Nature of the private hospital services toward universal health coverage: A systematic scoping review of the developing countries evidence

Razieh Fallah, Mohammadreza Maleki

Abstract:
Private hospital services (PHS) with the undeniable effects on the Universal Health Coverage (UHC) goals have a considerable contribution to the health system of developing countries. The purpose of this systematic scoping review (ScR) was to identify and map the available evidence regarding the developing countries to scrutinize the nature of the PHS toward UHC through providing graphical/tabular information of the records trends and types, sources of the records, frequent settings, drivers of the PHS growth, range of the PHS, behaviors of the PHS, and opportunities for policy actions. This study was performed following the 2017 published methodological guidance of the Joanna Briggs Institute for the conduct of ScR. Furthermore, a narrative-thematic synthesis integrated with the systematic analysis applying approach to health system strengthening (HSS) through systems thinking was employed. Thirty-two included records in English that met the inclusion criteria were found between 2011 and July 2020. There has been a sharp increase in the generation of the records with a 90.6% growth rate between 2015 and 2020. The most frequent records types were review article, and the lancet was the most specialized journal. India was the most frequent country. Near half of the growth drivers of PHS have been originated from the governance. Besides, the range of PHS was identified only about Mongolia, and the significant frequency of codes of the PHS behaviors (32.6%) was related to integrated people-centered health service delivery. 47.8% of the identified HSS interventions were recommended about governance. Governance plays a decisive role in the nature of the PHS in UHC. Concerning the dynamic architectures of interactions between health system functions, probably the countries themselves have realized the importance of the governance role in the HSS than other functions. Given the all of the recommended interventions were a combination of foundational and institutional, sustainable participation of PHS in the health system seems far and requires a solid will of the governments. Future research is needed about the range of PHS and its behaviors in terms of consumables, revenue-raising, and pooling of funds.

Keywords:
Policy-making, private hospitals, universal coverage, universal health

Introduction

Background, and theoretical framework
Private hospital services (PHS) with the undeniable effects on the Universal Health Coverage (UHC) objectives and goals, have had a considerable contribution to the health system of developing countries from the past to present. On the other hand, pursuant to the UHC pledge to leave no one behind -progress toward UHC that will be essential to Sustainable Development Goals, requires a fundamental shift toward integrated health-care systems. With respect to the complexity of health systems, systems thinking is inevitable. Since one
way to ensure the system’s performance is health system strengthening (HSS) and according to Figure 1, HSS also has impact on UHC. we chose theoretical approach to HSS through “systems thinking” as a powerful tool that first decodes the complexity of a health system and then applies that understanding to design better interventions to strengthen systems, increase coverage, and improve health.

Rationale and objective
There is evidence across the world that the private health sector can contribute effectively in all the three dimensions of UHC, but enhancement of the contribution of the private sector has recognized as one of the overarching challenges that influence the health system performance, and particularly, there is an urgent need to reassess the arguments used in favor of scaling-up the for-profit private sector in the poor countries.

Some successful efforts found compared the PHS in terms of the ownership, some others pointed only to private sector growth regardless of the private hospital, and also such evidence has grounded by the extracted data of some mapping or scoping studies. Nevertheless, there is a lack of evidence that has scrutinized systematically the nature of the PHS toward UHC in terms of the services range, growth, behaviors, and policy actions. Moreover, considering that Fallah and Bazrafshan identified the above-mentioned gaps in their study and suggested them as future research priorities, the objective of the current systematic scoping review (ScR) was identifying and mapping the available evidence about the nature of the PHS in the UHC journey of the developing countries through providing graphical/tabular some main information.

Materials and Methods

Study approach
This systematic ScR was conducted from May 2019 to July 2020. The nine-steps published methodological guidance of the Joanna Briggs Institute (JBI) for the conduct of ScR, that is congruent and consistent with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for ScR checklist along with the narrative synthesis integrated with the systematic analysis as knowledge synthesis methods to meet the objective.

Inclusion criteria
Defining the PCC elements for ScR (Population: Private hospitals, Concept: Service delivery, and Context: UHC in developing countries) was a substantial step in developing the inclusion and exclusion criteria [Table 1] to come to a shared conception. To gain comprehensive resources and to find the records were not indexed in databases, all relevant documents including gray literature were searched.

Research questions
Referring to the guidance, based upon the PCC elements, seven research questions (RQ) were derived from the objective of the study. To make better understand audiences, its priority is as follows in Table 2.

Search strategy
A three-step search strategy as posited in JBI guidance was undertaken after defining the RQ using PCC. Following initial scoping searches of online relevant databases and search engines (PubMed, Embase, and Google Scholar) using MeSH terms, Emtree, and similar databases and search engines (PubMed, Embase, and Google Scholar) were searched. Full searches were then performed regardless of the time and language limitations. To find gray literature such as dissertations and reports, and to attain some manuscripts before peer review in a journal some search engines and website were employed [Figure 2]. The inclusion of the search results was continued up to it was explicitly obvious that the listed results were irrelevant. The reference lists of found records were searched, and thus, backward and forward-searching was also employed. Some search strategies including search terms are presented in detailed [Box 1].

Selection of the evidence
To remove duplicates and simplify the reviewing process all records found in the search were managed by bibliographic software (EndNote version X8). According to Figure 2, the identified records were reviewed at all stages based upon the inclusion and exclusion criteria according to the PCC. The judgment about the fitness of records was made by both authors, and any disagreements were resolved in discussion with each other. The interdisciplinary essence of the retrieved records and the challenges of using quality criteria across the research paradigms meant that the appraisal of the included records classified in Table 3.
was confined to considerations of relevance rather than research quality.

