Progression pathway for governance of mixed health systems

Web Annex. Progress levels

World Health Organization

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Deliver strategy

Definition	What does progress look like?	Questions to guide the assessment of progress	Level 1 Nascent	Level 2 Developing	Level 3 Progressing	Level 4 Established
The for-profit private health sector → **Government has articulated clear strategic goals for the health system as a whole, and the role(s) of the for-profit private health sector in achieving these.**	**Effective delivery of strategy requires:** → The existence of up-to-date documents, e.g., legal documents or policy statements, that define clear objectives for the for-profit sector, in line with health system goals (e.g., univeral health coverage, emergency preparedness, and health promotion). → The inclusion, in such documents, an articulation of how specific policy mechanisms will be used to influence the operation and performance of the for-profit private sector in line with defined strategic objectives.	1. Do up-to-date documents exist that, individually or collectively, define the government's strategic goals in health? (Note: whether a document can be regarded as 'up-to-date' can be determined by whether the document is still 'in use' in guiding the policy direction of the relevant government entity.) 2. Do such documents outline clear role(s) for the for-profit private health sector in achieving these? 3. Do such documents outline specific policy mechanisms for achieving such outcomes? 4. Do they explain how such mechanisms will influence the operation and performance of the for-profit private health sector following the identified strategic goals? 5. Do they identify specific arrangements for implementing them (e.g., by allocating needed financial resources), tracking change, and evaluating the effects of change?	At this level, up-to-date policy statements articulating the government's strategic health system objectives and the role(s) of the private for-profit health sector in achieving these do not exist. Hence, legislation, National Health Policies, Strategies and Plans (NHPSPs), or documents of similar stature and importance (e.g., relating to health systems strengthening, health financing, public health capacities/emergency preparedness, etc.) exclusively focus on the public sector. Insofar as the for-profit private health sector is mentioned, its role is framed in terms of industrial policy or other (non-health system-related) policy objectives, e.g., expansion of medical tourism, foreign direct investment, technological development, digital transformation, etc. Thus, the government may not have a clear plan for influencing the operation and performance of the for-profit private health sector following its strategic health system objectives.	At this level, up-to-date policy statements articulating the government's strategic health system objectives and the role(s) of the for-profit private health sector in achieving these exist. Hence, legislation, NHPSPs, or documents of similar stature and importance (e.g., relating to health systems strengthening, health financing, or public health capacities/emergency preparedness, etc.) are weighted towards the public sector, the for-profit private health sector is beginning to feature in the government's strategic vision. Specific roles for the for-profit private health sector are defined, supported by a notional understanding of how such roles will be implemented in practice. However, the government may not have a clear plan for influencing the operation and performance of the for-profit private health sector following its strategic health system objectives.	At this level, up-to-date policy statements articulating the government's strategic health system objectives and the role(s) of the for-profit private health sector in achieving these exist. Specific roles for the for-profit private health sector have been defined, accompanied by a clear plan for implementing these in practice. Hence, at this level of progress, the government's strategic focus includes the public and the for-profit private health sectors. The government has a clear plan for influencing the operation and performance of the for-profit private health sector and, thus, for using the for-profit private health sector to achieve its strategic goals. However, at this level, arrangements for allocating sufficient resources that enable the implementation of relevant policies or for tracking changes in performance/the broader effects of change about this set of explicit policies may not have been defined – suggesting that the government may not be able to monitor the implementation of such mechanisms and/or measure their effects on health system outcomes in respect of the its objectives.	At this level, clear strategic objectives for the for-profit private health sector have been articulated, and explicit policies are in place to realise these. In addition, robust arrangements (including clear, well-specified indicators) for tracking changes in performance/the broader effects of change about this set of policies have been defined. This suggests that the government has a clear plan for influencing the operation and performance of the for-profit private health sector and, thus, for using it to achieve its strategic goals. In addition, it is serious about allocating sufficient resources to implement such policies. It has also established the capacity to monitor the implementation of related policy mechanisms and measure their effects on health system outcomes.
The non-profit private health sector → **Government has articulated clear strategic goals for the health system as a whole, and the role(s) of the non-profit private health sector in achieving these.**	**Effective delivery of strategy requires:** → The existence of up-to-date documents, e.g., legal documents or policy statements, that define clear objectives for the non-profit sector, in line with health system goals (e.g., univeral health coverage, emergency preparedness, and health promotion). → The inclusion, in such documents, an articulation of how specific policy mechanisms will be used to influence the operation and performance of the non-profit private sector in line with defined strategic objectives.	1. Do up-to-date documents exist that, individually or collectively, define the government's strategic goals in health? (Note: whether a document can be regarded as 'up-to-date' can be determined by whether the document is still 'in use' in guiding the policy direction of the relevant government entity.) 2. Do such documents outline clear role(s) for the non-profit private health sector in achieving these? 3. Do such documents outline specific policy mechanisms for achieving such outcomes? 4. Do they explain how such mechanisms will influence the operation and performance of the non-profit private health sector following the identified strategic goals? 5. Do they identify specific arrangements for implementing them (e.g., by allocating needed financial resources), tracking change, and evaluating the effects of change?	At this level, up-to-date policy statements articulating the government's strategic health system objectives and the role(s) of the non-profit private health sector in achieving these do not exist. Hence, legislation, National Health Policies, Strategies, and Plans (NHPSPs), or documents of similar stature and importance (e.g., relating to health systems strengthening, health financing, public health capacities/emergency preparedness, etc.) exclusively focus on the public sector. Insofar as the non-profit private health sector is mentioned, its role may be treated as separate to strategic goals and policy objectives (e.g., focused on outreach to specific populations or locations). Thus, the government may not have a clear plan for influencing the operation and performance of the non-profit private health sector following its strategic health system objectives.	At this level, up-to-date policy statements articulating the government's strategic health system objectives and the role(s) of the non-profit private health sector in achieving these exist. Hence, while legislation, NHPSPs, or documents of similar stature and importance (e.g., relating to health systems strengthening, health financing, or public health capacities/emergency preparedness, etc.) are weighted towards the public sector, the non-profit private health sector is beginning to feature in the government's strategic vision. Specific roles for the for-profit private health sector are defined, supported by a notional understanding of how such roles will be implemented in practice. However, the government may not have a clear plan for influencing the operation and performance of the for-profit private health sector following its strategic health system objectives.	At this level, up-to-date policy statements articulating the government's strategic health system objectives and the role(s) of the non-profit private health sector in achieving these exist. Specific roles for the private health sector have been defined, accompanied by a clear plan for realising these in practice. Hence, at this level of progress, the government's strategic focus is inclusive of both the public and private health sectors. The government has a clear plan for influencing the operation and performance of the non-profit private health sector; and thus, for using the non-profit private health sector to achieve its strategic goals. However, at this level, arrangements for tracking changes in performance/the wider effects of change with regard to this set of explicit policies may not have been defined – suggesting that the government may not be able to monitor the implementation of such mechanisms and/or measure their effects on health system outcomes in respect of its objectives.	At this level, clear strategic objectives for the non-profit private health sector have been articulated, and explicit policies are in place to realise these. In addition, robust arrangements (including clear, well-specified indicators) for tracking changes in performance/the broader effects of change about this set of policies have been defined. This suggests that the government has a clear plan for influencing the operation and performance of the non-profit private health sector and, thus, for using it to achieve its strategic goals. In addition, it is serious about allocating sufficient resources to implement such policies. It has also established the capacity to monitor the implementation of related policy mechanisms and measure their effects on health system outcomes.

