons.[45]

Ideas

Underpinning many of the cases and their analyses were fundamental ideational debates about the roles that can or should be assumed by the private sector in healthcare delivery and financing. Examples of ideational debates explored in the articles included those focused on evolving understandings of the right to health and healthcare, the state's responsibility in ensuring such rights, and the extent to which the private sector should be involved in expanding health service delivery and universal health coverage. The papers focused on Latin America provide a particularly strong description of these ideational shifts towards neoliberalism.[49 58] As noted by Iriart et al., 'In the official pronouncements we have

studied, healthcare no longer remains a universal right for whose fulfilment the state is responsible, but rather is converted into a good of the marketplace that individuals can acquire.' (p. 1246)[45] Similarly, in India, Chakravarthi *et al* provide a rich description of the ideational shifts in national and state-level policy towards the private healthcare sector.[17] Further, they describe the process by which corporate hospitals in India began to coalesce into organised interest groups, and to position corporate involvement in healthcare as not just 'a social good but also a viable economic activity' (p. 59).[17] In this way, the papers highlight an important ideational strategy of governments and the private sector in situating the latter's role as 'filling' a gap in service delivery and financing.

One of the key ideational debates involving private healthcare sector actors appeared to be the tension within the government regarding the concurrent growth and regulation of the sector. Governments wrestled with the push for economic development through the expansion of healthcare industries with the potential negative impacts of 'unchecked' regulation of the private sector, such as inequitable access to services, lack of affordability and concerns around quality. Under the growing financialisation of economies, national private groups may be under the strict rules of the stock exchange (including an obligation of high return on investment) or be bought by multinational companies, directions which may clash with some national health objectives.[17 44]

The diffusion of ideas across contexts was less frequently discussed, but select papers addressed the ways in which policy ideas 'transferred' from contexts, typically the USA or high-income countries, to LMIC settings through actors such as the diaspora,[17 48] international development agencies[45] or multinational companies.[45] Another angle to the discussion on policy diffusion was the concept referred to by Iriart et al as transnationalisation of health sector reform, particularly in terms of shaping the ideological boundaries of the types of health reform introduced (notably the introduction of multinational and domestic private players and capital into various aspects of healthcare service delivery and financing).[45 48]

Policy outcomes

The policy outcomes described in the cases were highly context-specific and dependent on the interaction between institutions, interests and ideas. The clearest example of this context specificity is the comparison between universal health coverage policy processes in Thailand and Brazil, where opposition from private sector actors in Thailand did not yield substantial benefits for the private sector, as it did in Brazil.[43] Authors discussed a variety of ways in which government stances on policy options—undergirded by its source of power to negotiate—impacted policy outcomes. For example in Mali, the role of the state as a primary purchaser of medicines through its central medical stores gave credibility to its bargaining claim that the government could import medicines rather than negotiate a higher price in the interest of suppliers and pharmacies.[55] In contrast, the case in Andhra Pradesh suggests that the state's bargaining position was weak, resulting in the need to agree to the requested 30% tariff increase requested by private sector hospitals.[47] The state's position was also influenced in some examples by opposing coalitions in a particular policy case. In South Africa, trade unions were able to draw on their networks with the ruling party to block the development of policies supported by one faction of the insurance industry.[51]

Some papers also suggested that the 'outcome' of the case was not decided by a particular policy decision. For example, in Lao PDR, class III pharmacists were able to use their political pressure to overturn regulations that would have restricted their practice in urban areas. However, it appears that by 1994, the Ministry of Public Health was able to stop issuing licenses for class III pharmacies given quality challenges, and began issuing licenses again in 1995 but only for remote locations.[49] In another example of the dynamic nature of these processes, the coalition of hospital owners and doctors in Karnataka, India was able to secure a position in the committee that would set costs for private sector services, resulting in significant power in agenda setting for these groups in this policy domain going forward.[53] Iriart *et al* described growing resistance to managed care in Ecuador and Brazil, with comparatively limited resistance in Chile and Columbia.[45]

Finally, some papers described the wider impacts of actions taken by private healthcare sector actors on the functioning of health systems. For example, in Latin American countries, disruptions in the public healthcare system include barriers for marginalised populations to access care, changes to the profile of patients using public hospitals, and shifts in organisational culture and management to compete with private hospitals (ie, reliance on private management firms to administer hospitals).[45] Similarly, in India, actions taken by corporate hospitals have resulted in mergers with trust and charitable hospitals that have further entrenched their position within markets and in policy spaces.[17]

DISCUSSION

The body of research reviewed in this paper emphasises the significant impact of the private healthcare sector on shaping healthcare policy and systems in LMICs, and underscores the necessity for a political economy perspective in examining healthcare systems in LMICs. The importance of the private sector in health systems in LMICs is strongly accepted and understood in health policy and systems research[1 3 13 59] and yet, there continues to be a gap in understanding how private healthcare sector actors engage in policy processes in these contexts. This scoping review sought to synthesise scholarship across disciplinary and contextual boundaries and elucidate patterns in the role of private health sector actors in health policy processes in LMICs.

