COUNTRY CONNECTOR

Let's align for public health

How to develop inclusive national health policy for the private sector in health

KEY TERMS

Health governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability

Health systems embody the people, institutions and resources, arranged together following policies established by a government to improve the health of the population it serves

Operational policies are the rules, regulations, guidelines, and administrative norms that governments use to translate national laws and policies into programmes and services

Pluralistic health systems are understood as the ensemble of all public and private organizations, institutions, and resources mandated to improve, maintain or restore health

Policy entrepreneurs are actors that operate within and outside of government with the knowledge, power, tenacity and luck to frame and promote policy solutions

Private sector in health consists of both formal and informal entities ranging from drug shops to specialised hospitals, comprising both for-profit and non-profit entities, both domestic and foreign. Digital health and self-care interventions may also be categorised as part of the private sector in health.

Public health policy sets out the rationale for private sector engagement and respective roles for the different types of private sector entities, including the means through which this will be achieved

Public health policy framework is the management of policies as an integrated whole rather than a dissociated collection of part

Rogue policies are understood as ones which contradict and/or does not align with national health policy. They may be programme specific or developed at lower administrative levels of the health system.

Situational awareness is defined as a well-informed interest in a particular situation or development

INTRODUCTION

Purpose

The 2030 Sustainable Development Goals (SDG), and specifically SDG 17, call for cooperation, collaboration and partnership between government, civil society and businesses to reach the agenda's goals. In the health sector, this creates a strong imperative to find ways to effectively harness and steer both the public, private and civic sectors to achieve health goals and targets, specifically the SDG target 3.8 on achieving Universal Health Coverage (UHC), including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.[1] This brief builds from a 2019 call to action on the private sector in health for UHC.[1] It aims to support countries in developing and implementing public health policy that is inclusive of the different parts of the private sector in health to maximize efforts towards the achievement of UHC.

Background

Health systems embody the people, institutions and resources, arranged together following policies established by a government to improve the health of the population it serves.[2] Within the health sector, arrangements are intended to improve health system performance - equity in the use of health services, service quality and financial protection. Most countries have pluralistic health systems, where a mix of public and private entities deliver health related goods and services. Pluralistic health systems are defined as "the ensemble of all public and private organizations, institutions, and resources mandated to improve, maintain or restore health."[3] Pluralistic health systems thus include a large variety of entities, from public to small not-for-profit providers to large multinational private for-profit companies.

Entities respond in very different ways to government efforts to steer public policy for UHC and require a variety of tools and incentives. An inclusive public health policy therefore should set out the rationale for private sector engagement and respective roles for the different types of private sector entities, including the means through which this will be achieved. We use the term public health policy throughout this guidance to emphasize the centrality of people – *the public* - in health systems.

An important challenge in governing pluralistic health systems relates to the diversity of characteristics and interests of health entities. This is especially challenging when it comes to the private sector in health. The private sector in health is less bounded than the public sector and is *"generally large, poorly documented, and very heterogeneous"*.[4] It consists of both formal and informal entities ranging from drug shops to specialised hospitals, comprising both for-profit and non-profit entities, both domestic and foreign. Digital health and self-care interventions may also be categorised as part of the private sector in health.

Outline

This brief is outlined as follows:

- **Section 1** defines key terms and the rationale for inclusive public health policy
- **Section 2** introduces the concept of an inclusive public health policy framework
- **Section 3** outlines recommended steps in developing inclusive public health policy

Audience

The audience for this brief is country-based policy makers and implementers, inclusive of public and private sector entities involved in health service and product delivery. A secondary audience is development and implementing partners working on health governance and health system strengthening.

