Inclusion of private family physicians in mixed health systems

Clearing house briefs series

World Health Organization

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Contents

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This series of briefs contributes to WHO's work in support of efforts by Member States to engage the private sector in health in order to achieve universal health coverage (UHC), providing country implementation experience in relation to specific health governance and service delivery issues.

This brief was developed by Gabrielle Appleford (Special Programme on Primary Health Care, WHO headquarters), with Anna Cocozza and David Clarke (Special Programme on Primary Health Care). Substantial review and inputs were provided by Faraz Khalid and Katherine Rouleau (Special Programme on Primary Health Care).

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Abbreviations

LMIC	low- and middle-income countries
OECD	Organisation for Economic Co-operation and Development
UHC	universal health coverage
WHO	World Health Organization

INDONESIA: Immunization Heroes, September 2024 © WHO / Harrison Thane

Abstract

Primary care is foundational to health service delivery and a primary health care (PHC) approach. It is the core of the service-fronting component of PHC and refers to essential health and social services that meet most of people's health needs, delivered close to home. In PHC-oriented systems, primary care enables first contact access, continuity, comprehensiveness and coordination. This brief explores the role of family physicians within the delivery of primary care, with a specific focus on those working in private practice. It considers the development of the profession, and the organization and contribution of family physicians in private practice to person-oriented high-quality primary care. The literature suggests that expanding opportunities for family physicians to apply their specialized skills and take on leadership roles within primary care teams can enhance the effectiveness of care delivery. This should take cognizance of the context in which they operate in relation to the overall health system and be guided by national policy.

Key messages

- Family medicine and family physicians are intended to be a source of comprehensive, first-contact, person-centered care.
- A lack of critical mass and ambivalence towards family medicine, has resulted in family physicians with "no clear role" in some health systems.
- Despite constraints, family physicians have strengthened models of care and improved the availability of people-centred care in a range of contexts albeit at different scales of practice.

Doctor Consulting Patient in Latvian Clinic - Riga. Latvia, April 2024
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Background

The clearing house briefs series is intended to provide short descriptive and comparative analysis of country implementation experience in relation to specific health governance and service delivery issues. As such, the series seeks to contribute insights on "how, why, for whom, in what contexts and to what extent health systems, programmes and/or policies function" *(1)* to inform governance practice.

This brief explores the role of family physicians in the delivery of primary care, with a specific focus on those in private practice. For this brief, we have used the terms family physician and primary care physician interchangeably.[1] The brief does not explicitly address the other two components of the primary health care (PHC) approach, however, recognises their interrelationships. Such interrelationships are intended to guide transition from traditional physician-centric primary care *(2)* to the development of primary care teams, that not only address the needs of the individuals, but also their social needs and those of the community more broadly *(3).*

More information on the methodology used to develop Clearing House briefs is available in **Annex 1**.

Primary care: what is it?

Primary care is foundational to health service delivery and a PHC approach. It is the point of first contact with health services and facilitates access to the rest of the health system.

Primary care is at the core of integrated health services, coordinated across various settings, to meet people's health needs throughout their lives *(4).* It is characterized as the delivery of a full spectrum of services, from health promotion and disease prevention to treatment, rehabilitation and palliative care, close to where people live and work, through a person-centred approach and a population-level focus. Care may involve 'traditional' forms of physical interaction between a patient/consumer and healthcare provider and 'virtual' care through digital innovations such as telemedicine. Ideally primary care enables seamless transition across platforms and other levels of care given the risks posed at care transition points, where a patient moves to, or returns from, a particular care location or makes contact with a health care professional for the purposes of receiving care *(5).* As such, it is intended to be "longitudinal, comprehensive and coordinated", spanning the life course from "cradle to grave" *(6, 7).*

Seamless primary care entails the movement of the person across the whole experience of care between providers, locations, types of services freely and with purpose, along the evolving episode or demand for care.

Implementing the Primary Health Care Approach: A Primer (2024)

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[1] Family physicians may also be referred to as general practitioners in the United Kingdom, Denmark, and the Netherlands. In other contexts, general practitioners are considered medical school graduates who enter clinical practice without further postgraduate training. For this brief, we have retained the term family physician or primary care physician.

Primary care is the foundation for all health services and core to the integrated health services delivery component of a PHC approach. The other two components address (a) the broader determinants of health through multisectoral policy and action and (b) empowering individuals, families and communities to take charge of their own health *(4).* PHC itself has been reinterpreted and redefined in the years since the 'health for all' declaration in Alma-Ata in 1978. Recent conceptualization of PHC envisions 'a whole-of-society approach' to organize and strengthen national health systems for the delivery of services for health and well-being closer to communities *(4).*

Substantial variation exists in the organization and delivery of primary care services among countries. They may also vary within countries, in contexts where primary care models are left to sub-national authorities to innovate, based on national policy and standards of care *(8).* Examples of sub-national models of primary care include Canada, Australia, France, Germany, the Netherlands, New Zealand, Sweden, the United Kingdom, and the United States (*2).* Such variation serves to reinforce that there is no single 'right' model for the funding, organization, and delivery of evidence-based primary care *(8).* Furthermore, primary care models may or may not take cognizance of mixed health systems in which the private healthcare sector plays a large, and often growing role *(9).*

Family physicians in private practice within primary care: what is the governance problem?