**Data extraction, synthesis, and analysis**

Choosing the narrative synthesis as a systematic and transparent approach, after further familiarization with the data, data coding was undertaken in deduction, induction, and verification phases. In the first phase, the framework method following Gale et al. model was selected as a systematic and flexible approach, particularly in multidisciplinary research teams were not all members have experience of qualitative data analysis. The retrieved data were informed applying the theoretical approach to HSS through “systems thinking.”
For the second phase, the free code was dedicated to the messages extracted from the records which allow new themes to emerge inductively. The coding schema was refined through the continuous comparative analysis. Whereby the coded concepts were certified, modified, unified, and/or added to through several iterations of analysis. Entire this process, a team approach was applied to minimize individual bias pertained to multiple analysts involved in coding and interpreting data. Hence, both authors committed to validate coding decisions and discuss emerging themes finally, the themes, categories, and codes were searched aiming to explore other classification in terms of the conflict situations and WHO regions. The findings were synthesized in both quantitative (using frequencies) and qualitative (thematic analysis) format through Excel.

### Results

The electronic databases and search engines identified 1440 records of which 36 were deemed as potentially eligible. After screening, 32 records were eligible for the inclusion in this review. The findings were classified based on each RQ and then were illustrated as tabular or visual representations.

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**Table 2: Research questions sets and sub-set**

| Research questions | Remarks |
|--------------------|---------|
| BRQ1 - Records trend and types | Evidence about PHS dealing with UHC was found and selected [Figure 3]. In the absence of explicit research design in some of the records, the designs were determined by analyzing the circumstances of the information and the activities utilized |
| BRQ2 - Sources of the records | The sources of the retrieved records were reported based on the referred journal or corresponding organization |
| CRQ1 - The frequent settings | The geographical coverage of the records was searched to find the location that was mentioned empirically around the nature of the PHS towards UHC. Where the document was about a region (a set of countries) and the data were presented as a general conclusion and not separately for each country, the coding was done based on the region |
| PRQ1 - Drivers of the PHS growth | The drivers were explored thematically with the lens of privatization forms, wherever has been stated clearly |
| CoRQ1 - Range of the PHS | It was responded according to available evidence, wherever had been exactly reported concerning the level and type |
| CoRQ2 - Behaviors of the PHS | Health System behavior which reveals itself as a series of events over time can affect positively or negatively in the health system context[8]. In this question, the emergent behaviors influenced by PHS were reviewed in the context of relationships with the other health system functions. The action refers to system-level interventions that aim at HSS[7,8] and were coded following the strategies of the integrated people-centered health services framework |

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BRQ=Bibliometric research questions, PHS=Private hospital services, UHC=Universal health coverage, CRQ=Context research questions, PRQ=Population research questions, CoRQ=Concept research questions, HSS=Health system strengthening

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**Figure 3**: Chronological trends of the available evidence
| Authors/reference | Title | Year | Type of review | Contributions |
|-------------------|-------|------|----------------|---------------|
| Reddy et al.[27] | Towards achievement of universal health care in India by 2020: A call to action | 2011 | Proposal paper | Proposes the creation of the integrated national health system to achieve health care for all by 2020 |
| Zaidi et al.[2] | Role and contribution of private sector in moving towards universal health coverage in the Eastern Mediterranean region | 2012 | Report | Discusses the current role of the private sectors with a focus on regulation, consumer information financing of the private sector towards UHC |
| | | | | Analysis of success drivers and constraints in strengthening the role of the private sector in regulation and service delivery |
| | | | | Proposes a framework that includes regulation, service delivery, and financing |
| | | | | Proposes a list of priorities for EMR states and the role of the WHO in supporting states in strengthening PPP |
| EMRO*[15] | Analysis of the private health sector in countries of the Eastern Mediterranean: An exploring unfamiliar territory | 2014 | Report | Presents information on trends in privatization and implications for the private health sector |
| | | | | Display the current status of the private health sector in countries of the region |
| | | | | Discusses challenges and gaps in relation to the private health sector |
| Morgan et al.[28] | Performance of private sector health care: Implications for universal health coverage | 2016 | Review | Reviewed the evidence of important individual factors and consider the implications for UHC in LIMICs |
| | | | | Identified factors that affect private sector performance |
| | | | | Developed a conceptual framework theorizing the links between individual performance characteristics and system-level effects that determine progress towards UHC |
| Mackintosh et al.[29] | What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries | 2016 | Report | Proposed a set of metrics to identify the structure and dynamics of private provision in their particular mixed health systems; and to identify the consequences of specific structures, the drivers of change, and levers available to improve efficiency and outcomes |
| Montagu and Goodman[30] | Prohibit, constrain, encourage, or purchase: How should we engage with the private health-care sector? | 2016 | Systematic review | Reviewed the evidence for the effectiveness and limitations of such private sector interventions in LMICs |
| McPake and Hansor[31] | Managing the public–private mix to achieve universal health coverage | 2016 | Review | Extrapolated and discussed main messages from the papers to inform policy and research agendas in the context of global and country-level efforts to secure UHC in LMICs |
| Tsevelvaanchig et al.[32] | Role of emerging private hospitals in a postsoviet mixed health system: a mixed methods comparative study of private and public hospital inpatient care in Mongolia | 2017 | Mixed methods approach of quantitative and qualitative techniques | Identified the geographical distribution of private hospital admissions |
| | | | | Showed the main types of private inpatient services delivered by private hospitals, in comparison with public hospitals |
| | | | | Highlighted reasons for the urban concentration of private hospital admissions |
| | | | | Identified conditions that do not require hospitalization and root causes |
| Gele et al.[33] | Beneficiaries of conflict: a qualitative study of people’s trust in the private health care system in Mogadishu, Somalia | 2017 | Qualitative | Explored the accessibility to, as well as people’s trust in, the private sector |
| Sean et al.[34] | Organizing health coverage goals the private sector to support universal | 2017 | Report | Highlighted success stories: SHOPS plus examined six diverse countries (Japan, Philippines, Indonesia, Brazil, Germany, and South Africa) that have successfully organized private providers to identify lessons on strengthening their voice, improving quality of care, and expanding their access to revenue opportunities |