This policy brief is part of a technical workstream on the governance of the private sector in health. The workstream employs a collaborative and iterative process for the design of interim "modular" products. These have been used as a basis for engaging WHO teams and other country stakeholders in the process of refinement and/or further inquiry to improve the utility and application of the technical resources available on the Country Connector on Private Sector in Health (CCPSH). The CCPSH is a platform to support countries to manage the private sector's contribution to the response consistent with national health priorities.[5]

RATIONALE FOR INCLUSIVE PUBLIC HEALTH POLICY

Inclusive public health policy

Public health policy is defined as the "decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society".[6] An explicit public health policy can achieve several things: it defines a vision for the future; it outlines priorities and the expected roles of different groups; and it builds consensus and informs people.[6] In contrast, operational policies are the rules, regulations, guidelines, and administrative norms that governments use to translate national laws and policies into programmes and services.[7] These may also be referred to as policy instruments or implementation tools. Figure 2 depicts linkages between public health policy, operational policy (e.g., rules, regulations and norms), and related implementation tools such as licensure, accreditation, communication, and information systems.

Figure 1. Example of hierarchy of policy and tools

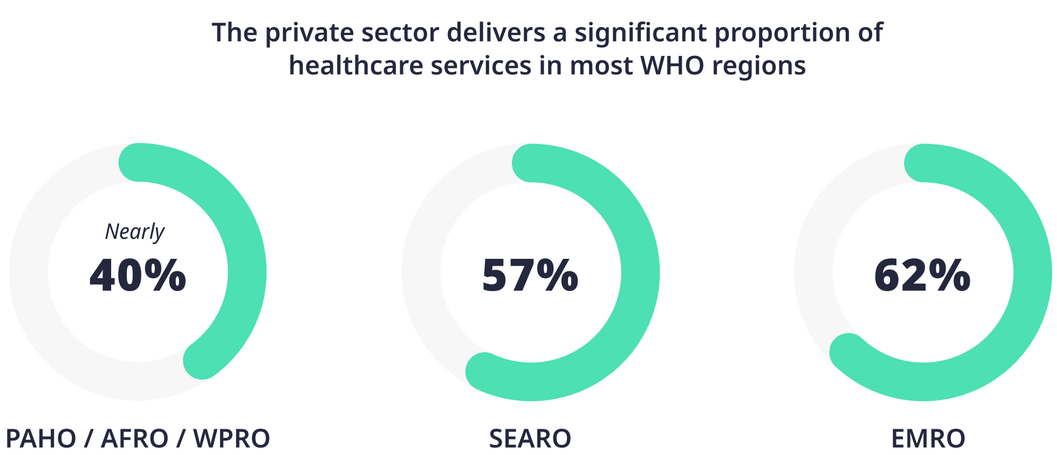
Rationale for inclusive public health policy

As previously mentioned, an inclusive public health policy should set out the rationale for private sector engagement and respective roles for the different types of private sector entities, including the means through which this will be achieved. This is particularly important in the context of pluralist health systems as goals and priorities need to be shaped, shared and ultimately implemented across all health entities, including the private sector in health.

In many lower- and middle-income countries (LMICs) the private sector in health contributes a large and growing proportion of healthcare services. Such contribution is estimated to range from 40 to 62 per cent and varies across WHO regions (Figure 2). This level of healthcare provision underscores the importance of ensuring that formal private entities (including pharmacies) are integrated into overall health systems.[8] It also suggests that informal private healthcare entities cannot be ignored by governments if health systems are to deliver equity in service use, quality, and financial protection.

An inclusive health policy may also need to calibrate the rationale and roles of the public sector to those of the private sector in health. Increasingly ministries of health are less involved in supervising service delivery and more involved in strategic planning, target setting, and monitoring of the component parts of the health sector. The management of contracted services, in particular, is an increasing function of government while many LMICs have embarked on administrative decentralization of health service delivery. Despite this, few ministries of health have reassessed their own structures, staffing, and operations, particularly in relation to overall information and liaison functions with multiple entities, including the private sector in health.