High-quality primary care is both effective and cost effective. In high performing health systems, it is estimated that primary care physicians can effectively address the majority of common health issues in a given population *(10).* Furthermore, health systems with a strong primary care orientation and 'navigator function' [2] are more cost effective *(3)* and facilitate coordinated, comprehensive, person-centred care. However this ability is not evident everywhere, and, in many contexts, primary care involves "uncoordinated access to hospital, and specialist care is unrestricted for those who can afford it" with the potential to create a "costly cascade of diagnostic and therapeutic interventions" *(3).* This is of particular concern in low- and middle-income countries (LMICs) where primary care may be under resourced and delivered through ineffective models of care. In these settings, primary care fails often to deliver the expected quality, health outcomes, equity and value, perpetuating the perception of primary care as 'minimal'.

In all contexts, marshalling the resources of the whole health system is needed, wherein the private sector plays a complementary role to that of the public sector. Primary care services delivered through private providers are expanding in both low- and middle-income countries as well as in high-income countries *(11).* This growth is described in the literature as largely driven by various challenges, including limited public funding, shifts in disease burden from communicable to chronic non-communicable diseases, demographic changes, population displacement, and political and economic instability *(12).* In sub-Saharan Africa and South Asia, respectively, 49% and 81% of all patients present initially to private or informal providers to seek primary care *(13).* In Malaysia, the number of private practices outweigh public clinics by a ratio of six to one *(12).* Primary care services in 15 out of 32 OECD countries is predominantly delivered in the private sector *(14).* In Sweden, there are about 1,200

[2] A navigator function ensures that patients are referred to the right services, particularly those in need of comprehensive and coordinated care.

primary care centres, whereof about 40% are private, predominately for profit (15). Despite an increasing proportion of primary care service delivery in the private sector, privately funded and delivered primary care services may result in different sub-systems of care which may not be effective, equitable, or people-centred *(16, 17).* Furthermore, differences in the provision of primary care between the public and private sectors in terms of organisation, source of finances, governance and regulations, and in provider and patient characteristics may affect the quality of primary care service delivery in countries with mixed health system and may drive or contribute to health inequities *(18).* Despite the large contribution to health services, including primary care, the private health sector remains poorly governed in most LMICs *(9)*. This situation can compromise the ability of health systems to achieve universal health coverage (UHC) and deliver people-centred primary care *(19)*. Indeed, a Lancet Commission on health system quality found "major gaps in safety, prevention, integration, and continuity, reflected by poor patient retention and insufficient coordination across platforms of care" *(17).*