Contd...
| Authors/reference | Title | Year | Type of review | Contributions |
|-------------------|-------|------|----------------|---------------|
| Wadge *et al.*[35] | How to harness the private sector for universal health coverage | 2017 | Commentary | Commented on the framework, evaluating the impact of private providers on health and health systems which has been piloted in Narayana health, a private hospital chain in India will be launched on June 28, 2017 |
| Maurya *et al.*[36] | Horses for courses: Moving India towards universal health coverage through targeted policy design | 2017 | Current opinion | Presented information on health system and policy options for universal coverage. Investigated challenges of replicating high performing primary healthcare systems nationally. Reviewed experience of purchasing care in social health insurance programs and improving the effectiveness of Shi programs. |
| Zaidi *et al.*[37] | Expanding access to healthcare in South Asia | 2017 | Review | Present recent proliferation of policy initiatives Afghanistan, Pakistan, Bangladesh, and India. |
| Alami[38] | Health financing systems, health equity and universal health coverage in Arab Countries | 2017 | Literature review | Placed the region in an international context, benchmarking reform efforts against the experiences of developing countries in working towards UHC. |
| Zodpey and Farooqui[39] | Universal health coverage in India: Progress achieved and the way forward | 2018 | Editorial | Suggested the way forward for UHC in India. |
| Makinde *et al.*[40] | Distribution of health facilities in Nigeria: Implications and options for universal health coverage | 2018 | Review | Reviewed the geographic and sectoral distribution of health facilities in Nigeria. Discussed implications on the UHC strategy selected. |
| Tangcharoensathien *et al.*[41] | Health systems development in Thailand: A solid platform for successful implementation of universal health coverage | 2018 | Review | Presented successful implementation of UHC in Thailand. |
| Kwon[42] | Advancing universal health coverage: What developing Countries can learn from the Korean experience? | 2018 | Organizational paper-study series | Presented Korean experience in advancing UHC. |
| EMRO[43] | Private sector engagement for advancing universal health coverage | 2018 | Organizational paper | Proposed a framework for action for effective engagement with the private health sector to move towards UHC. The framework for the analysis of the private health sector followed the conceptual framework of the six health system building blocks. |
| Lu and Chiang[44] | Developing an adequate supply of health services: Taiwan’s path to universal health coverage | 2018 | Review | Analyzed how Taiwan historically built up the supply of health services that made achieving UHC possible. Identified four key strategies adopted in the health service sector development. |
| Tsevelaanchig *et al.*[45] | Regulating the for the profit private healthcare providers towards universal health coverage: A qualitative study of legal and organizational framework in Mongolia | 2018 | Qualitative | Maps the current regulatory architecture for private healthcare in Mongolia. Explored its role for improving accessibility, affordability, and quality of private care and identified gaps in policy design and implementation. |
| Chapman and Dharmaratne[46] | Sri Lanka and the possibilities of achieving universal health coverage in a poor country | 2019 | Review | Identify factors enabling Sri Lanka to progress toward UHC. Presented Sri Lanka’s healthcare challenges. |
show except in 2011, publication in the journals was started in 2016 from the Lancet that encompassing 35% of all the journal articles. It was also revealed that 75% of the articles were published in 2019.

Table 3: Contd...

| Authors/reference | Title | Year | Type of review | Contributions |
|-------------------|-------|------|----------------|---------------|
| Erdenee et al.    | Mongolian health sector strategic master plan (2006–2015): A foundation for achieving universal health coverage | 2019 | Review         | Analyzed changes in the health sector toward achieving UHC based on relevant literature, government documents, and framework analysis |
| Zhu et al.        | Analysis of strategies to attract and retain rural health workers in Cambodia, China, and Vietnam and context influencing their outcomes | 2019 | Qualitative    | Described the strategies supporting rural health worker attraction and retention in Cambodia, China, and Vietnam and explored the context influencing their outcomes |
| Clarke et al.     | The private sector and universal health coverage | 2019 | Perspectives   | Suggested approaches to managing, and where appropriate, engaging the private sector as part of efforts to achieve UHC |
| Cowley and Chu    | Comparison of private sector hospital involvement for UHC in the Western Pacific Region | 2019 | Commentary    | Summarized the growth of private hospitals in China, Vietnam, and Lao PDR** according to some UHC attributes such as quality, accountability, equity, and efficiency |
| Yip et al.        | 10 years of health-care reform in China: Progress and gaps in universal health coverage | 2019 | Review        | Reviewed progress and gaps in UHC in China |
| Danaei et al.     | Iran in transition | 2019 | Review        | Presented transition trends and lessons learnt from Islamic republic of Iran |
| Titoria and Mohandas | A glance on public private partnership: An opportunity for developing nations to achieve universal health coverage | 2019 | Review        | Showed the necessity of public-private partnership and related challenges in India |
| Stewart and Wolvaardt | Hospital management and health policy—a South African perspective | 2019 | Review        | Addressed policy evolution, Current policy issues that are ended to the need for UHC, hospital management in South Africa |
| Khoonthaweelaphon Woraset | The liberalization of Thailand medical services industry: Case study between Thailand and South Korea | 2019 | Thesis-case study | Focused on the examination of the medical service industry in Thailand and South Korea |
| Asbu and Masri     | Determinants of hospital efficiency: insights from the literature | 2020 | Literature review | Reviewed the literature on hospital efficiency and its determinants |

PPP=Public-private partnership, UHC=Universal health coverage, EMRO=Eastern Mediterranean Regional Office’s, LMIC=Low- and middle-income countries

Bibliometric research questions

Records types

Figure 3 demonstrates a sharp increase in the generation of the records with the 90.6% growth rate between 2015 and 2020. The classifications of the records according to their contributions [Table 3 and Figure 4] show that the most frequent records type was review articles (47%). Furthermore, it is seen that during the peak, the review article was the most frequent type of record (60%). Another point we found out was that Zaidi et al.[9,16] and Tsevelaanchig et al.[32,44] were the most repeated corresponding authors among the records.