Enable stakeholders _1/5

Definition	What does progress look like?	Questions to guide the assessment of progress	Level 1 Nascent	Level 2 Developing	Level 3 Progressing	Level 4 Established
The for-profit private health sector → **Government acts to influence the operation and performance of the for-profit private health sector through regulation and financing.**	**Enabling stakeholders means:** *Regulatory interventions, and specifically:* For-profit facility registration and licensing processes are well-specified and well-enforced, such that all private facilities are competent to provide safe, effective, high-quality health care.	1. Are private for-profit facilities legally required to be registered/licensed? 2. Is the law well-enforced? (E.g. are licensed facilities >50% or >80% of the total number?) 3. Are licensing conditions well-specified and scaled to the requirements of each service level/ facility type? 4. Are there well-defined compliance mechanisms – linked to the risks of each service level/facility type? 5. Do registration/licensing conditions connect to other regulatory goals – e.g. compliance with clinical guidelines and data reporting rules? 6. Does the capacity exist in the relevant national agency to fully implement registration and licensing processes? (E.g., are inspections undertaken for >50% or >80% of the total number of license applications?) 7. Are procedures transparent as a way to reduce the potential for bias or corruption in decision-making?	At this level, only a minority (<30%) of private for-profit health facilities are registered/ licensed. This is either because there is no legislation requiring private for-profit health facilities to be registered/licensed, or if there is legislation, it is not considered and/or is not enforced – perhaps due to a lack of qualified human resources. Registration/licensing conditions may not connect to other regulatory goals – e.g., observance of clinical guidelines, compliance with data reporting rules, or clinical referral criteria.	At this level, many (30- <50%) of private for-profit health facilities are registered/licensed. There is legislation that requires private for-profit health facilities to obtain a license. The mechanisms are in place for this law to be effective, and thus, most, but not all, facilities have obtained a license. Licensing conditions are in place and may be quite detailed – but they are not scaled to practice type, nor are they connected to other regulatory goals – e.g., observance of clinical guidelines, compliance with data reporting rules, or clinical referral criteria. There is a lack of capacity for registration and licensing (e.g., inspections tend to be both ad hoc and reactive); the process is subject to discretionary decision-making by the registration/licensing authorities, creating potential risks of bias/ corruption.	At this level, it is estimated that 50-80% of private for-profit health facilities are registered/ licensed. Legislation requires private for-profit health facilities to obtain a license. Enforcement of the law is effective enough to ensure that the majority of facilities choose to obtain a license, and compliance with requirements is routinely assessed, with a frequency set according to the risk status of the services provided. Licensing conditions are clear – specific to each service level/facility type, scaled to practice type, and connected to other regulatory goals – e.g., clinical guidelines observance or compliance with data reporting rules. There is sufficient capacity for registration and licensing (e.g., to enable a comprehensive, routinised schedule of inspections, with the frequency determined by service level/facility type); however, the process is subject to discretionary decision-making, creating potential risks of bias/corruption.	At this level,>80% of private for-profit health facilities are estimated to be registered/licensed. Legislation requires private for-profit health facilities to obtain a license. Enforcement of the law is effective enough to ensure that almost all facilities choose to obtain a license, and compliance with requirements is routinely assessed, with a frequency set according to the risk status of the services provided. Licensing conditions are clear – specific to service level/facility type, scaled to practice type, and connected to other regulatory goals – e.g., clinical guidelines observance or compliance with data reporting rules. Sufficient capacity exists for registration and licensing to enable a comprehensive, routinised schedule of inspections, and inspections are conducted in a scheduled manner, with frequency determined by service level/facility type, and in a transparent way, with effective oversight in place to reduce potential risks of bias/conflicts of interest. A clear and transparent mechanism for re-assessment/appeal exists.
	The regulation of private healthcare training/ education institutions ensures that all graduates from such institutions can provide safe, effective, and high-quality health services in the professional domains/clinical areas in which they are qualified.	1. Is there a well-defined system for accrediting and inspecting private medical training institutions? 2. Is there a well-defined system for indexing students joining private medical training institutions to: (a) align these to the teaching capacity of the institution, and (b) manage the number and quality of professionals entering the health sector? 3. Do accreditation/inspection agencies have the human resources/technical capacity to exercise their role correctly?	At this level, there is no quality assurance process for: → curriculum development, or → teaching, learning and assessment (TLA) approach (beyond the general regulations of the Ministry of Education). The number of students joining private medical training institutions is not regulated.	At this level, there are defined quality assurance processes for: → curriculum development, or → teaching, learning and assessment (TLA) approach (beyond the general regulations of the Ministry of Education). However, there is no clear mechanism for conducting regular inspections post-approval. The number of students joining private medical training institutions is not regulated.	At this level, there are defined quality assurance processes for: → curriculum development, or → teaching, learning and assessment (TLA) approach (beyond the general regulations of the Ministry of Education). → There are clearly defined mechanisms for conducting regular inspections post-approval. Related agencies (e.g., accreditation agencies) can conduct these effectively. The number of students joining private medical training institutions is not regulated to align these with health facilities' needs and/or the teaching capacity of the institution.	At this level, there are defined quality assurance processes for: → curriculum development, or → teaching, learning and assessment (TLA)-approaches (beyond the general regulations of the Ministry of Education). → There are clearly defined mechanisms for conducting regular inspections post-approval. Related agencies (e.g., accreditation agencies) can conduct these effectively. The number of students joining private medical training institutions is regulated; thus, these are aligned with both health facilities' needs and the teaching capacity of the institution.