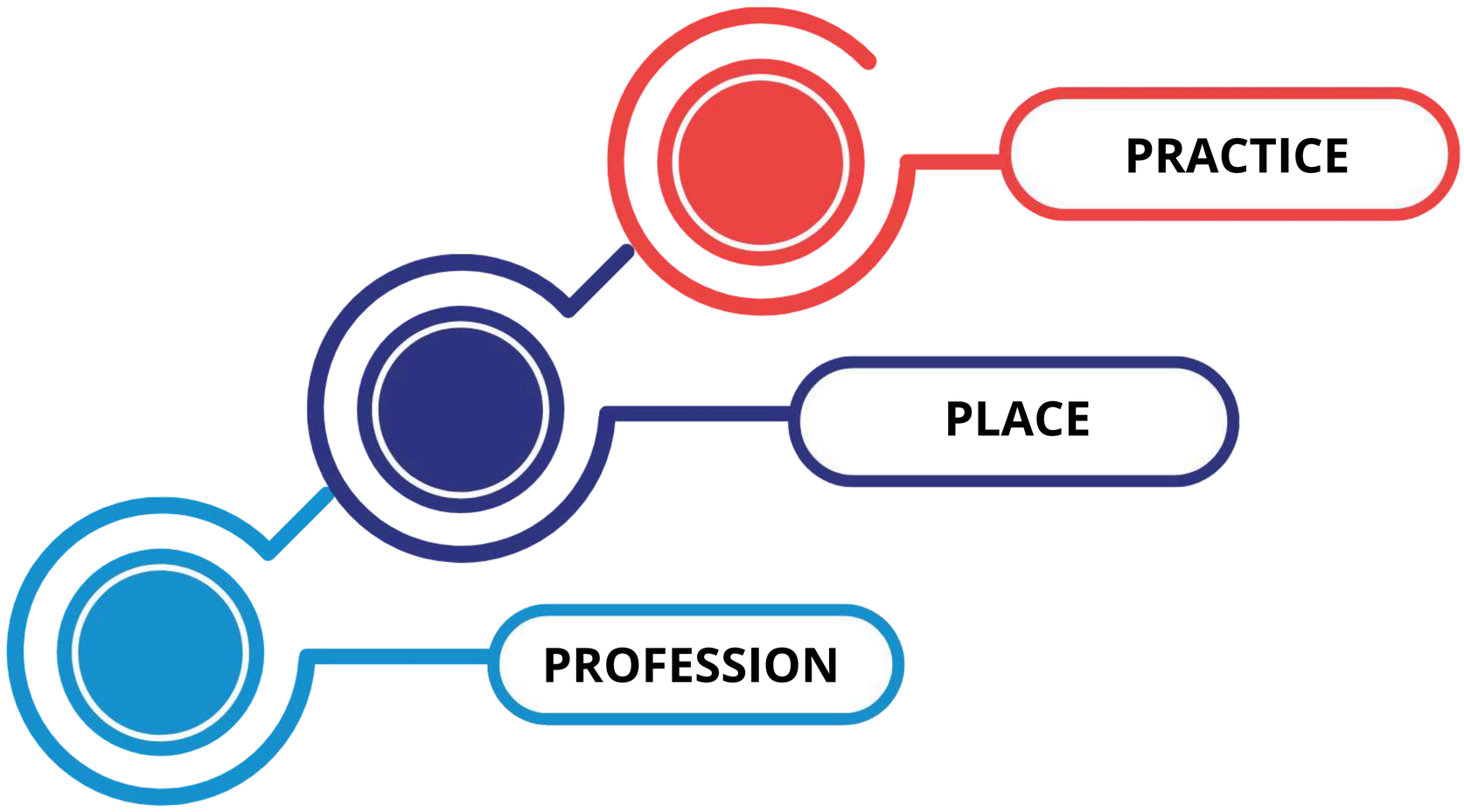
This brief explores the role of family physicians working in private practice and their inclusion within primary care teams in the context of mixed health systems. It seeks to identify the constraints to optimization of such cadres in relation to the overall health system and national policy. The brief has a specific focus on primary care within LMICs, however it draws on experience from OECD contexts. Literature on primary care was included under the "Align Structures" governance behaviour of the WHO's Strategy Report on "Engaging the private health service delivery sector through governance in mixed health systems", Papers that addressed primary care and family medicine were extracted for review, with a particular focus on mixed health systems. More information on the methodology used to develop Clearing House briefs is available in **Annex 1.** The literature reviewed for the country case examples is included here.

Strategy: what is the policy response to the inclusion of family physicians in private practice within primary care?

The delivery of primary care requires a clear vision, goals and objectives together with a set of strategies for achieving ambitions *(8).* Strategy should not be specific to the public sector but rather set in relation to the overall health system and guided by national policy. Within the literature, three policy considerations were identified for family physicians working in private practice and may be considered as strategic entry points for integration within models of care (see **Figure 1**). A fourth consideration, that of public funding and provider payment, is not included within the scope of this brief.

- Profession: the role of family physicians in private practice within the family medicine discipline and healthcare workforce.
- Place: the organization of primary care in terms of scope, function and models of care and the limitations this may present for optimization of family physicians in private practice.
- Practice: the professional contribution of family physicians in private practice to person-oriented quality primary care.

Figure 1. Strategies for physician-led primary care



Profession

The role of private primary care physicians needs to be understood within the context of family medicine within a given context. Family medicine, sometimes referred to as community medicine, is intended to be a source of "comprehensive, first-contact, person-centered, and community-based generalist medical care"*(20).* Family physicians, at the core of family medicine, are intended to play a clinical leadership and nodal role in primary care and PHC more broadly *(21).* They are medical practitioners with postgraduate qualification in family medicine, purposefully trained as medical generalists increasingly called to work in multidisciplinary primary care teams *(22).* The discipline started in the 1960s and has its origins in OECD countries *(3).* While family medicine as a discipline was not included within Alma-Ata nor the Astana declarations, the cadre is of particular relevance to PHC *(23).*

All WHO regions have family medicine programmes, established in collaboration with local and international universities. Between 1995 and 2015, countries with family medicine programmes grew from 56 to 132 *(20).* However, the scope of family medicine and the nature of family medicine training vary extensively between countries *(6);* and family physicians do not have a standard and clearly defined role within health systems *(10).* A lack of critical mass (e.g., adequate number and distribution) and ambivalence towards family medicine, has resulted in family physicians with "no place" in some health systems *(6).* Given this and the lack of physicians more generally in some LMIC contexts, other cadres such as nurses, medical assistants or clinical officers, may be more prominent in terms of workforce size and contribution to primary care.