Sources of the records

We found that the selected records were published in 16 journals (approximately 81%) and produced by six organizations (approximately 19%). Figures 5 and 6 show except in 2011, publication in the journals was started in 2016 from the Lancet that encompassing 35% of all the journal articles. It was also revealed that 75%
Box 1: Some search strategies and search terms for this review

Search in PubMed through both MeSH terms and manual search

(((Private Sector[tiab]) OR “private sector”[Title/Abstract]) OR (“Private Sector”[tiab] OR “Private Sectors”[tiab]) OR (“Private Enterprise”[tiab] OR “Private Enterprises”[tiab]) OR (“Public Private Partnerships”[tiab] OR “public private sector partnerships”[Title/Abstract]) OR (“Public Private Sector Partnerships”[tiab] OR “Public Private Sector Partnership”[tiab]) OR (“Public Private Cooperation”[tiab] OR “Public private cooperation”[Title/Abstract]) OR (“private hospital”[tiab] OR “private hospitals”[tiab]) OR “private hospital”[Title/Abstract]) OR (“universal health coverage”[tiab] OR “UHC”[tiab]) OR “universal health coverage scheme”[Title/Abstract])

Search in Embase through both Emtree and manual search

(private sector/exp OR ‘private hospital’/exp OR ‘public-private partnership’/exp OR ‘private sector’:ab, ti OR ‘private sectors’:ab, ti OR ‘private hospital’:ab, ti OR ‘private hospitals’:ab, ti OR ‘public private partnerships’:ab, ti OR ‘private economy’:ab, ti OR ‘for profit hospital’:ab, ti OR ‘for profit hospitals’:ab, ti OR ‘investor owned hospitals’:ab, ti OR ‘investor owned hospital’:ab, ti OR ‘private clinic’:ab, ti OR ‘private clinics’:ab, ti OR ‘public-private sector partnerships’:ab, ti OR ‘public-private sector partnership’:ab, ti OR ‘public-private public cooperation’:ab, ti OR ‘private-public collaboration’:ab, ti OR ‘private-public collaborations’:ab, ti OR ‘private-public cooperation’:ab, ti OR ‘private-public cooperations’:ab, ti OR ‘private-public mix’:ab, ti OR ‘private-public mixes’:ab, ti AND ‘universal health coverage’ OR uhc)

Table 4: The frequency of the contributed settings

| Settings/year | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Total frequency of settings | Proportion (%) |
|---------------|------|------|------|------|------|------|------|------|------|------|-----------------------------|----------------|
| India         | 1    | 3    | 1    | 1    | 6    | 6    | 15   |      |      |     | Total frequency of settings  | Proportion (%) |
| LMICs         |      |      |      |      |      |      |      | 4    | 4    | 10  |                             |                |
| China         |      |      |      |      |      |      |      | 3    | 3    | 8   |                             |                |
| EMRO          | 1    | 1    | 1    | 1    | 3    | 8    |      |      |      |     | Total frequency of settings  | Proportion (%) |
| Mongolia      |      |      |      |      |      |      |      | 1    | 1    | 3   |                             |                |
| South Africa  | 1    | 1    | 1    | 2    | 5    |      |      |      |      |     | Total frequency of settings  | Proportion (%) |
| South Korea   | 1    | 1    | 2    | 5    |      |      |      |      |      |     |                             |                |
| Thailand      | 1    | 1    | 2    | 5    |      |      |      |      |      |     | Total frequency of settings  | Proportion (%) |
| Vietnam       | 2    | 2    | 5    |      |      |      |      |      |      |     |                             |                |
| Bangladesh    | 1    |      |      | 2    | 5    |      |      |      |      |     | Total frequency of settings  | Proportion (%) |
| Arab countries| 1    |      |      | 1    | 3    |      |      |      |      |     |                             |                |
| Cambodia      | 1    |      |      | 1    | 3    |      |      |      |      |     | Total frequency of settings  | Proportion (%) |
| Islamic republic of Iran | 1    |      |      | 1    | 3    |      |      |      |      |     |                             |                |
| Nigeria       | 1    |      |      | 1    | 3    |      |      |      |      |     | Total frequency of settings  | Proportion (%) |
| Somalia       | 1    |      |      | 1    | 3    |      |      |      |      |     | Total frequency of settings  | Proportion (%) |
| Pakistan      | 1    |      |      | 1    | 3    |      |      |      |      |     | Total frequency of settings  | Proportion (%) |
| Sri Lanka     | 1    | 1    | 3    |      |      |      |      |      |      |     | Total frequency of settings  | Proportion (%) |
| Taiwan        | 1    |      |      | 1    | 3    |      |      |      |      |     | Total frequency of settings  | Proportion (%) |
| Lao PDR       | 1    |      |      | 1    | 3    |      |      |      |      |     | Total frequency of settings  | Proportion (%) |
| Total frequency of settings | 1    | 1    | 0    | 1    | 0    | 4    | 10   | 7    | 14  | 0   | Total frequency of settings  | Proportion (%) |
| Number of records per year | 1    | 1    | 0    | 1    | 0    | 4    | 7    | 6    | 8   | 0   | Total frequency of settings  | Proportion (%) |
| Number of participating settings | 1    | 1    | 0    | 1    | 0    | 4    | 6    | 7    | 11  | 0   | Total frequency of settings  | Proportion (%) |

LLMIC=Low- and middle-income countries, EMRO=Eastern Mediterranean Regional Office’s, PDR=Prescriber’s digital reference
Concept research questions

Range of the private hospital services

As Table 6 shows, among the identified countries, Sri Lankan PHs are an exception that did not provide inpatient services,[45] and only China provided PHS through both the PH and PPP.[48]

Behaviors of the private hospital services

Figure 7 shows that the significant frequency of codes (32.6%) was related to integrated people-centered health service (IPCHS) delivery and it may indicate an inherent direct effect of this function on UHC; however, the extracted codes related to the indirect effects of service delivery through other functions and sub-functions (especially benefit package) as system-wide effects on UHC objective and goals can confirm the need for systems thinking in the analysis. Based on the predefined categories, no data were found around behaviors of the PHS in terms of the consumable, revenue-raising, and pooling of funds.

Opportunities for policy actions

Most of the identified interventions [Table 7] were recommended about governance (47.8%) and South Africa (30%).