Enable stakeholders _2/5

Definition	What does progress look like?	Questions to guide the assessment of progress	Level 1 Nascent	Level 2 Developing	Level 3 Progressing	Level 4 Established
The for-profit private health sector → **Government acts to influence the operation and performance of the for-profit private health sector through regulation and financing.**	**Enabling stakeholders means:** *Regulatory interventions, and specifically:* There is a well-defined, comprehensive suite of regulations for healthcare professionals employed in the private health sector (i.e., including doctors, nurses, pharmacists, and other cadres important to the operations of the domestic private health sector). To be comprehensive, the regulation of healthcare professionals should address registration, licensing, and standards of practice (including standards for continued professional development) and provide for complaints and disciplinary functions.	1. Is there a well-defined registration system for all health professionals, including cadres within the country's private health sector? 2. Is the related system well-enforced (i.e., are numbers of registered professionals >30%,>50%,>80% or 100% of total numbers in the related cadres)? 3. Is there an institutional framework for maintaining active registers of all healthcare professionals? 4. Is there a well-defined system for licensing all health professionals, including all cadres, that is important for the country's private sector? 5. Is the licensing system well-enforced (i.e., are numbers of registered professionals >50% or >80% of total numbers in the related cadres)? 6. Is this linked to defined standards for professional education, practice and ethics? 7. Do disciplinary procedures exist for professionals who fail to comply with defined standards? 8. Is there an institutional framework for ensuring that all professionals are re-licenced on a regular basis, with appropriate continuing professional development (CPD)/competence criteria?	At this level, there is no government-defined system for registration of all the relevant professional healthcare cadres, including those operating within private health facilities and pharmacies. Less than 30% of relevant professionals are registered. There is no government-defined system for licensing all the relevant professional healthcare cadres within the private health sector. Less than 30% of relevant professionals are licensed.	At this level, there is a government-defined system for the registration of some, but not all, relevant professional healthcare cadres, including those operating within the private health sector. 30%-<50% of relevant professionals are registered. There is a government-defined system for licensing some, but not all, the relevant professional healthcare cadres operating within the for-profit private health sector. 30%- <50% of relevant professionals are licensed. Systems to ensure that re-licensure is conditional on demonstrating appropriate qualifications, standards in practice, and ethical behaviours are under-developed – such that the regulatory apparatus fails to uphold defined standards for professional education, practice and ethics.	At this level, there is a government-defined system for registration of many, but not all, the relevant professional healthcare cadres, including those operating within the private health sector. Systems are in place to maintain active, up-to-date professional registers. 50%- <80% of relevant professionals are registered. There is a government-defined system for licensing most, but not all, the relevant professional healthcare cadres operating within the private health sector. In addition, systems are in place to base re-licensure on the demonstration of appropriate qualifications, standards in practice and ethical behaviours, but these are not fully enforced - such that the regulatory apparatus fails to uphold defined standards for professional education, practice and ethics. 50%-<80% of relevant professionals are licensed.	At this level, a government-defined system registers all relevant professional healthcare cadres, including those operating within the private health sector. Systems are in place for maintaining active registers of professionals. Between 80-100% of relevant professionals are registered. There is a government-defined system for licensing all relevant professional healthcare cadres operating within the private health sector. In addition, systems are in place and enforced to ensure that re-licensure is conditional on demonstrating appropriate competence – such that systems are in place to uphold defined standards for professional education, practice and ethics. Between 80-100% of relevant professionals are licensed.
	Evidence-based clinical practice guidelines, treatment guidelines, clinical protocols, and care pathways apply to both public and private sectors (for-profits and non-profits) and are used as key mechanisms for improving the safety, efficacy and quality of care in the private health sector.	1. Does a suite of national clinical guidelines, standards, and protocols that apply to both public and for-profit private sectors exist? 2. Are such guidelines, standards and protocols evidence-based (e.g., based on a systematic review of the existing scientific literature and/or expert evidence - or some other formal process for ensuring alignment with international best practice)? 3. Are the guidelines, standards and protocols mandatory in private for-profit health facilities? 4. If the guidelines, standards and protocols are mandatory, is their application enforced? 5. Is there a specific entity that is in charge of enforcement mechanisms? 6. Does the capacity exist for effective enforcement, e.g., within the relevant regulatory bodies? 7. Do outcome measures and performance-based reporting frameworks exist and are implemented?	No suite of mandatory national clinical guidelines, standards and/or protocols exists at this level. As a result, clinical decisions in public and private facilities are mainly made based on individual expert opinions, norms, conventions and/or incentives. Thus, there is likely no regulatory apparatus focused on quality of care, reducing variation in clinical practice and the error rate in medical care.	At this level, a suite of mandatory national clinical guidelines, standards and/or protocols exists. Public facilities must observe the relevant guidelines, but it is not mandatory for private facilities. Thus, there is likely no regulatory apparatus focused on quality of care, reducing variation in clinical practice, and the rate of error in medical care in the for-profit private or public health sectors.	At this level, a comprehensive suite of national clinical guidelines, standards and protocols exists. These cover the full range of essential/ prioritised health services. Facilities in both the public and private health sector are expected to observe the relevant guidelines. However, enforcement is absent or inadequate for for-profit private sector entities. No entity has a clear responsibility to undertake inspections and/or cannot apply sanctions or incentives to encourage adherence to the guidelines among private facilities.	At this level, clinical guidelines, standards and protocols exist – and are applied across public and for-profit private facilities in a unified way. The guidelines are effectively enforced across all facilities. A robust inspection regime – undertaken by an entity or group of entities with clear responsibility to enforce the guidelines - confirms adherence to the guidelines among all facilities, and an effective system of sanctions and incentives is in place. Thus, there is a strong regulatory apparatus focused on quality of care, reducing variation in clinical practice, and the rate of error in medical care inclusive of all facilities, regardless of sector.

Enable stakeholders _3/5

Definition	What does progress look like?	Questions to guide the assessment of progress	Level 1 Nascent	Level 2 Developing	Level 3 Progressing	Level 4 Established
The for-profit private health sector → **Government acts to influence the operation and performance of the for-profit private health sector through regulation and financing.**	**Enabling stakeholders means:** *Regulatory interventions, and specifically:* The registration and licensing regime for private retail pharmacies is well-defined and well-enforced, such that all private retail pharmacies must take steps to ensure that they provide safe, effective, and high-quality health products.	1. Is there a well-defined system for regulating the operation of private pharmacy retailers, including specifications on the presence of a qualified pharmacist for each retail outlet? 2. Is the related system enforced effectively (i.e., are the numbers of registered pharmacies >50% or >80% of the total number of such retailers)? 3. Is there an institutional framework for maintaining active registers of all licensed pharmacies? 4. Are there mechanisms to ensure compliance and enforce defined standards for pharmacies (e.g., sanctions for non-compliance)? 5. What actions, if any, have been taken to reduce the potential for bias, conflict of interest or corruption in authorities' decisions about licensing? 6. What actions have been taken to address the availability and use of informal medicine retailers?	At this level, private pharmacies have no government-led or government-mandated registration process. There is no government-led licensing process for private pharmacies. In addition, there are no government-led compliance requirements or auditing or inspection processes for privatepharmacy retailers. Other medicine retailers operate without government registration or regulatory intervention.	At this level, there is a government-led registration process for private pharmacies. There is a government-led licensing process for private pharmacies but no re-licensing process. The government makes systematic efforts to improve compliance for private pharmacies, including the specification that all pharmacies should employ a qualified pharmacist, but other medicine retailers (e.g., patent and proprietary medicine vendors or drug shops) are not covered by these.	At this level, there is a government-led registration process for private pharmacies. However, the list of registered outlets is incomplete and out-of-date (i.e., 50-80% of active retailers are not on the list). There is a government-led (re-)licensing process for private pharmacies. However, licensed outlets account for only 50-80% of the estimated total active retailers in the country. There is a re-licensing process. The government makes systematic efforts to improve compliance with the registration and licensing requirements by pharmacies, including the specification that all pharmacies should employ a qualified pharmacist, but less than 50% of outlets are considered fully compliant. There are efforts to regulate the use of informal medicine retailers (e.g., what over-the-counter medicines are offered and selling of prescription-only medicines).	At this level, there is a government-led registration process for private pharmacies. The list of registered outlets is reasonably complete and up to date (i.e., >80% of active retailers are on the list). There is a government-led licensing process, which includes re-licensing for private pharmacies.). The list of licensed outlets is reasonably complete and up to date (i.e., >80% of active retailers are on the list). The government makes systematic efforts to improve compliance with pharmacies' registration, licensing, and re-licensing requirements, including the specification that all pharmacies should employ a qualified pharmacist and that more than 50% of outlets are considered fully compliant. There are systematic efforts to regulate the use of informal medicine retailers (e.g., what over-the-counter medicines are offered and selling of prescription-only medicines).
The private health insurance (PHI) industry is regulated to protect consumers.		1. Are policies in place to safeguard consumers' rights (e.g., guarding against insolvency, fraud, or overly restrictive pay-out clauses)? 2. Are there policies in place to ensure that (e.g., due to under-insurance) the sickest patients are not being referred to public facilities at a cost to those facilities?	At this level, the development of the PHI sector is not closely monitored or may not be well-understood by the government. In effect, the PHI sector may be considered outside of the purview of health system governance (for instance, no unit or division of the MoH is devoted to it). Thus, the government is not engaged - through regulation or other policies - in the sector's activities. Policies to safeguard consumers' rights or guard against under-insurance are either absent or inadequate.	At this level, the development of the PHI sector is not closely monitored or well-understood by the government. In effect, the PHI sector may be considered outside of the purview of health system governance (for instance, no unit or division of the MoH is devoted to it). Thus, the government is not engaged - through regulation or other policies - in the sector's activities. However, some regulations focusing on safeguarding consumers' rights exist, although these may not be well-enforced. Regulations to guard against under-insurance are either absent or inadequate.	At this level, the development of the PHI sector is well-monitored and well-understood by the government. It is recognised that the PHI sector is an important focus of health system governance (for instance, an MoH unit or division is devoted to it). Thus, the government is engaged in the sector's activities through regulation and/or other policies. Regulations include mechanisms to safeguard consumers' rights, which are well-enforced (e.g., consumer complaints are taken seriously and, where regulatory violations are exposed, action is taken). There are also mechanisms to guard against under-insurance, but these may not be well-enforced (e.g., consumers may not have clear routes to make complaints and/or, if they do, there is no apparent evidence that enforcement action is being taken).	At this level, the development of the PHI sector is well-monitored and well-understood by the government. It is recognised that the PHI sector is an important focus of health system governance (for instance, an MoH unit or division is devoted to it). Thus, the government is engaged in the sector's activities through regulation and/or other policies. Regulations include mechanisms to safeguard consumer's rights, and these are well-enforced. There are also mechanisms to guard against under-insurance, which are well-enforced. In both cases, consumer complaints are taken seriously, and where regulatory violations have been exposed, enforcement action is taken.