The role of family physicians is highly contextual, and reflective of diversity in health systems. Systems straddle well-developed, for-profit private provision to those that are largely government-run and funded *(6).* Family physicians work at different levels of the healthcare system and across the public

and private sectors. Within the private sector, family physicians may run their own practices, or be employed in primary, specialist or tertiary care facilities (e.g., public, private, faith-based, military, non-governmental or quasi-government facilities). The dispersion of family physicians within health systems (i.e., their distribution across diverse roles) creates a "tension between concept and reality" and the "identity of the discipline"*(10).* Family physicians operating in private practice may be a lost resource for family medicine if not explicitly recognized within policy or service delivery arrangements. Even within OECD contexts critical mass may be an issue where family physicians are engaged more as hospitalists and within long-term care institutions. **Box 1** elaborates on some of these tensions.

Box 1. Challenges for family physicians within LMICs

- A lack of critical mass (e.g., adequate number and distribution) of family physicians.
- A lack of clear and explicit role/function for family medicine ad family physicians in national health policies, plans and strategies.
- A lack of acceptance and recognition of the role of family physicians by other medical professionals (e.g., hospital-based specialists) or government authorities.
- A general lack of understanding of the value and expertise of family medicine among the general population/intended beneficiaries of care (which translates into low/inadequate demand.
- A lack of resources and capabilities and challenges in brokering effective partnerships.
- A lack of engagement in comprehensive practice and internal movement of family physicians to better resourced roles, e.g., vertical disease programmes or tertiary care.
- External movement of family physicians to the private sector or out-migration overseas.

Place

The organization of models of primary care has implications for optimizing the contributions of family physicians within mixed health systems. These may explicitly recognise the role of family physicians in private practice. For example, In Canada, Australia and France, primary care physicians comprise almost half of all physicians *(6);* and many of these are in private practice. They sometimes operate within wider networks and teams of practitioners (**Box 2**). In Canada, for example, given that the organization of primary care is provincially determined, primary care teams range from formal to informal networks, and may be government mandated or voluntary/non-profit *(2).* In all cases, they are intended to "facilitate comprehensive, continuous, and person-centered care; mobilization of health care resources; and patient navigation of the health care system" *(2).* In other contexts, the role of family physicians in enabling first contact care and navigation to tertiary and more specialised care is less clear. This is the case in many LMICs where patients often access family physicians for acute episodic care and their role in longitudinal or comprehensive care is more limited *(6).*

Box 2. Primary care teams

Primary care teams may include a range of medical practitioners including general and family physicians, paediatricians, geriatricians, and nurse practitioners. They may be supported by a wider medical team including nutritionists, physiotherapists, psychologists, social workers and clinical pharmacists.

The development of family medicine and deployment of family physicians, including in the private sector, necessitates that the health system provides 'practice opportunities' alongside a clear role and scope *(24).* However, in many contexts, family physicians are not fully integrated into health systems or able to deliver upon their envisaged roles *(10).* In Kenya, although the role of family physician is defined by government, there is a lack of understanding of what this 'looks like' in practice *(25);* in this context, family physicians work in both the public and private sectors, and at different levels of care. In Somaliland, some family physicians work in private practice as they lack the authority to effect change in their roles within the public sector *(26).* In contrast, family physicians in Brazil are established as core members of an estimated 40 000 family health teams and cover more than 60% of Brazil's population; these estimates have since grown however only a fraction of such teams include a postgraduate-trained family physician *(6).*

Comparative studies *(20)* conducted in Brazil, Canada, Ethiopia, Haiti, Indonesia, Kenya, and Mali have helped to elicit enablers for the organization and delivery of family medicine which are instructive **(Table 1)**. Country case studies either explicitly or implicitly recognise the place of private physicians within family medicine but often this is not a primary focus of study.

Table 1. Enablers for the establishment of family medicine

Committed Partnerships • Conferred family medicine programmes with legitimacy and visibility • Enabled family medicine programmes to procure needed resources and capabilities	**Champions** Champions were critical in brokering ties with key family medicine stakeholders that had decision-making authority
Adaptable core Family medicine programmes that adapted to their respective local context achieved greater success in implementation	**Policy windows** Some programmes were able to leverage policy windows, which enabled swifter implementation

Source: Rouleau et al, 2018 *(20)*

Practice

When there is not a clear and explicit role for family medicine within the health systems, family physicians engage in a wide range of practices, and patients may be left to devise their own care pathways. For example, in Sri Lanka primary physicians in dual practice interacted with patients as 'channelling centre' to fast-track entry into tertiary and specialised care *(27).* This was facilitated by state tolerance of dual practice and an 'open-door policy' that allowed private patients to transfer-in to public care *(28).* In Barbados, a more complementary function was carved for private physicians in primary care, however, this was neither comprehensive nor uniform *(27).* As noted in Kenya, family physicians were 'hiding comfortably' in other medical disciplines, "what is actually lacking is us ourselves to do what we are trained to do" *(25).* These are but a few examples of the strategies employed by patients and family physicians where models of primary care and the role of private family physicians are less defined.