Figure 2. Private Sector Landscape in Mixed Health Systems (WHO, 2020)



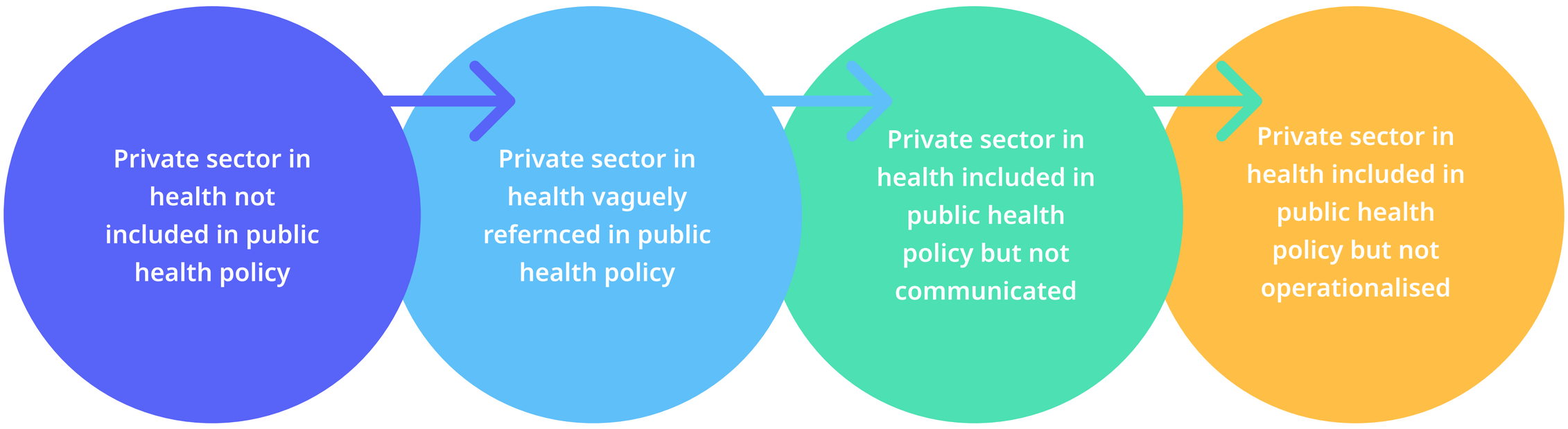
Private sector in health vacuums in public health policy

Despite recognition of the importance of the private sector in health for public health goals, including the achievement of UHC, there remains little consensus on how to develop and implement inclusive public health policy. Many countries do not have explicit policy related to the private sector in health or to the role of its component entities in national health systems. In the absence of clear direction, a policy vacuum may coalesce in which the growth, form, and function of the private sector in health are left to other forces, to the detriment of efficiency, quality, and equity.[1] This can occur in different ways:

- A policy vacuum may occur due to the absence of a specific policy for the private sector in health. This brief does not presume the need for a dedicated private sector policy and argues for inclusive public health policy that considers the role of the private sector and its dynamics.
- A policy vacuum may occur due to vague statements about the private sector in health within policy. This brief therefore presumes 'situational awareness' in the way the private sector in health is referenced in public health policy. Situational awareness is defined as a well-informed interest in a particular situation or development,[12] reflected in inclusive public health policy.
- A policy vacuum may occur due to lack of engagement of key stakeholders in policy development and dissemination, including healthcare users. This brief presumes that inclusive public health policy is a means to build consensus and accountability amongst health entities, and not an end in itself.
- Finally, a policy vacuum may occur in the context of policy fragmentation, either due to numerous and misaligned policies and/or due to lack of operational policy, in the form of rules, regulations, and administrative norms and related implementation tools.

Policy vacuums are illustrated in Figure 3, showing how these may occur and combine.

Figure 3. Policy vacuums for the private sector in health



INCLUSIVE PUBLIC HEALTH POLICY FRAMEWORK

Governance behaviours

While policy is a tool to deliver strategy, it must be governed, managed, communicated, monitored, and enforced. We thus propose a "framework" approach in which the roles of ministries of health are re-oriented towards the provision of support and guidance to public and private entities, a "steering" rather than a "doing" approach to inclusive public health policy. Similar to other forms of corporation, a policy framework should embody the "governance posture, corporate culture, behavioural boundaries and objectives"[9] of the whole health sector. The governance behaviours presented in the 2020 WHO Strategy report on the Engagement of the Private Sector in Health uses simple descriptors to convey behavioural intent and goal-oriented interaction between public and private health entities.[10] This in recognition that behaviour change is not a quick fix but a series of connected actions that should be approached consistently and with constancy. Inclusive health policy is - or should be - the pinnacle upon which other behaviours are framed and executed. This is elaborated on in Box 1.