Enable stakeholders _4/5

Definition	What does progress look like?	Questions to guide the assessment of progress	Level 1 Nascent	Level 2 Developing	Level 3 Progressing	Level 4 Established
The for-profit private health sector → **Government acts to influence the operation and performance of the for-profit private health sector through regulation and financing.**	**Enabling stakeholders means:** *Regulatory interventions, and specifically:* The anti-trust/economic regulation regime is robust enough to protect the public against the accumulation and/or abuse of market power among private healthcare providers.	1. Do government authorities undertake assessments of the competitive situation of the private health sector, either in general or in specific service levels/facility types/services domains (e.g., PHC, outpatient specialist care (or specific specialist services), hospitals, diagnostic services, and pharmacy retail)? 2. Do government authorities use policy mechanisms to influence the competitive situation of the private health sector in general or specific service domains (e.g., PHC, outpatient specialist care, hospitals, diagnostics, and pharmacy retail)? 3. Are the extant policy mechanisms effective in preventing the accumulation or abuse of market power (e.g., price or rate-of-return regulation and/or scrutiny of or prevention of mergers and acquisitions)?	At this level, government authorities are not familiar with the competitive dynamics of the private health sector and may not use policy mechanisms to influence this – in general or in specific service domains.	At this level, government authorities have limited knowledge of the competitive dynamics of the private health sector – in general or specific service domains. However, neither the MoH nor other public health sector authorities (e.g., state purchasers) are mandated to use policy mechanisms to prevent the accumulation or abuse of market power.	At this level, government authorities have good knowledge of the competitive dynamics of the private health sector – in general, and specific service domains. The MoH and/or other public health sector authorities (e.g., state purchasers) can use policy mechanisms to prevent the accumulation or abuse of market power. However, action is rarely taken.	At this level, government authorities have good knowledge of the competitive dynamics of the private health sector – in general, and specific service domains. The MoH and/or other public health sector authorities (e.g., government purchasers) can use policy mechanisms to prevent the accumulation or abuse of market power. Action is taken through instruments such as price regulation or/or rate-of-return regulation. In addition, there is regular scrutiny and (if appropriate) prevention of mergers and acquisitions to guard against large incumbent firms' accumulation or abuse of market power.
	And Financing interventions, and specifically: The government acts to ensure that purchasing and/or contracting arrangements are well-designed and effectively implemented. This ensures that the resources and activities of private providers contribute to policy goals such as equity of access, financial protection and quality of care, without detriment to the financial sustainability of public health expenditure.	1. To what extent are private for-profit facilities included in publicly financed service delivery (e.g., % of providers contracts (e.g. for inpatient, outpatient, other service areas) with government purchasers is <20%, <50%, >50%, >80)? 2. To what extent and in what ways do eligibility criteria and contract specifications align with equity of access, financial protection, and quality of care objectives alongside the financial sustainability of public spending? (Note that specific sub-questions may include: (i) Is purchasing selective, criteria-based, or open to all willing providers? (ii) Is balance/extra billing allowed (and, if so, is it regulated or unregulated) or disallowed?; (iii) Are prices and service volumes controlled, and in what ways? (iv) Do contracting mechanisms support the ability of small healthcare providers to administer contracts effectively?) 3. To what extent do monitoring arrangements ensure that equity of access, financial protection and quality of care objectives are met in practice? (Note that specific sub-questions may include: Are controls on service volumes incorporated in agreements?)	The for-profit private health sector is not included in publicly financed service delivery.	The for-profit private health sector is included in publicly financed service delivery. However, eligibility criteria and contract specifications are not considered sufficient to: → promote equity of access and financial protection (e.g., balance/extra billing may be allowed, and amounts are unregulated); and/or → ensure the quality of care and/or the financial sustainability of public spending (e.g., purchasing may be criteria-based or general rather than selective, and there may be no controls on service volumes – enabling supplier-induced demand). In addition, monitoring arrangements may be absent or inadequate.	The for-profit private health sector is included in publicly financed service delivery. Eligibility criteria and contract specifications are, in principle, sufficient to: → promote equity of access and financial protection (e.g., balance/extra billing are explicitly disallowed, or, if allowed, amounts are regulated); and → ensure the quality of care and/or the financial sustainability of public spending (e.g., purchasing is selective and focused on high-quality providers, and there are controls on service volumes/payments – discouraging supplier-induced demand). However, monitoring arrangements may be absent or inadequate – such that the impact of the above sources of performance pressure may be undermined.	The for-profit private health sector is included in publicly financed service delivery. Eligibility criteria and contract specifications are, in principle, sufficient to: → promote equity of access and financial protection (e.g., balance/extra billing are explicitly disallowed, or, if allowed, amounts are regulated); and → ensure the quality of care and/or the financial sustainability of public spending (e.g., purchasing is selective and focused on high-quality providers, and there are controls on service volumes/payments – discouraging supplier-induced demand). Monitoring arrangements are robust and comprehensive – such that the above performance pressure sources exert meaningful influence on providers' performance.