Table 5: Drivers of private hospital’s growth

| Theme                  | Category                        | Code                                                                 | Countries                                      |
|------------------------|---------------------------------|----------------------------------------------------------------------|------------------------------------------------|
| Governance             | Lack of regulation              | The absence of significant regulation resulted in an increase of PPPs | China and Viet Nam[46]                         |
|                        | Competitive constraint caused by lax regulatory environment |                                                                      | South Africa[34,52]                            |
|                        | Poor public hospitals management|                                                                      | South Africa[44]                               |
| Dysfunctional          | Management                      | More attractive incentives introduced by the private hospital regulations| Lao PDR[49]                                    |
| Supportive regulations | Set of regulations that better define cost support policy          |                                                                      | China, Vietnam, and Lao PDR[46]                |
|                        | The introduction of licensing regulation by the MOH††              |                                                                      | Mongolia[27]                                   |
|                        | PPP policy due to moving toward fully autonomous public hospitals caused by social mobilization policy |                                                                      | Viet Nam[48]                                  |
| Supportive policy      | Initiatives                     | Government pro-privatization policies                                | South Africa[34,52]                            |
|                        | PPP initiatives                 | Racial desegregation of government hospitals                         | Pakistan[9]                                    |
|                        | Public sector reforms advocated downsizing hospital beds and inpatient care |                                                                      | South Africa[29]                               |
|                        | Legal mandate for private providers to participate in NHI          |                                                                      | Mongolia[37]                                   |
|                        | Economic liberalization or market-based economy effect on health market |                                                                      | China, Vietnam, and Lao PDR[46]                |
| Service delivery       | Insufficient public hospital services | Public sector vacuum in deprived areas                               | Somalia[33]                                    |
|                        | Insufficient public hospital services |                                                                      | Mongolia[27]                                   |
|                        | Over-burdening of public hospital                                     |                                                                      | Jordan[9]                                      |
|                        | To supplement the damaged and weekend public sector during conflict |                                                                      | Lebanon[9]                                     |
|                        | Limited capacities of public sector                                 |                                                                      | Tunisia[9]                                     |
|                        | Capacity constraints to offer tertiary services                      |                                                                      | Jordan[9]                                      |
|                        | To provide hospital services in the postconflict period              |                                                                      | Afghanistan[30]                                |
|                        | Preference of specialists for private practice                        |                                                                      | Nigeria[39]                                    |
|                        | Profit seeking by private providers                                  |                                                                      | South Korea[41]                                |
| Resources              | Health workforce               | Governmental financial incapacity to provide high-quality health care in tertiary health services | Occupied Palestinian Territories[15]            |
| Creation               | Low funding to the public sector                                      | Low funding to the public sector                                      | India[26]                                      |
|                        | Expansion of for-profit hospital because of under-founded and less developed public hospital |                                                                      | Jordan[9]                                      |
| Financing              | Low funding to the public sector                                      | Poor financial ability of the government for health expenses rendered by decades of armed conflict | Somalia[33]                                    |
|                        | Governmental financial incapacity to provide high-quality health care in tertiary health services |                                                                      | China, Vietnam, and Lao PDR[46]                |
|                        | Recurrent cost support of the government resulted in PPP policy      |                                                                      | South Korea[41]                                |

PPP=Public–private partnership, MOH=Ministry of Health, NHI=National Health Insurance, PHS=Private Hospital Services, PDR=Prescriber’s digital reference
Discussion

Bibliometric research questions

Records types

According to findings, the increase in the number of review articles in recent years can indicate the global motivation to produce this scientific product. Furthermore, a low number of the systematic review\(^\text{[30]}\) \((n: 1)\) and a significant number of records (20\%, \(n: 3\)) that was extracted from a mapping or ScR\(^\text{[9,15,16]}\) can indicate three points: (1) being unknown of this topic, (2) lack of the sufficient data to perform a systematic review, and (3) confirming the rationale for the current review.

Sources of the records

The *lancet* was the most specialized journal due to the publication of nine articles belonging to two series of papers entitled *UHC and private health care*, and *India: Towards UHC*. Furthermore, the WHO\(^\text{[15,42]}\) was more precedent, although Aga Khan University was the pioneer.

Context research questions

The frequent settings

Mapping the results shows that 18.4\% \((n: 7)\) of all records belonged to EMRO and two of them\(^\text{[9,15]}\) has grounded by the extracted data of some mapping or scoping studies. It could be presumably due to the incentive strategy\(^\text{[10]}\) of this region.

Population research questions

Drivers of the private hospital services growth

The successful and unsuccessful experiences of countries show the importance of the political support and commitments of the governments for the growth of the private sector beds. As in Viet Nam, China, and Lao PDR, although policies encouraging the role of the PHs are actively being implemented, the insufficient capital, and fierce competition from public hospitals as a consequence of the PPP policy has reduced the proportion of the private for-profit hospitals.\(^\text{[32,48]}\) On the other hand, the South Korean experience shown that the government support of the PH overcame this problem and made it being a full UHC partner.\(^\text{[41,48]}\)

The next noteworthy point is the importance of regulating competition in the health market. For example, despite the PPP policy and cost support of the government in China and Viet Nam, the absence of regulation guides has led to an increase of PPPs\(^\text{[48]}\) and a dominant share of the public hospitals, by the same
token, the lax regulation allowed private corporate entities to dominate the PHSs in South Africa. Furthermore, in spite of the mixed health system strategy in Mongolia, the lack of the implementation guide resulted in a rapidly unrestricted growth of the small PH that include the low proportion of total hospital beds (20%) and play an increasing role in providing inpatient care.

Governments need to pay attention to the forms of privatization. Furthermore, in the 25% of the countries (Lebanon, Afghanistan, Occupied Palestinian Territories, and Somalia), PHSs have grown during the conflict or postconflict period which necessitates national and international attention toward the rational contribution of the PHS in achieving UHC through the resilient health system.