Despite constraints, family physicians have strengthened models of care and improved the availability of people-centred care in a range of contexts, albeit at different scales of practice *(6, 10, 20, 22).* There is also an emerging body of evidence that suggests that family medicine, compared to other specialties, is effective in the provision of healthcare for those in underserved areas *(6, 10, 24).* This suggests that investing in family medicine can make an important contribution to primary care and PHC-oriented health systems. However family medicine is sometimes perceived as "poor medicine" *(20)* which may negate investment in the discipline and contribution of private family physicians to the practice.

Tools: what policy tools are deployed to facilitate the integration of family physicians in private practice in primary care?

Policy tools are 'how' strategy – or policy response – is implemented. **Table 2** provides examples of tools that have been used for the development of family medicine and deployment of family physicians. Some policy tools, but not all, take cognizance of the role of family physicians within mixed health systems.

Table 2. Policy tools and examples

Policy tools	Examples
Legal	Laws and regulations
Partnerships	Roadmaps, research collaboration
Information	Measurement and monitoring

Legal

The literature cited several legal tools that were used to ensure that family medicine and the availability of family physicians were institutionalised. In Brazil, for example, the Ministry of Health and Education introduced the More Doctors Law which stipulated that every graduate was required to do at least one year in a family residency programme *(20).* In Indonesia, regulations were introduced that specifically acknowledged the role of private physicians within primary care. In this context, the introduction of national health insurance was used as a means of advancing family medicine; and, as part of this, regulations were enacted that permitted family physicians to simultaneously work in public and private clinics as part of primary models of care *(15).*

Partnerships

Primary care partnerships have been catalysed both within and across countries to further family medicine and the role of family physicians. Countries such as Ethiopia have deployed roadmaps for family medicine to align stakeholders around the discipline and support its development *(20).* It is unclear if such tools have considered private physicians within the wider health eco-system or how effective such partnerships are at countering the tenuous political economy of family medicine in many contexts. Other collaborations have been North-South in nature, sustained through collaborative research. The Besrour Centre has developed an interactive database to describe family medicine and training in individual countries *(6).* The Centre facilitates peer exchange and has developed a series of papers that feature key issues, lessons, and outcomes from collaboration. Continental collaboration is also prevalent. For example, the African Journal of Primary Health Care and Family Medicine has provided an academic platform since 2008 to further "a contextual and holistic view of family medicine and primary health care as practised across the continent" *(9).* Contributions within these collaborations have included family physicians in private and dual practice.

Information

The Declaration of Alma Ata made no reference to the private sector, perhaps due to its growth being a more recent phenomenon. However, the private sector is recognized within the Astana Declaration and related operational and measurement frameworks *(4, 23, 29).* Frameworks have seen vitalisation of efforts to monitor and measure progress on primary care and PHC more broadly, premised on the need for better, more consistent and comprehensive data and measurement. For example, the Primary Health Care Performance Initiative was designed to support measurement of PHC-related variables including the role and engagement of the private primary care providers (disciplines unspecified) *(30).* Individual countries, such as South Africa, have developed their own impact evaluation tools seeking to understand where, and under what conditions, family physicians are able to guide the delivery of high quality, people-centred primary care *(10).* This has considered the role of family physicians in the private sector within primary care teams and district health systems.

Conclusions

Family physicians are a critical resource for the delivery of high-quality primary care and therefore for the alignment of health system with the PHC approach and the achievement of the SDGs. In many contexts, family physicians, in both public service and private practice, have improved the availability of high-quality and people-centred care. However, this is not always the case, where family physicians are left to interact outside of prescribed disciplinary practice or defined models of care. More opportunity for family physicians to deliver on their specialization and lead primary care teams is needed. This should take cognizance of the context in which they operate in relation to the overall health system and be guided by national policy. The WHO Special Programme on PHC has developed a PHC primer as a resource for countries as they seek to strengthen the role family physicians within primary care teams and models of care.

About the Clearing House

The Clearing House is part of a WHO compendium series that explores existing literature on strategies, tools and experience related with the governance of the private sector in national health systems. Clearing Houses publications do not aim to comprehensively scope the entirety of the literature within a defined topic. Instead, they are designed to offer summaries derived from a rapid analysis of relevant literature concerning a specific aspect of the governance of the private sector in healthcare. Their principal objective is to provoke interest by disseminating insights taken from the available literature, identifying gaps, and fostering further research on the topic.