Enable stakeholders _5/5

Definition	What does progress look like?	Questions to guide the assessment of progress	Level 1 Nascent	Level 2 Developing	Level 3 Progressing	Level 4 Established
The non-profit private health sector → **Government acts to influence the operation and performance of the non-profit health sector through the use of financing and regulatory policy mechanisms.**	**Enabling stakeholders means:** *Regulatory interventions, and specifically:* Non-profit facility registration and licensing processes are well-specified and well-enforced, such that all private facilities are competent to provide safe, effective, high-quality health care.	1. Are private non-profit facilities legally required to be registered/licensed? 2. Is the law well-enforced? (E.g. are licensed facilities >50% or >80% of the total number?) 3. Are licensing conditions well-specified and scaled to the requirements of each service level/ facility type? 4. Is there a well-defined inspection regime – linked to the risks of each service level/facility type? 5. Do registration/licensing conditions connect to other regulatory goals – e.g. compliance with clinical guidelines observance and data reporting rules? 6. Does the capacity exist in the relevant agency to fully implement this regime? (E.g., are inspections undertaken for >50% or >80% of the total number of license applications?) 7. Are procedures in place to reduce the potential for bias or corruption in decision-making?	At this level, only a minority (<30%) of private non-profit health facilities are registered/licensed. This is either because there is no legislation requiring private non-profit health facilities to be registered/licensed, or if there is legislation, it is not considered and/or is not enforced – perhaps due to a lack of qualified human resources. Registration/licensing conditions may not connect to other regulatory goals – e.g., observance of clinical guidelines, compliance with data reporting rules, or clinical referral criteria.	At this level, a majority (30- <50%) of private non-profit health facilities are registered/licensed. There is legislation that requires private non-profit health facilities to obtain a license. The mechanisms are in place for this law to be effective, and thus, most, but not all, facilities choose to obtain a license. Licensing conditions are in place and may be quite detailed – but they are not scaled to practice type, nor are they connected to other regulatory goals – e.g., observance of clinical guidelines, compliance with data reporting rules, or clinical referral criteria. There is a lack of technical capacity for inspections (thus, inspections tend to be both ad hoc and reactive); the process is subject to discretionary decision-making by the registration/licensing authorities, creating potential risks of bias/ corruption.	At this level, it is estimated that 50-80% of private non-profit health facilities are registered/licensed. Legislation requires private non-profit health facilities to obtain a license. Enforcement of the law is effective enough to ensure that the majority of facilities choose to obtain a license, and compliance with requirements is routinely assessed, with a frequency set according to the risk status of the services provided. Licensing conditions are clear – specific to each service level/facility type, scaled to practice type, and connected to other regulatory goals – e.g., clinical guidelines observance or compliance with data reporting rules. Sufficient technical capacity exists to enable a comprehensive, routinised schedule of inspections, with the frequency determined by service level/facility type; however, the process is subject to discretionary decision-making, creating potential risks of bias/corruption.	At this level,>80% of private non-profit health facilities are estimated to be registered/licensed. Legislation requires private non-profit health facilities to obtain a license. Enforcement of the law is effective enough to ensure that almost all facilities choose to obtain a license, and compliance with requirements is routinely assessed, with a frequency set according to the risk status of the services provided. Licensing conditions are clear – specific to service level/facility type, scaled to practice type, and connected to other regulatory goals – e.g., clinical guidelines observance or compliance with data reporting rules. Sufficient technical capacity exists to enable a comprehensive, routinised schedule of inspections, and inspections are conducted in a scheduled manner, with frequency determined by service level/facility type, and in a transparent way, with effective oversight in place to reduce potential risks of bias/conflicts of interest. A clear and transparent mechanism for re-assessment/appeal exists.
	And Financing interventions, and specifically: The government acts to ensure that purchasing and/or contracting arrangements are well-designed and effectively implemented. This ensures that the resources and activities of private providers contribute to policy goals such as equity of access, financial protection and quality of care, without detriment to the financial sustainability of public health expenditure.	1. To what extent are private facilities included in publicly financed service delivery (e.g., % of providers contracts (e.g. for inpatient, outpatient, other service areas) with government purchasers is <20%, <50%, >50%, >80)? 2. To what extent and in what ways do eligibility criteria and contract specifications align with equity of access, financial protection, and quality of care objectives alongside the financial sustainability of public spending? (Note that specific sub-questions may include: (i) Is purchasing selective, criteria-based, or open to all willing providers? (ii) Is balance/extra billing allowed (and, if so, is it regulated or unregulated) or disallowed?; (iii) Are prices and service volumes controlled, and in what ways? (iv) Do contracting mechanisms support the ability of small healthcare providers to administer contracts effectively?) 3. To what extent do monitoring arrangements ensure that equity of access, financial protection and quality of care objectives are met in practice? (Note that specific sub-questions may include: Are controls on service volumes incorporated in agreements?)	The non-profit private health sector is not included in publicly financed service delivery.	The non-profit private health sector is included in publicly financed service delivery. However, eligibility criteria and contract specifications are not considered sufficient to: → promote equity of access and financial protection (e.g., balance/extra billing may be allowed, and amounts are unregulated); and/or → ensure the quality of care and/or the financial sustainability of public spending (e.g., purchasing may be criteria-based or general rather than selective, and there may be no controls on service volumes – enabling supplier-induced demand). In addition, monitoring arrangements may be absent or inadequate.	The non-profit private health sector is included in publicly financed service delivery. Eligibility criteria and contract specifications are, in principle, sufficient to: → promote equity of access and financial protection (e.g., balance/extra billing are explicitly disallowed, or, if allowed, amounts are regulated); and → ensure the quality of care and/or the financial sustainability of public spending (e.g., purchasing is selective and focused on high-quality providers, and there are controls on service volumes/payments – discouraging supplier-induced demand). However, monitoring arrangements may be absent or inadequate – such that the impact of the above sources of performance pressure may be undermined.	The non-profit private health sector is included in publicly financed service delivery. Eligibility criteria and contract specifications are, in principle, sufficient to: → promote equity of access and financial protection (e.g., balance/extra billing are explicitly disallowed, or, if allowed, amounts are regulated); and → ensure the quality of care and/or the financial sustainability of public spending (e.g., purchasing is selective and focused on high-quality providers, and there are controls on service volumes/payments – discouraging supplier-induced demand). Monitoring arrangements are robust and comprehensive – such that the above performance pressure sources exert meaningful influence on providers' performance.