Concept research questions

Range of the private hospital services

Although the private sector is the main provider of hospital services in the Arab countries, and also most countries of EMRO have a reasonable supply of PHS, there is limited information available on the range of services offered in EMRO. This is also confirmed in this study, and limited information was obtained from only four countries (IR Iran, Jordan, Tunisia, and Occupied Palestinian Territories). Future research is needed to fill this gap. Across the all identified countries, the range of services was mentioned only in Mongolia that the two private and public hospitals have overlapped and duplicated services.

Behaviors of the private hospital services

Findings regarding this section can make an important contribution to the existing body of knowledge about the status of PHS in different countries and settings. Concerning governance, although the records pointed to private hospital role in formulating health policy, the data indicated that evidence for evidence-based policy-making in most countries was incomplete and inadequate, or was incomparable. Since the report

Table 7: Policy actions

| Theme                                    | Category                        | Code                                                                 | Countries                                                                 |
|------------------------------------------|---------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------|
| Strengthening governance and accountability | Regulation                      | Strengthen the framework, mechanisms and regulatory bodies          | India, Mongolia, Somalia, South Africa, China, Viet Nam, and Laos         |
|                                          |                                 | Balancing of both statutory and market harnessing approaches in regulation consistency and its enforcement | Mongolia                                                                  |
| bolstering participatory governance       |                                 | Strengthen effective stewardship role of government                  | South Africa                                                              |
|                                          |                                 | Remove of political interference in managers appointments            | South Africa                                                              |
|                                          |                                 | Accountability of the managers for the outcomes of the service they manage | South Africa                                                              |
|                                          |                                 | Legal support to make private hospital services more dominant rather than isolated | Mongolia                                                                  |
| Reorienting the model of care             | Defining services based on the needs | Creating a comprehensive policy to define a complementary role for the PHS | Mongolia, India                                                          |
|                                          |                                 | Defining the benefit package by keeping in account people social and economic context and their health-care needs | India                                                                     |
|                                          |                                 | Strategic purchasing                                                  | India                                                                     |
|                                          | Coordinating across sectors      | Review of the syllabus used by medical faculties to improved and provide knowledge and skills of maintaining professional rapport with patients, uphold patients' dignity, and respect their rights | Somalia                                                                   |
|                                          | Coordinating health programs and providers | Systematic improvement program across the health system to ensure good services for patients | South Africa                                                              |
|                                          |                                 | Accountability of the health care workers for their actions           | South Africa                                                              |
|                                          |                                 | Movement of the health-care workers to a mindset of continuous improvement | South Africa                                                              |
| Creating an enabling environment          | Reorienting the health workforce | Quality education for medical students                                | Somalia                                                                   |
|                                          |                                 | Hospital management needs to be professionalized requiring managers to be able to demonstrate managerial competency | South Africa                                                              |
|                                          | Improving funding levers          | Applying targeted incentives for engaging private investments such as government-subsidies for PHS, contracting | Mongolia, Somalia                                                        |

PHS=Private hospital services
of EMRO emphasized the need for developing a regional strategy for collecting, monitoring, and evaluating private health governance in all EMRO countries and given India’s successful strategy, there is a need for the adoption and implementation of policies and strategies by other governments to improve private hospital evidence.

The results about the benefits package design were heterogeneous and indicated that PHS obligations restricted access to services in South Africa. Benefits package design has been challenging in two countries. Respectively, in Mongolia in terms of entitlement and in South Korean private hospitals which provided benefit package services similar to public hospitals in terms of both obligations and entitlement. Accordingly, Mauzy et al. reported that each of the service levels related to private hospitals due to their distinctive characteristics requires different approaches or policy tools depending on the context of the countries.

UHC is people-centered though, this review showed gaps between private and public hospital services in Mongolia, while according to Wadge et al., “governments should invest first in primary care and prevention to achieve UHC, the private sector in some settings can fill in the gaps in secondary and tertiary care provision.” Furthermore, the absence of the referral system, its poor implementation, and its related consequences were observed in some countries. Thus, according to Makinde et al., the need for a strategy to ensure continuity of care through a referral system is substantial.

Opportunities for policy actions
There are three noteworthy points: (1) Among all countries, only in India interventions were proposed for both short-term and long-term; (2) Since, most of the growth factors and HSS interventions were...
originated to the governance, it can be concluded that the countries themselves have realized the importance of the governance role in the HSS; (3) A mix of foundational and institutional HSS interventions based on the WHO proposed approach[3] was observed. To achieve transformational HSS efforts that are focused on sustainability and exploring new ways of providing services that provide additional benefits, prerequisites are definitely needed.

The innovation of this review, which is also its strength is the simultaneous applying of three inherently systematic tools that make this study more systematic than a common ScR: (1) ScR which is inherently systematic, (2) Systems-thinking approach for HSS, and (3) Framework method.

Limitation and recommendation
This review was subjected to several limitations, including (a) this study was finished in July 2020, and the time spent on its preparation and publishing lasted more than half of a year. Thus, the records related to this time range were not included, as we had already reached the results and prepared the diagrammatic and tabular forms. (b) The quality assessment of the included records was not conducted because of two reasons: (1) unlike the systematic reviews, ScR provide an overview of the existing evidence, irrespective of quality,[17] and (2) we did not want to miss any evidence.

The quantity and variety of the found records confirmed the rationale of the current study, thus, regarding the identified knowledge gap future research is recommended about the range of PHS, and its behaviors in terms of the consumable, revenue-raising, and pooling of funds.

Conclusions
To build a healthier world by 2030, UHC is a direction rather than a destination.[60] Furthermore, not every country can achieve a “full UHC package” at the same speed.[60] In other words, choosing the right road to UHC through the right policies will vary significantly according to countries’ starting point.[60] Although especially in conjunction with PHSs, regarding the dynamic architectures of interactions between system functions, with a glance at originating most of the growth factors and HSS interventions from governance, the upshot of this review to address both national and international audiences such as health policy-makers and other stakeholders show that probably the countries themselves have realized the importance of the governance role in the HSS. It seems that about the interested countries in similar cases, governance needs more attention than other functions of the health system.

Given that most of the recommended HSS interventions based on the IPCHS strategies were a combination of foundational and institutional, it seems that to leaving no one behind, sustainable participation of private hospitals in the health system is far and it requires a solid will of the governments.