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Annex. Methodology

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Introduction

The private sector's involvement in health systems is growing in scale and scope. It includes the provision of health-related services, medicines and medical products, financial products, training for the health workforce, information technology, infrastructure, and support services. The private sector in health is heterogeneous and constitutes a range of providers and organizations that are both for-profit and not-for-profit in nature *(1)*. Whilst the private sector has emerged as a key partner in delivering essential services and products, the sector remains under-governed in many contexts, particularly amongst LMICs. While it has been posited that partnerships with the private sector can increase access, improve equity and quality of health services *(2)* robust evidence is lacking and LMICs experience, where documented, is usually descriptive, not evaluative *(3)*.

With the aim to provide more understanding on how governments have moved towards strengthened governance of the private sector in health, in 2022 the World Health Organization (WHO) Systems Governance and Stewardship (SGS) unit commissioned a scoping review on governance of the private sector in health. The review aimed to synthesize available literature on governance of the private sector in healthcare. The review was contracted to Oxford Policy Management (OPM) and conducted from late 2022 through to late 2023. The review focused on national and sub-national governance, excluding topics related to global and multilateral governance. Health systems governance was defined as "ensuring [that] strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability" *(4)*.

Strategic frame

The scoping review search formed the basis for the development on these Clearing House briefs. It was framed using the governance behaviours, an approach to foster effective public-private engagement, as part of more resilient and responsive health systems. The governance behaviours were conceptualised as part of the WHO strategy report on "Engaging the private health service delivery sector through governance in mixed health systems". As specified in the strategy, government sets the lead as steward of all health system entities, both public and private. The governance behaviours are fundamentally a socio-ecological approach. They build from an understanding of health systems as "everybody's business" and governance as a dynamic process through which governments engage public, private, and civic health actors to achieve public policy and improve health system performance.

Deliver strategy and Enable stakeholders focus on broader institutional arrangements for health system performance; these include health priorities and strategic direction, articulation of the principles and values of the health system and the underlying policy and regulatory framework. Align structures considers the organisation of the health system to deliver on health priorities, principles and values. This focuses on the mix of public-private entities, the division of roles and activities among entities, and the integration of entities within the health system. Build understanding and Foster relations consider system and interactive processes using information and engagement as levers for improving institutional and organisational (structural) performance. Nurture trust considers how well this is done, in terms of the quality of integrative engagement, how power and responsibilities are exercised, and the centrality of people, principles and values to sectoral roles and interactions.

The governance behaviours definitions are outlined in **Box A1.**

Box A1. Governance behaviours definitions

Deliver strategy: Government has articulated clear strategic goals and objectives for the health system and a clear definition of roles for the private health sector (both for-profit and not-for-profit) in achieving these

Align structures: The government has established the organizational structures required to achieve its identified strategic goals and objectives in relation to the private health sector (both for-profit and not-for-profit)

Build understanding: The government has access to comprehensive, up-to-date and high-quality data on the operation and performance of the private health sector (both for-profit and not-for-profit)

Enable stakeholders: Government acts to influence the operation and performance of the private health sector (both for-profit and not-for-profit) through the use of financing and regulatory policy mechanisms

Foster relations: The government has established inclusive policy processes, in which a broad range of stakeholders (including the private health sector - and both for-profits and non-profits) plays an active role

Nurture trust: Government takes action to safeguard patients' human rights, health and financial welfare in relation to their interaction with the private sector (both for-profit and not-for-profit)

The scoping review commissioned to Oxford Policy Management (OPM) *(5)* sought to address the following three research questions:

- What are the different approaches adopted to govern the private sector?
- How effective are these approaches?
- What are the key enablers and barriers to adoption of the approaches, and what potential avenues have been identified to strengthen governance behaviours across different contexts?

Sub-assessment research questions were developed and included in the research protocol, framed under each of the governance behaviours. However, these questions revealed a breadth of governance activity and the varied approaches used to engage the private sector in health. Given that the scoping review was to inform the development of a governance progression pathway, it was decided to perform additional searches of the literature for each of the governance behaviours. These were framed using the sub-assessment research questions. Unique search terms were developed for each of the governance behaviours. Development of unique search strategies for each of the governance behaviours and sub-assessment areas are described in the next section.

Search strategy development

To develop these Clearing House briefs, we retained similar inclusion and exclusion criteria as was used for the OPM scoping review. This included a focus on private actors (formal and informal, for-profit and not-for-profit) involved in the delivery of health-related goods and services. We excluded other private actors such as the manufacturing sector, social care, training institutions, and producers of unhealthy commodities e.g., sugary drinks, tobacco.