Foster relations

Definition	What does progress look like?	Questions to guide the assessment of progress	Level 1 Nascent	Level 2 Developing	Level 3 Progressing	Level 4 Established
The for-profit private health sector → **Government has established inclusive policy processes, in which a broad range of stakeholders (including the private health sector, but also other actors) play an active role.**	**Foster relations involves:** → Government has established platforms for open, transparent and purposeful policy dialogue. → These platforms have been institutionalised (i.e., are sustained over time), and have a meaningful impact on the nature of policy formulation in the long-term beyond the scope of individual programmes (e.g., donor-funded programmes). → Government encourages the private sector to establish representative bodies, with whom it engages in purposeful and sustained dialogue. → Government ensures that a broad range of other stakeholders – including patients' associations, community leaders, representatives of vulnerable groups, etc - are also included, as a matter of routine, in dialogue structures. → Government takes robust action to mitigate the potential for bias, conflict of interest, or corruption, in policy formulation.	1. Has the government established platforms for open, transparent, and purposeful policy dialogue, and do these have a meaningful impact on policy formulation and implementation? 2. Has the government encouraged the private sector (for-profit) to establish representative bodies to engage in purposeful and sustained dialogue? 3. Have such bodies been established? 4. How representative are these bodies, that is are they inclusive of the full range of ownership types (sole-proprietor businesses, SMEs, large, limited companies; and facility types - rural/urban clinics, hospitals, etc)? 5. Has the government taken action to ensure 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? 6. Has the government taken robust action to mitigate the potential for bias, conflict of interest or corruption in decision-making?	At this level, no formalised structures for multi-stakeholder dialogue exist. Hence, while the policy process may include the private sector, this may not occur openly, inclusively or transparently. In addition, civic stakeholders are rarely, if ever, invited to participate. There are no clear procedures in place to guard against bias or corruption in relation to decision-making.	At this level, structures for multi-stakeholder dialogue are becoming more formalised. Hence, while most engagement in the policy process is by individual private sector entities, the private sector is forming representative bodies to engage. However, civic stakeholders are rarely, if ever, invited to participate. Clear procedures do not appear to be in place to guard against bias or corruption in relation to decision-making.	At this level, structures for multi-stakeholder dialogue have become institutionalised and these are now routinely used to share information/deliberate on relevant policy issues. The institutionalisation of multi-stakeholder dialogue has led to private entities (for-profit) forming strong, representative associations that advocate for their interests. However, the process remains closed and lacking in transparency - civic stakeholders are rarely, if ever, invited to participate. There are, however, procedures in place to guard against bias and corruption in relation to decision-making. For example, conflicts of interest must be declared, and individuals with such conflicts must be recused from related policy discussions/decisions.	At this level, structures for multi-stakeholder dialogue have become established and these are now routinely used to share information/ deliberate on relevant policy issues. The formalisation of multi-stakeholder dialogue has led the private sector (for-profit) to form strong, representative associations that advocate for its interests. The process has advanced in the degree of openness and transparency - civic stakeholders are routinely invited to participate, such that a diverse range of perspectives and interests are reflected in policymaking about the operation and performance of the private health sector. Robust procedures are in place to guard against bias and corruption in decision-making.
The non-profit private health sector → **Government has established inclusive policy processes, in which a broad range of stakeholders (including the private health sector, but also other actors) play an active role.**	**Foster relations involves:** → Government has established platforms for open, transparent and purposeful policy dialogue. → These platforms have been institutionalised (i.e., are sustained over time), and have a meaningful impact on the nature of policy formulation in the long-term beyond the scope of individual programmes (e.g., donor-funded programmes). → Government encourages the private sector to establish representative bodies, with whom it engages in purposeful and sustained dialogue. → Government ensures that a broad range of other stakeholders – including patients' associations, community leaders, representatives of vulnerable groups, etc - are also included, as a matter of routine, in dialogue structures. → Government takes robust action to mitigate the potential for bias, conflict of interest, or corruption, in policy formulation.	1. Has the government established platforms for open, transparent, and purposeful policy dialogue, and do these have a meaningful impact on policy formulation and implementation? 2. Has the government encouraged the private sector (non-profit) to establish representative bodies to engage in purposeful and sustained dialogue? 3. Have such bodies been established? 4. How representative are these bodies, that is, are they inclusive of the full range of ownership types (sole-proprietor businesses, SMEs, large, limited companies; and facility types - rural/urban clinics, hospitals, etc)? 5. Has the government taken action to ensure 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? 6. Has the government taken robust action to mitigate the potential for bias, conflict of interest or corruption in decision-making?	At this level, no formalised structures for multi-stakeholder dialogue exist. Hence, while the policy process may include the private sector, this may not occur openly, inclusively or transparently. In addition, civic stakeholders are rarely, if ever, invited to participate. There are no clear procedures in place to guard against bias or corruption in relation to decision-making.	At this level, structures for multi-stakeholder dialogue are becoming more formalised. Hence, while most engagement in the policy process is by individual private sector entities, the private sector is forming representative bodies to engage. However, civic stakeholders are rarely, if ever, invited to participate. Clear procedures do not appear to be in place to guard against bias or corruption in relation to decision-making.	At this level, structures for multi-stakeholder dialogue have become institutionalised and these are now routinely used to share information/deliberate on relevant policy issues. The institutionalisation of multi-stakeholder dialogue has led to private entities (not-for-profit) forming strong, representative associations that advocate for their interests. However, the process remains closed and lacking in transparency - civic stakeholders are rarely, if ever, invited to participate. There are, however, procedures in place to guard against bias and corruption in relation to decision-making. For example, conflicts of interest must be declared, and individuals with such conflicts must be recused from related policy discussions/decisions.	At this level, structures for multi-stakeholder dialogue have become established and these are now routinely used to share information deliberate on relevant policy issues. The formalisation of multi-stakeholder dialogue has led the private sector (non-profit) to form strong, representative associations that advocate for its interests. The process has advanced in the degree of openness and transparency - civic stakeholders are routinely invited to participate, such that a diverse range of perspectives and interests are reflected in policymaking about the operation and performance of the private health sector. Robust procedures are in place to guard against bias and corruption in decision-making.