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References
1. Fallah R, Bazrafshan A. Participation of delivering private hospital services in universal health coverage: A systematic scoping review of the developing countries’ evidence. J Educ Health Promot 2021;10:13.
2. Russo G. The role of the private sector in health services: Lessons for ASEAN. ASEAN Econ Bull 1994;11:190-211.
3. WHO Regional Office for Africa. Leave No One Behind: Strengthening Health Systems for UHC and the SDGs in Africa. Brazzaville: WHO; 2017.
4. Frenk J, Gómez-Dantés O. Health systems in Latin America: The search for universal health coverage. Arch Med Res 2018;49:79-83.
5. Godinho MA, Jonnagaddala J, Gudi N, Islam R, Narasimhan P, Liaw ST. mHealth for integrated people-centred health services in the western Pacific: A systematic review. Int J Med Inform 2020;142:104259.
6. World Health Organization, Organisation for Economic Co-Operation and Development, and The World Bank. Delivering Quality Health Services: A Global Imperative for Universal Health Coverage. Geneva: World Health Organization; 2018.
7. Kieny MP, Bekedam H, Dovlo D, Fitzgerald J, Habicht J, Harrison G, et al. Strengthening health systems for universal health coverage and sustainable development. Bull World Health Organ 2017;95:537-9.
8. De Savigny D, Adam T, editors. Systems Thinking for Health Systems Strengthening. Alliance for Health Policy and Systems Research. Geneva: World Health Organization; 2009.
9. Zaied S, Riaz A, Taver A, Mukhi A, Khan LA. Role and contribution of private sector in moving towards universal health coverage in the eastern Mediterranean region 2012. Available from: http://ecommons.aku.edu/pakistan_fs_mc_chs_chs/193. [Last accessed on 2019 Jun 20].
10. Regional Committee for the Eastern Mediterranean Office of World Health Organization F-ns. Health Systems Strengthening in Countries of the Eastern Mediterranean Region: Challenges, Priorities and Options for Future Action. Cairo: World Health Organization; 2013.
11. Marriott A. Blind optimism: Challenging the myths about private health care in poor countries. Oxfam Policy Pract 2009;6:1-55.
12. Horwitz J. Nonprofit ownership, private property, and public accountability: Implementing policies that undermine the private nature of nonprofits is risky. Health Aff 2006;25 Suppl 1:W308-11.

13. Tiemann O, Schreyögg J, Busse R. Hospital ownership and efficiency: A review of studies with particular focus on Germany. Health Policy 2012;104:163-71.

14. Herrera CA, Rada G, Kuhn-Barrientos L, Barrios X. Does ownership matter? An overview of systematic reviews of the performance of private-for-profit, private not-for-profit and public healthcare providers. PLoS One 2014;9:e93456.

15. World Health Organization, Regional Office for the Eastern Mediterranean. Analysis of the Private Health Sector in Countries of the Eastern Mediterranean: Exploring Unfamiliar Territory. Cairo: World Health Organization, Regional Office for the Eastern Mediterranean; 2014.

16. Zaider S, Saligram P, Ahmed S, Sonderp E, Sheikh K. Expanding access to healthcare in South Asia. BMJ 2017;357:j1648.

17. Aromataris E, Munn Z, editors. Joanna Briggs Institute Reviewer's Manual. Adelaide: Joanna Briggs Institute; 2017. Available from: https://reviewersmanual.joannabriggs.org/. [Last accessed on 2019 May 20].

18. Tricco AC, Lillie E, Zarir W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA extension for scoping reviews (PRISMA-ScR): Checklist and explanation. Ann Intern Med 2018;169:467-73.

19. Kastner M, Tricco AC, Soobiah C, Lillie E, Perrier L, Horsley T, et al. What is the most appropriate knowledge synthesis method to conduct a review? Protocol for a scoping review. BMC Med Res Methodol 2012;12:114.

20. Munn Z, Peters MD, Stern C, Tufanaru C, McArthur A, Aromataris E. Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. BMC Med Res Methodol 2018;18:143.

21. Peters MD, Godfrey CM, Khalil H, McInerney P, Parker D, Soares CB. Guidance for conducting systematic scoping reviews. Int J Evid Based Healthc 2015;13:141-6.

22. Clarke D, Doerr S, Hunter M, Schmets G, Soucat A, Pavica A. The private sector and universal health coverage. Bull World Health Organ 2019;97:434-5.

23. European Foundation for the Improvement of Living and Working Conditions. Delivering Hospital Services: A Greater Role for the Private Sector? Luxembourg: Publications Office of the European Union; 2017.

24. Pearson M, Colombo F, Murakami Y, James C. Universal Health Coverage and Health Outcomes. Final Report for the G7 Health Ministerial Meeting, Paris; 2016. Available from: https://www.oecd.org/els/health-systems/Universal-Health-Coverage-and-Health-Outcomes-OECD-G7-Health-Ministerial-2016.pdf. [Last accessed on 2019 Nov 19].

25. World Health Organization. The World Health Report 2010-Health Systems Financing: The Path to Universal Coverage. Geneva: World Health Organization; 2010. Available from: http://www.who.int/whr/en/index.html. [Last accessed on 2019 Oct 20].

26. United Nations. World Economic Situation and Prospects 2020. New York. United Nations; 2020. Available from: https://unctad.org/en/PublicationsLibrary/wesp2020_en.pdf. [Last accessed on 2019 Nov 19].

27. Reddy KS, Patel V, Jha P, Paul VK, Kumar AK, Dandonia L, et al. India: Towards Universal Health Coverage 7 Towards achievement of universal health care in India by 2020: A call to action. Lancet 2011;377:760-8.

28. Morgan R, Ensor T, Waters H. Performance of private sector health care: Implications for universal health coverage. Lancet 2016;388:606-12.

29. Mackintosh M, Channon A, Karan A, Selvaraj S, Cavagnero E, Zhao H. What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. Lancet 2016;388:596-605.

30. Montagu D, Goodman C. Prohibit, constrain, encourage, or purchase: How should we engage with the private health-care sector? Lancet 2016;388:613-21.