The search strategies for each governance behaviour were based on a multi-step approach. The Information Specialist (KK) received the research questions and sub-assessment areas which were developed by the System's Governance and Stewardship (SGS) Unit private sector team (DC, GA, and AC). These were used to define scope and understand the topic area for each governance behaviour. This led to initial framing sub-assessment areas and key terms for inclusion in the search strategies. A minimum set of terms were chosen that captured the topic, which were then further refined using proximity or an additional term.

A draft search was presented at weekly meetings and reviewed in collaboration with the SGS technical team and the information specialist. Terminology used was discussed and checked by the technical unit to determine applicability as well as the information specialist for effective searchability. If the difference between a sensitive search and a specific search was very large, a pilot screening of the sensitive search was carried out to assess if a more specific search was sufficient.
Searches were tested comparing against a set of seed articles provided by the SGS technical unit. Most searches were refined to include all seed articles, but there were times where certain articles were too obscure in their terminology and couldn't be captured without largely expanding the search. This was often an iterative process.

The search, once confirmed in Embase, was translated to Pubmed and Web of Science. The Information specialist relied on personal experience to determine best approaches to translation.

Guiding questions, sub-assessment areas and key terms

Research questions, sub-assessment areas and key terms by governance behaviour are presented here. The annexes provide the Embase search strategies.

Deliver Strategy

Guiding questions

- Do government documents articulate clear strategic objectives for the operation and performance of the private health sector, in line with defined health system goals?
- Do the different private sector actors have clear roles and responsibilities in the implementation of the National Health Policy/ Strategy?
- Is there an inclusive process for national health policy review?
- Are there defined national health policy monitoring mechanisms in place for monitoring the effects of change?

Sub-assessment 1. Private sector inclusion within NHPSPs

In National Health Policies, Strategies and Plans (NHPSPs), or in other, equivalent government documents, the roles of the private sector in the health system are defined, alongside specific policies to realise roles, with explicit and logical connections made between policies and movement towards UHC and other policy goals.

Sub-assessment 2. Policy reform/processes

The private sector is included in mechanisms to develop and monitor NHPSPs and contribute to review and reform of NHPSPs and related operational policies.

Key terms: policy, strategy, roadmap, national strategic plan, vision, framework, government objectives, principles, values, monitoring and evaluation, roles, responsibilities, multistakeholder review.

Align Structures

Guiding questions

- Are private sector health entities integrated into health service delivery organisational arrangements (e.g., do arrangements account for formal and informal health entities, digital health, and self-care services, etc).
- Are systems used to align public and private healthcare providers towards a PHC-oriented and nationally defined service delivery model? (e.g., referral, quality assurance, supervision)?
- Are structures in place to coordinate the engagement of donors/ development actors with private healthcare providers in alignment with the stated roles of the private sector in national health strategies?
- Is the private health sector included in all relevant priority health programmes and quality improvement initiatives – e.g., ensuring that reciprocal arrangements are in place to encourage and enable the private sector to contribute to programme goals?

Sub-assessment 1. Organizational arrangements (such as primary care models, group practices, etc)

The private sector is incorporated within service organization arrangements (as guided by national policy/organizational directives).

Sub-assessment 2. Priority public health programmes

The private sector participates in programmes of public health importance, including preventive, promotive and emergency response measures.

Sub-assessment 3. Quality of care and referral systems

The private sector is incorporated in quality-of-care initiatives and referral systems.

Key terms: public health programmes, training, supervision, essential health package, referral system, standards, procedures, directives, guidelines, quality, assurance, service delivery organization, models (of care), group practice, franchising, networks (practice, inter-organizational), out-sourcing, in-kind support.

Enable Stakeholders

Guiding questions

- What regulations are in place for the private sector? (e.g., licensure, accreditation, etc)
- Do public financing arrangements include the private sector? (e.g., grants, in-kind, contracting, strategic purchasing, etc)
- Is there adequate public sector capacity to ensure compliance with regulations and rules?
- What are the incentives that are being developed to encourage compliance and alignment of private sector activities with national health priorities?
- What measures are taken by the health authorities to create an enabling business environment for the private sector to be able to contribute effectively to the health sector and address existing gaps?

Sub-assessment 1. Facility registry and licensing

Facility registration and licensing processes are well-defined and effectively enforced, such that all health facilities are competent to provide safe, effective, and high-quality health services.

Sub-assessment 2. Training institutions

Regulation of private health care training institutions ensures that all trainees are competent to provide safe, effective, and high-quality health services.

Sub-assessment 3. Registration and licensing of health professionals

Registration and licensing of health professionals is well-defined and comprehensive (i.e., including doctors, nurses and pharmacists, and other cadres that are important to the domestic private sector).