Build understanding

Definition	What does progress look like?	Questions to guide the assessment of progress	Level 1 Nascent	Level 2 Developing	Level 3 Progressing	Level 4 Established
The for-profit private health sector → **Government has taken action to ensure that it has access to comprehensive, up-to-date and high-quality data on the operation and performance of the for-profit health sector. This information is used for strategic and operational decision-making, and relevant data is also shared with the public.**	**Effective building of understanding involves:** → Government acts to ensure that the for-profit sector is integrated in all relevant facility-level public health reporting systems. → Government acts to ensure that the for-profit sector is integrated in all relevant facility-level service delivery reporting systems. → Government acts to ensure that all such data is organised to enable and encourage evidence-based strategic and operational decision-making. → Government acts to ensure that the data is used in this way (i.e., to increase the extent to which strategic and operational decision-making is evidence-based).	1. Is there a national HIS? Are private for-profit 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)? 2. To what extent do for-profit 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 for-profit private sector data/information available and used? (e.g., surveys, assessments, research) 3. 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? 4. Do relevant government/public health authorities systemically use the information to monitor, evaluate and improve policy development and implementation (e.g., through identifying successful pilots of for-profit private sector engagement activities that may be considered for scale-up)? 5. Is any of the data shared with the public, as appropriate, to improve its understanding of the operation and performance of the health sector in general or individual entities/providers in particular?	At this level, for-profit private providers' reporting into HIS, alongside service utilisation and/or disease surveillance, is not mandated across all levels of care (e.g., reporting by the private sector is < 30%). Such reporting is not a condition of licensing or re-licensing - for-profit private sector data is therefore not considered by policy analysts/policymakers as part of health system performance monitoring and cannot inform either the strategic and operational decisions of government/other public health authorities or the population's understanding of the operations and performance of the health system as a whole, taking into account both the public and the for-profit private sectors.	At this level, for-profit private providers' reporting into the HIS is growing. However, it remains inconsistent across different entities and levels of care (e.g., reporting by the private sector is > 30% but < 50%). Reporting routine service statistics and/or disease surveillance may be mandatory (as a licensing condition), and guidelines and processes for reporting may be established. Still, it may not be well-enforced, and thus, concerns remain about the quality and comprehensiveness of data. As a result, government/other public health authorities may lack the complete data required to make strategic and operational decisions on an informed basis or to inform public understanding of the operations and performance of the health system as a whole, taking into account both the public and the for-profit private sectors.	At this level, the for-profit private providers' reporting into the national HIS is established but has not reached national reporting benchmarks or data quality standards across all levels of care (e.g., reporting by the private sector is < 50% but less than 80%). Reporting into HIS is mandatory (as part of license conditions), and efforts have been made by government/other health authorities - and for-profit private sector entities - to improve compliance over time. HIS data has been converted into information and may be combined with other data sources such as surveys and studies. Government/other public health authorities have the information required to make strategic and operational decisions. However, these data are not consistently used in strategic and operational decision-making. Nor are they used to inform the public about the operations and performance of the health system as a whole. Data is not shared with the public to improve its understanding of the operation and performance of the for-profit private sector in general and individual for-profit private sector entities/providers.	At this level, the for-profit private providers' reporting into the national HIS meets national reporting benchmarks across all levels of care and is of high quality (e.g., reporting by the private sector is greater than or equal to 80%). Reporting into HIS is mandatory (as part of license conditions), and efforts have been made by government/other health authorities - and for-profit private sector entities - to improve compliance over time. HIS data has been converted into information and is combined with other data sources such as surveys and studies (particularly for entities not mandated to report into HIS, e.g., pharmacies). Government/other public health authorities have combined datasets and information in usable formats to make strategic and operational decisions on a well-informed basis. Information is systematically placed in the public domain, if appropriate, to inform the public's understanding of the operations and performance of the health system as a whole. In addition, data is shared with the public to improve its understanding of the operation and performance of the for-profit private sector in general and individual for-profit private sector entities/providers.
The non-profit private health sector → **Government has taken action to ensure that it has access to comprehensive, up-to-date and high-quality data on the operation and performance of the non-profit sector, and relevant data is also shared with the public.**	**Effective building of understanding involves:** → Government acts to ensure that the non-profit sector is integrated in all relevant facility-level public health reporting systems. → Government acts to ensure that the non-profit sector is integrated in all relevant facility-level service delivery reporting systems. → Government acts to ensure that all such data is organised to enable and encourage evidence-based strategic and operational decision-making. → Government acts to ensure that the data is used to inform strategic and operational decision-making is evidence-based, and shared with the public.	1. Is there a national HIS? Are private non-profit sector entities required to report within the national HIS? What are the incentives and disincentives for doing so? 2. To what extent do private non-profit 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 non-profit private sector data/information available and used? (e.g., surveys, assessments, research) 3. 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? 4. Do relevant government/public health authorities systemically use the information to monitor, evaluate and improve policy development and implementation (e.g., through identifying successful pilots of non-profit private sector engagement activities that may be considered for scale-up)? 5. Is any of the data shared with the public, as appropriate, to improve its understanding of the operation and performance of the health sector in general or individual entities/providers in particular?	At this level, non-profit private providers' reporting into HIS, alongside service utilisation and/or disease surveillance, is not mandated across all levels of care. Such reporting is not a condition of licensing or re-licensing - non-profit private sector data is therefore not considered by policy analysts/policymakers as part of health system performance monitoring and cannot inform either the strategic and operational decisions of government/other public health authorities or the population's understanding of the operations and performance of the health system as a whole, taking into account both the public and the non-profit private sectors.	At this level, non-profit private providers' reporting into the HIS is growing. However, it remains inconsistent across different levels of care. Reporting routine service statistics and/or disease surveillance may be mandatory (as a licensing condition), and guidelines and processes for reporting may be established. Still, it may not be well-enforced, and thus, concerns remain about the quality and comprehensiveness of data. As a result, government/other public health authorities may lack the complete data required to make strategic and operational decisions on an informed basis or to inform public understanding of the operations and performance of the health system as a whole, taking into account both the public and the non-profit private sectors.	At this level, the non-profit private providers' reporting into the national HIS is established but has not reached national reporting benchmarks or data quality standards across all levels of care. Reporting into HIS is mandatory (as part of license conditions), and efforts have been made by government/other health authorities - and non-profit private sector entities - to improve compliance over time. HIS data has been converted into information and may be combined with other data sources such as surveys and studies. Government/other public health authorities have the information required to make strategic and operational decisions. However, these data are not consistently used in strategic and operational decision-making. Nor are they used to inform the public about the operations and performance of the health system as a whole. Data is not shared with the public to improve its understanding of the operation and performance of the non-profit private sector in general and individual non-profit private sector entities/providers.	At this level, the non-profit private providers' reporting into the national HIS meets national reporting benchmarks across all levels of care and is of high quality. Reporting into HIS is mandatory (as part of license conditions), and efforts have been made by government/other health authorities - and non-profit private sector entities - to improve compliance over time. HIS data has been converted into information and is combined with other data sources such as surveys and studies (particularly for entities not mandated to report into HIS, e.g., pharmacies). Government/other public health authorities have combined datasets and information in usable formats to make strategic and operational decisions on a well-informed basis. Information is systematically placed in the public domain, if appropriate, to inform the public's understanding of the operations and performance of the health system as a whole. In addition, data is shared with the public to improve its understanding of the operation and performance of the non-profit private sector in general and individual non-profit private sector entities/providers.

Align structures

Definition	What does progress look like?	Questions to guide the assessment of progress	Level 1 Nascent	Level 2 Developing	Level 3 Progressing	Level 4 Established
The for-profit private health sector → **The government has established the organisational structures required to achieve its identified strategic goals and objectives for the for-profit private health sector**	**Effective alignment of structures involves:** Government act to ensure that health policy objectives are reflected within organisational structures, service delivery models and financing arrangements and integrate the for-profit private sector as guided by national policy, strategy and plans.	Where relevant and in line with national health policy: 1. Are for-profit private health sector 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)? 2. Are systems used to align public and for-profit private healthcare providers towards a PHC-oriented and nationally defined service delivery model? (e.g., referral, quality assurance, supervision)? 3. Are structures in place to coordinate the engagement of donors/development actors with for-profit private healthcare providers in alignment with the stated roles of the for-profit private sector in national health strategies? 4. Is the for-profit private health sector included in relevant priority health programmes and quality improvement initiatives – e.g., ensuring that reciprocal arrangements are in place to encourage and enable the for-profit private sector to contribute to programme goals?	At this level, no clear roles and responsibilities are defined for private for-profit health sector entities delivering services at national and subnational levels. As such, they are not recognised within service delivery arrangements to ensure continuity of care and integrated service delivery. There are no inter- and intra-sectoral referral systems, quality assurance (clinical guidelines, standards, and protocols) or supervision.	At this level, there are overarching roles and responsibilities defined by policy for the delivery and financing of services. Still, they remain limited to certain levels of care, providers or programmes (e.g., large hospitals, faith-based organisations or disease programmes). Other private for-profit healthcare providers are not accounted for within defined roles and responsibilities. As such, systems for inter- and intra-sectoral referral, quality assurance (clinical guidelines, standards, and protocols) or supervision reflect this limitation. In addition, systems to coordinate the engagement of donors/ development actors with private for-profit providers in line with the stated roles of the for-profit private sector in national health strategies remain absent.	At this level, clear roles and responsibilities exist as defined in the policy for delivering and financing services for a broader range of private for-profit healthcare entities to ensure continuity of care and integrated service delivery. Systems for inter- and intra-sectoral referral, quality assurance (clinical guidelines, standards, and protocols) and supervision exist but are not fully functional or enforced. Systems to coordinate the engagement of donors/development actors with private for-profit healthcare providers in line with the stated roles of the private for-profit health sector in national health strategies are present but not fully enforced.	At this level, clear roles and responsibilities exist as defined in the policy for delivering and financing services for a broader range of private for-profit healthcare entities to ensure continuity of care and the integrated delivery of health services. Systems for inter- and intra-sectoral referral, quality assurance (clinical guidelines, standards, and protocols) and supervision exist, are fully functional and enforced. Moreover, systems to coordinate the engagement of donors/development actors with private for-profit healthcare providers in line with the stated roles of the private for-profit health sector in national health strategies are present and enforced to a great extent.
The non-profit private health sector → **The government has established the organisational structures required to achieve its identified strategic goals and objectives for the non-profit private health sector**	**Effective building of understanding involves:** Government act to ensure that health policy objectives are reflected within organisational structures, service delivery models and financing arrangements and integrate the non-profit private sector as guided by national policy, strategy and plans.	Where relevant and in line with national health policy: 1. Are non-profit private health sector entities integrated into health service delivery organisational arrangements? Does this account for formal and informal health entities, digital health, and self-care services? 2. Are systems used to align public and non-profit private healthcare providers towards a PHC-oriented and nationally defined service delivery model? (e.g., referral, quality assurance, supervision)? 3. Are structures in place to coordinate the engagement of donors/ development actors with non-profit private healthcare providers in alignment with the stated roles of the non-profit private health sector in national health strategies? 4. Is the non-profit private health sector included in relevant priority health programmes and quality improvement initiatives – e.g., ensuring that reciprocal arrangements are in place to encourage and enable the non-profit private sector to	At this level, no clear roles and responsibilities are defined for private non-profit health sector entities delivering services at national and subnational levels. As such, they are not recognised within service delivery arrangements to ensure continuity of care and integrated service delivery. There are no inter- and intra-sectoral referral systems, quality assurance (clinical guidelines, standards, and protocols) or supervision.	At this level, there are overarching roles and responsibilities defined by policy for the delivery and financing of services. Still, they remain limited to certain levels of care, providers or programmes (e.g., large hospitals, faith-based organisations or disease programmes). Other private non-profit providers are not accounted for within defined roles and responsibilities. As such, systems for inter- and intra-sectoral referral, quality assurance (clinical guidelines, standards, and protocols) or supervision reflect this limitation. In addition, systems to coordinate the engagement of donors/ development actors with private non-profit providers in line with the stated roles of the non-profit private sector in national health strategies remain absent.	At this level, clear roles and responsibilities exist as defined in the policy for delivering and financing services for a broader range of private non-profit healthcare entities to ensure continuity of care and integrated service delivery. Systems for inter- and intra-sectoral referral, quality assurance (clinical guidelines, standards, and protocols) and supervision exist but are not fully functional or enforced. Systems to coordinate the engagement of donors/development actors with private non-profit private healthcare providers in line with the stated roles of the private non-profit sector in national health strategies are present but not fully enforced.	At this level, clear roles and responsibilities exist as defined in the policy for delivering and financing services for a broader range of private non-profit healthcare entities to ensure continuity of care and the integrated delivery of health services. Systems for inter- and intra-sectoral referral, quality assurance (clinical guidelines, standards, and protocols) and supervision exist, are fully functional and enforced. Moreover, systems to coordinate the engagement of donors/development actors with private non-profit healthcare providers in line with the stated roles of the private non-profit health sector in national health strategies are present and enforced to a great extent.