One of our key findings concerns the nascent stage of the literature, despite clear global relevance. Our search yielded a few papers, several with limited methodological descriptions and robust theory guiding the analysis. The geographical diversity of studies in this review confirms global significance of health policy analysis inclusive of the private healthcare sector in LMICs. Many of the countries included in this review are middle-income countries that are largely not dependent on aid (for example, South Africa, Brazil, Thailand and India). In these contexts, domestic policy processes involving private sector actors—arguably more so than global development actors—are likely to be influential in shaping the policy and sectoral landscape. The role of global development actors remains, however, a key focus within the domain of health policy analysis; surely, given pervasive power and resource asymmetries within global health architectures,[60] the roles of these actors rightly deserve scrutiny. Yet, one may wonder whether giving considerable attention to the technocratic façade of the health policy processes led by aid agencies masks the active influence of private healthcare sector actors on other matters, which may be less of a focus for the aid sector (although with some key exceptions). While the aid ecosystem is largely focused on primary healthcare, private interests may be securing control of the national policy space for more investment in hospitals, medical technologies or even just business models, which will put health systems on a path difficult to reverse.[61]

One of the overarching challenges in this research area is its interdisciplinary nature, involving research from health, political science, development studies, area studies and other domains. Interdisciplinary approaches allow us to bring new questions to the global health community, for instance, how countries should balance efforts for improving health of their people and the objective of economic development through a private sector-led industrialisation. Interdisciplinarity will allow the use of other typologies and concepts, for instance, those developed in business politics and governance literature within political science. The use of such typologies and concepts will also aid in stronger comparisons across contexts, an important dimension of research in this space given policy diffusion across domestic and multinational contexts. At the same time, a context-sensitive approach is key to explaining how policymaking regarding healthcare works in a specific context and the interactions between this policy-making landscape and the private sector. In this regard, studies on the private sector in healthcare in LMICs could benefit from the heuristic value of area studies to achieve contextually richer analyses. The need for context-specific and interdisciplinary understandings of health policy processes further underscores the need to expand the field of health policy and systems research.

The papers included in this review unequivocally confirm that private healthcare sector actors are not passively responding to changes in market conditions; rather, these players are actively reshaping institutional frameworks to bolster their market share and also their political power in governance processes. The nature of these subsectors certainly varies—for example, how clinician entrepreneurs and small hospitals and nursing homes organise and advocate for their policy demands differs in some respects from large multinational corporations: clinician entrepreneurs and small hospitals might use strike action or protests to draw attention to their demands, while multinational insurance companies might be 'silent' approaches with policy elites that are hidden from public scrutiny. Yet, these diverse industries are bound together in their active management of their constituencies, their cultivation and maintenance of networks with decision-makers and industry, and their utilisation of diverse sources of power through formal and informal channels in policy development. Our analysis, therefore, suggests important linkages with the scholarship with other commercial determinants of health, the pharmaceutical industry in health policy processes, and those producing unhealthy commodities.[62 63]

Our analysis raises some key questions that need to be addressed in contemporary policy debates around the private sector engagement for universal health coverage. For example, what types of institutional mechanisms have been most suitable in engaging the private sector in policymaking in health for universal health coverage? What types of ideas motivate the interests and policy preferences of private sector actors that might be aligned or at odds with universal health coverage? How are those ideas shaped by multinational and transnational networks? What types of advocacy strategies do private healthcare sector actors use in achieving their goals? And importantly, what types of theorisations can be developed around the link between private healthcare sector influence on health policy processes and policy outcomes? Some of the papers included in this review suggest intriguing answers to these questions but a greater body of evidence needs to be built up before we can sufficiently address them. Other papers that were not included also suggest important directions for future work, such as the role of private equity in health sector policy processes[69], cross-sectoral interest groups, such as intellectual property law associations, and policy interfaces between the public and private sectors (ie, dual practice).

There are several limitations to our review that must be considered in interpreting our findings. First, the term 'private sector' is heterogeneous and includes for-profit and not-for-profit actors. In our review, we refrained from distinguishing different subtypes of private healthcare sector actors and included a few papers that discussed both for-profit and not-for-profit actors within the same paper. It is likely that papers largely focusing on the for-profit sector were identified in our search due to the search terms used. Future research in this space should adopt a search strategy that more clearly distinguishes between the subtypes of private sector actors, as well as more clearly addressing the partnerships or linkages between for-profit and not-for-profit actors in policy

processes Further studies may also consider levels of informality and explicitly include papers examining the role of informal private healthcare sector actors. Second, we potentially excluded key papers due to the nature of our search terms or mismatches in keywords and cataloguing. We also note that the use of select databases might have limited papers from particular disciplines (ie, legal studies). Future studies may consider building on our approach and adopting a more comprehensive or systematic approach by searching literature across disciplines and exploring particular subsectors. Third and finally, the exclusion of books and book chapters from this review limited important insights from those forms of scholarship, but unfortunately, could not be incorporated due to time and resource constraints. Similarly, a wider range of grey literature searching could have potentially identified resources for inclusion in the review.

CONCLUSION

Private healthcare sector actors are key players in health policy processes across LMICs; yet, scholarship on the role of these actors in influencing policy processes in these contexts remains limited. The findings of this scoping review indicate that research on the role of these actors in healthcare policy-making in LMICs remains nascent. Critical approaches to the role of private healthcare sector actors in health policy are especially needed to inform the growing policy interest in this field, especially in the context of the calls for a whole-of-sector approach to healthcare to achieve universal health coverage in LMICs. This review underlines the importance of the often-overlooked governance dimension in the global policy agenda on private sector engagement in health. The emerging global policy paradigm often exhibits a naïve teleology in which private sector engagement necessarily results in a step towards universal health coverage. We document limited but important evidence that not all forms of private sector engagement in healthcare contribute to the goals of universal health coverage. Therefore, this review suggests that strengthening the evidence base for the influence of private healthcare sector actors on health policy processes will provide a greater understanding of governance factors that enable countries to achieve universal health coverage.

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