Box 1. Governance behaviours

Health systems have been conceptualised as "everybody's business"[11]. The governance behaviours build from this understanding. They seek to breakdown what have tended to be long lists of essential governance duties. For example, the WHO framework for action listed governance duties as *"ensuring [that] strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability"*.[11] Within this framework, governance is presented as one of six building blocks, not as foundational architecture. Relational arrangements are implicit, not explicit to the framework: *"it is the multiple relationships and interactions among the blocks – how one affects and influences the others and is in turn affected by them – that converts these blocks into a system"*[12]. The governance behaviours seek to activate the governance building block and explicitly recognise the "messy" and interconnected relationships found within health systems.

The **six governance behaviours** presented in the 2020 WHO Strategy report convey goal-oriented *interaction* between public and private health system entities. They use simple descriptors to convey behavioural intent. This recognises that behaviour change is not a quick fix but a series of connected actions that should be approached consistently and with constancy. Government sets the lead as orchestrator and modulator of all health entities, both public and private.

- **Deliver strategy** and **enable stakeholders** focus on broader institutional arrangements for health system performance; this includes 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 actors, and the integration of entities within the health system.
- **Build understanding** and **foster relations** consider systems 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 health people, principles and values to sectoral roles and interactions.

Problem diagnosis (prioritisation)

We recognise that other policies exist within and outside of the health sector that come to bear on public health policy and need to be aligned. An inclusive public health policy framework approach can support this, through management of policies as an integrated whole rather than a dissociated collection of parts. This framework approach may reveal unnecessary and 'rogue' policies, allowing governments to prioritise (which is a key purpose of policy). Rogue policies are understood as ones which contradict and/or does not align with national health policy. They may be programme specific or developed at lower administrative levels of the health system.

An inclusive public health policy framework approach is necessary for two reasons:

- Because ministries of health are responsible for the whole health sector, not just the part for which it has direct financial responsibility.
- Where policy makers have actively pursued private sector initiatives, the primary rationale has not been that of equity and may be more focused on market development and private investment.

RECOMMENDED STEPS IN DEVELOPING INCLUSIVE PUBLIC HEALTH POLICY

As defined, inclusive national health policy should provide the vision for the future, outline the priorities and the expected roles of different groups, build consensus and inform people of policy intent. Here we outline recommended steps to develop an inclusive health policy. A companion brief discusses the **policy cycle** and entry points for intervention. Entry points do not necessarily occur in linear, sequential stages as policy windows may be opened at different points in policy development process when problem, policy and politics converge.[13] Policy windows are points in time when convergence arises for an issue or problem to be taken seriously with a view to action. Our guidance starts from this understanding of policy development and the active role of policy entrepreneurs in the process. Policy entrepreneurs are actors that operate within and outside of government "with the knowledge, power, tenacity and luck" to frame and promote policy solutions.[14]

Situational awareness (policy entry)

Most policy development starts with agenda setting. This may take the form of a situation assessment of the private sector in health, which can be lengthy and expensive, and, as such, may not be done with regularity. We argue that complete information on the private sector in health may not be practical, particularly if policy is directed towards parts of the private sector in health, such as formal providers, and their integration into health systems.

Understand existing roles and relationships between key health entities may provide adequate situational awareness for policy formulation. More than data and information, situational awareness can be thought of as a well-informed interest in a particular situation or development.[9] This can be built through an inclusive policy development process. We illustrate how such a process could be structured in the steps below. An **Excel tool** has also been developed to support this process. While it is essential to start with problem diagnosis other steps in the process can be done in a different sequence that what is presented in the brief and tool.