Sub-assessment 4. Pharmacy licensing

Pharmacy licensing is well-defined and effectively enforced, such that all retailers are competent to provide safe, effective, and high-quality health products.

Sub-assessment 5. Anti-trust/economic regulation

The anti-trust / economic regulation regime is robust enough to protect the public against the accumulation and/or abuse of market power.

Sub-assessment 6. Private health insurance

There is strategic understanding of the role played by private health insurance and consumer rights are protected.

Sub-assessment 7. Purchasing and contracting

Purchasing, contracting, other agreements re well-designed and effectively implemented, enabling the private sector to contribute to policy goals such as equity of access and financial protection.

Key terms: regulations, licensing, registration, accreditation, framework, compliance, oversight, inspection, public financing, grants, contracting, strategic purchasing, provider payment, capitation payments, incentives, taxation, private health insurance, anti-trust, competitive assessment.

Build Understanding

Guiding questions

- Is there a national HIS? Are private sector entities required to report within the national HIS? What are the incentives and disincentives for doing so (e.g., is reporting mandated as part of licensing)?
- To what extent do private sector entities report into the national HIS? Are there concerns with the quality and regularity of reporting (e.g., accuracy, completeness, reliability, relevance, and timeliness)? Are other sources of private sector data/information available and used? (e.g., surveys, assessments, research)
- Is the resulting information available in a format that enables all relevant government/health authorities - at the national, regional and local levels - to make evidence-based strategic and operational decisions?
- Do relevant government/health authorities systemically use the information to monitor, evaluate and improve policy development and implementation (e.g., through identifying successful pilots of private sector engagement activities that may be considered for scale-up)?
- Is any of the data shared with the public to improve its understanding of the operation and performance of the health sector in general or individual entities/providers in particular?

Sub-assessment area 1: sentinel events, adverse events, vital statistics

Private sector reporting on reportable events and Civil Registries and Vital Statistics (CRVS) is sufficient to support evidence-based public health policy.

Sub-assessment area 2: routine service statistics

Private sector reporting on service delivery data enables government to track service coverage, utilization, and access across the whole health system (public / private).

Sub-assessment area 3: data for decision making

Data and information are used for governance of the private sector in health, drawing on routine and other information sources, including those from surveys and studies.

Key terms: data, information, statistics, study, survey, assessment, report, routine, vital, adverse, sentinel, requirement, process, system, utilization, exchange, decision making, interoperability, analytics, performance, monitoring.

Foster Relations

Guiding questions

- Has government established platforms for open, transparent and purposeful policy dialogue; and do these have a meaningful impact on policy formulation?
- Has government encouraged the private sector (for-profit and non-profit) to establish representative bodies, with whom it can engage in purposeful and sustained dialogue?
- Have such bodies been established? How representative are they?
- Has government taken action to ensures that a broad range of other stakeholders – including patients' associations, community leaders, representatives of vulnerable groups, etc - are included in dialogue structures, as a matter of routine?

Sub-assessment 1: Private sector organization

The private sector is organized to represent and engage with government on issues of relevance to national health policy, programmes and priorities.

Sub-assessment 2: Public sector organization

The public sector is organized to engage with the private sector on issues of relevance to national health strategy, programmes and operational policy.

Sub-assessment 3: Coordination platforms

Platforms/modalities exist to enable cross-sector dialogue, coordination and communication (national and sub-national).

Key terms: coordination, communication, collaboration, consultation, dialogue, bodies (association, syndicate, council, federation, unit, network), system, structure, platform, organization, engagement, working group, committee.

Nurture Trust

Guiding questions

- Do consumer protection laws and social accountability mechanisms exist, and are they sufficiently well-specified to protect users private providers services?
- Does government act to ensure that such laws and mechanisms are well-enforced, such that they exert meaningful influence on for profits' incentives and decision-making, thereby protecting patients' human rights, health, and financial welfare?
- Are both sectors (public and private) equally accountable to the stated measures in a way that fosters trust between all health systems actors and between the health system as a whole and the population it serves?
- How are competing and conflictive cross-sectoral interests managed? Are there recourse and mitigation measures in place? Are they used in a consistent and timely way?
- How central are patient/civic interests to cross-sectoral engagement? Do these adequately consider gender, diversity and equity?

Sub-assessment 1. Conflicts of interest

Public-private collaboration is guided by patient/civic interests and public policy and competing and conflictive interests are managed.

Sub-assessment 2. Role of intermediaries

Intermediaries (can be defined) are engaged to ensure that patient/civic interests are upheld, and engagement is guided by public policy.

Key terms: trust, shared governance, accountability, transparency, corruption, patient protection, consumer-protection, conflict-of-interest, competing-interest, confidence, openness.

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