31. McPake B, Hanson K. Managing the public-private mix to achieve universal health coverage. Lancet 2016;388:622-30.

32. Tsevelvaanchig U, Gouda H, Baker P, Hill PS. Role of emerging private hospitals in a post-Soviet mixed health system: A mixed methods comparative study of private and public hospital inpatient care in Mongolia. Health Policy Plan 2017;32:476-86.

33. Gele AA, Ahmed MY, Kour P, Moallim SA, Salad AM, Kumar B. Beneficiaries of conflict: A qualitative study of people's trust in the private health care system in Mogadishu, Somalia. Risk Manag Healthc Policy 2017;10:127-35.

34. SeanCN,SparksS,NelsonG.Organizing the Private Sector to Support Universal Health Coverage Goals. Bethesda, MD. Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates; 2017. Available from: https://www.shopsplusproject.org/resource-center/organizing-private-sector-support-universal-health-coverage-goals. [Last accessed on 2019 Nov 19].

35. Wedge H, Roy R, Sripathy A, Fontana G, Marti J, Darzi A. How to harness the private sector for universal health coverage. Lancet 2017;390:e19-20.

36. Maurya D, Virani A, Rajasulochana S. Horses for courses: Moving India towards universal health coverage through targeted policy design. Appl Health Econ Health Policy 2017;15:733-44.

37. Alami R. Health financing systems, health equity and universal health coverage in Arab countries. Dev Change 2017;48:146-79.

38. Zodpey S, Farooqui HH. Universal health coverage in India: Progress achieved & the way forward. Indian J Med Res 2018;147:327-9.

39. Makinde OA, Sule A, Ayankogbe O, Boone D. Distribution of health facilities in Nigeria: Implications and options for Universal Health Coverage. Int J Health Plann Manage 2018;33:e1179-92.

40. Tangcharoensathien V, Wittayapipopsakul W, Panichkriangkrai W, Patcharanarumol W, Mills A. Health systems development in Thailand: A solid platform for successful implementation of universal health coverage. Lancet 2018;391:1205-23.

41. Kwon S. Advancing Universal Health Coverage: What Developing Countries Can Learn from the Korean Experience? Universal Health Care Coverage Series No. 33. Washington, DC: World Bank Group; 2018.

42. World Health Organization, Regional Office for the Eastern Mediterranean. Regional Committee for the Eastern Mediterranean Sixty-fifth Session-Provisional Agenda Item 4(e): Private Sector Engagement for Advancing Universal Health Coverage; 2018. Available from: http://applications.emro.who.int/docs/RC_Technical_Papers_2018_8_20546_EN.pdf. [Last accessed on 2019 Nov 19].

43. Lu JR, Chiang TL. Developing an adequate supply of health services: Taiwan’s path to Universal Health Coverage. Soc Sci Med 2019;17:2.

44. Tsevelvaanchig U, Narula I, Gouda H, Hill PS. Role of emerging private healthcare providers towards universal health coverage: A qualitative study of legal and organizational framework in Mongolia. Int J Health Plann Manage 2018;33:185-201.

45. Chapman AR, Dharmaratne SD. Sri Lanka and the possibilities of achieving universal health coverage in a poor country. Glob Public Health 2019;14:271-83.

46. Erdenee O, Narula IS, Yamazaki C, Kameo S, Koyama H. Beneficiaries of conflict: A qualitative study of people’s trust in the private health care system in Mogadishu, Somalia. Risk Manag Healthc Policy 2017;10:127-35.

47. Zhu A, Tang S, Thu NT, Supheap L, Liu X. Analysis of strategies to attract and retain rural health workers in Cambodia, China, and Vietnam and context influencing their outcomes. Hum Resour Health 2019;17:2.
48. Cowley P, Chu A. Comparison of private sector hospital involvement for UHC in the western pacific region. Health Syst Reform 2019;5:59-65.
49. Yip W, Fu H, Chen AT, Zhai T, Jian W, Xu R, et al. 10 years of health-care reform in China: Progress and gaps in Universal Health Coverage. Lancet 2019;394:1192-204.
50. Danaei G, Farzadfar F, Kelishadi R, Rashidian A, Rouhani OM, Ahmadnia S, et al. Iran in transition. Lancet 2019;393(10184):1984-2005. [doi: 10.1016/S0140-6736(18)33197-0].
51. Titoria R, Mohandas A. A glance on public private partnership: An opportunity for developing nations to achieve universal health coverage. Int J Community Med Public Health 2019;6:1353-7.
52. Stewart J, Wolvaardt G. Hospital management and health policy – A South African perspective. J Hosp Manag Health Policy 2019;3:14. [doi: 10.21037/jhmhp.2019.06.01].
53. Khoonthaweelapphon Woraset. The Liberalization of Thailand Medical Services Industry-Case Study between Thailand and South Korea, Master’s Thesis of International Commerce. Graduate School of International Studies, Seoul National University; 2019. Available from: http://hdl.handle.net/10371/150912. [Last accessed on 2019 Oct 11].
54. Asbu EZ, Masri MD, Al Naboulsi M. Determinants of hospital efficiency: A literature review. Int J Healthcare 2020;6:44-53.
55. Mays N, Pope C, Popay J. Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. J Health Serv Res Policy 2005;10 1 Suppl: 6-20.
56. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Med Res Methodol 2013;13:117.
57. Kumar AK, Chen LC, Choudhury M, Ganju S, Mahajan V, Sinha A, et al. India: Towards Universal Health Coverage 6 Financing health care for all: Challenges and opportunities. Lancet (London, England) 2011;377:668-79.
58. European Foundation for the Improvement of Living and Working Conditions. Impacts of the Crisis on Access to Healthcare Services in the EU; Dublin; 2013.
59. Kutzin J. Health financing for universal coverage and health system performance: Concepts and implications for policy. Bull World Health Organ 2013;91:602-11.
60. World Health Organization. Together on the Road to Universal Health Coverage: A Call to Action. Geneva: World Health Organization; 2017.