Nurture trust

Definition	What does progress look like?	Questions to guide the assessment of progress	Level 1 Nascent	Level 2 Developing	Level 3 Progressing	Level 4 Established
The for-profit private health sector → **The government takes action to safeguard patients' rights and financial welfare through their interaction with the for-profit private health sector and provides structures to ensure public accountability/patient redress.**	**Nurturing of trust in the mixed health system requires:** → Government acts to ensure that consumer protection laws are well-specified and well-enforced, such that they: → ensure that the rights of patients receiving care in the for-profit sector are enforced; → ensure that patients do not receive unsafe, inappropriate or unnecessary care in the for-profit sector; and → ensure that patients are not financially exploited in the for-profit sector. → Government ensures that patients have a voice in relation to the private health sector's activities and their experiences in related facilities - including via structures such as: patient fora, AGMs, complaints processes (with defined processes, including recording of complaints, and mechanisms for enforcement of disciplinary measures); and monitoring by CSOs.	1. Do consumer protection laws and social accountability mechanisms exist, and are they sufficiently specified to protect users of the for-profit private health sector's services? 2. Does government act to ensure that such laws and mechanisms are well-enforced and exert meaningful influence on the for-profit private health sector's incentives and decision-making, thereby protecting patients' rights, health interests, and general well-being? 3. 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?	At this level, consumer protection laws and social accountability mechanisms are absent. Thus, there are no safeguards for protecting patients' health rights, or general well-being vis-à-vis their engagement with health providers (public and private).	At this level, there are consumer protection laws and/or social accountability mechanisms; however, these are not systematically or equally enforced, such that safeguards the protection of patients' health rights, or general well-being vis-à-vis their engagement with health providers (public and private) remain largely ineffective. Clear mechanisms that ensure that patients have a voice in the private and public sectors' activities may not be in place.	At this level, there are consumer protection laws and/or social accountability mechanisms, and these are generally well-enforced/observed in the public and for-profit private sectors, such that they safeguard the protection of patient's health rights, or financial welfare vis-à-vis their engagement with health providers exist, albeit they are limited. Clear mechanisms that ensure that patients have a voice in the private and public sectors' activities may not be in place and sectors (public and private) are not equally accountable.	At this level, consumer protection laws and/or social accountability mechanisms are clear, comprehensive and well-enforced/observed in the public and for-profit private sectors. These provide robust safeguards regarding protecting patients' health rights, and financial welfare vis-à-vis their engagement with health providers. The government has ensured that patients have a voice in the private and public sectors' activities. Relevant structures are in place, examples of which are patient fora, annual general meetings, complaints processes (with defined processes, including recording of complaints and mechanisms for enforcement of disciplinary measures), and potential monitoring by CSOs. In addition, both sectors (public and private) are equally held to account.
The non-profit private health sector → **The government takes action to safeguard patients' rights and financial welfare through their interaction with the non-profit private health sector and provides structures to ensure public accountability/patient redress.**	**Nurturing of trust in the mixed health system requires:** → Government acts to ensure that consumer protection laws are well-specified and well-enforced, such that they: → ensure that the rights of patients receiving care in the non-profit sector are enforced; → ensure that patients do not receive unsafe, inappropriate or unnecessary care in the non-profit sector; and → ensure that patients are not financially exploited in the non-profit sector. → Government ensures that patients have a voice in relation to the non-profit sector's activities and their experiences in related facilities - including via structures such as: patient fora, AGMs, complaints processes (with defined processes, including recording of complaints, and mechanisms for enforcement of disciplinary measures); and monitoring by CSOs.	1. Do consumer protection laws and social accountability mechanisms exist, and are they sufficiently specified to protect users of the non-profit private health sector's services? 2. Does government act to ensure that such laws and mechanisms are well-enforced and exert meaningful influence on the non-profit private health sector's incentives and decision-making, thereby protecting patients' rights, health interests, and general well-being? 3. 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?	At this level, consumer protection laws and social accountability mechanisms are absent. Thus, there are no safeguards for protecting patients' health rights, or general well-being vis-à-vis their engagement with health providers (public and private).	At this level, there are consumer protection laws and/or social accountability mechanisms; however, these are not systematically or equally enforced, such that safeguards the protection of patients' health rights, or general well-being vis-à-vis their engagement with health providers (public and private) remain largely ineffective. Clear mechanisms that ensure that patients have a voice in the private and public sectors' activities may not be in place.	At this level, there are consumer protection laws and/or social accountability mechanisms, and these are generally well-enforced/observed in the public and non-profit private sectors, such that they safeguard the protection of patient's health rights, or financial welfare vis-à-vis their engagement with health providers exist, albeit they are limited. Clear mechanisms that ensure that patients have a voice in the private and public sectors' activities may not be in place, and sectors (public and private) are not equally accountable.	At this level, consumer protection laws and/or social accountability mechanisms are clear, comprehensive and well-enforced/observed in the public and non-profit private sectors. These provide robust safeguards regarding protecting patients' health rights, and financial welfare vis-à-vis their engagement with health providers. The government has ensured that patients have a voice in the private and public sectors' activities. Relevant structures are in place, examples of which are patient fora, AGMs, complaints processes (with defined processes, including recording of complaints and mechanisms for enforcement of disciplinary measures), and potential monitoring by CSOs. In addition, both sectors (public and private) are equally held to account.

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