Problem diagnosis (prioritisation)

Problem definition is a critical strategic decision that governs policy development. This is not an easy step as there may not be consensus on health system performance problem. Problems may be framed in terms of 'favourite' solutions (i.e., those that have been promoted in other contexts or are the purview of a particular partner or intermediary) which may limit analysis, or the problem may be left so broad that it is not easily amenable to intervention. Problems should be of an order that they generate attention and are responsive to policy intervention. For example, performance problems in relation to healthcare access, utilisation, quality, and affordability are likely to generate attention, from different directions – the media, civil society, medical professions, the private sector, and government.

Health system performance problems should be prioritised by considering both relevance and feasibility for intervention. It is important to focus on performance problems in which the private sector plays an important, not peripheral role. Problem prioritisation should balance risks and demands and be "dramatic enough" to rally support from different directions.[15] On balance, performance problems are likely to be complex and interconnected, but should be distilled for communication and coherence. The process of problem distillation needs organisation, led by a multi-sectoral (e.g., inclusive) task team.

Role diagnosis (expected versus actual)

Health system performance problems should be understood in relation to constituent entities. This moves problem analysis from a sectoral to a more granular focus, so that "ownership" of the performance problem is distilled. This should consider the public and private entities engaged in the performance area, the scope and consistency of performance, the population affected and their location, and the quality of information available for analysis. This may necessitate data entrepreneurship to look beyond routine information systems, to grey and published literature, expert opinion, or rapid research. Data lacunas may be more in how data and information are shared (and used) rather than in a real absence of data.

Health entities should be analysed in relation to the prioritised problem. This should consider what health entities are supposed to do and what they do in practice.

Roles are likely to be inter-related and trigger a response or reaction across health entities. A list of potential health entities is illustrated in Table 1.

These demonstrate interconnectedness of roles, if not actual relationships, which may be absent or weak. Role analysis should focus on the most critical entities in relation to the health system performance problem.

Table 1. Examples of public and private sector entities

ENTITIES	PUBLIC ENTITIES (FORMAL)	PRIVATE ENTITIES (FORMAL & INFORMAL))
Health service entities	**Tertiary:** teaching, specialized and referral hospitals **Secondary:** district hospitals, health centres and maternity homes Primary: health dispensaries/clinics, community health workers, outreach sites **Digital:** Telemedicine, mHealth Monitoring and compliance units (inspection, supervision)	**Tertiary:** teaching, specialized and referral hospitals **Secondary:** smaller hospitals, large/ group-owned clinics and maternity homes **Primary:** general practitioners, allopathic doctors, indigenous providers, traditional birth attendants, community health workers Digital: Telemedicine, mHealth
Health management entities	National health departments (programmes, planning, financing) National health information departments/systems Sub-national health departments (devolved management, service delivery) Regulation and standards departments Governments' PPP units	NGO programmes Umbrella organisations (e.g., federations, Faith-based bureaus) Networks, platforms (may be virtual) Other industry representative groups
Professional entities	Training institutes Councils (doctors, nurses, clinical officers, pharmacists) Research institutes	Training institutes Associations (doctors, nurses, clinical officers, pharmacists) Technical agencies Research institutes
Funding entities	Ministry of finance National health insurance agency Ministry of health budget holders Management agent (vouchers, RBF) sub-national health budget holders	Private health insurance agencies Micro-insurance/credit agencies Domestic financing (donations, CSR) Bi-lateral and multi-lateral agencies Foundations Global health programmes Digital finance
Health product entities	National medical stores Regulatory boards	Medical stores/pooled procurement Pharmacies, drug shops Social marketing, e-pharma organisations Manufacturers First line buyers Distributors

Other entities with a role in health	Ministry of education Ministry of women's affairs, youth, disability Office of the President Public services commission Inter-governmental bodies Local government National planning authority	Traditional leaders Community development committees
Oversight entities	Office of the president Parliament (legislation) Oversight/redressal (parliamentary, judicial, Ombud's offices) Formal (boards, committees, working groups)	Patient/consumer groups Press and media Research institutes CSOs Unions

Policy diagnosis (where is the vacuum?)

Health policies may guide performance or play a more performative role. This step therefore seeks to diagnose the existing health policy framework, to understand where the policy vacuum is, if any, for the private sector in health.

This step considers:

- What policies are in place to guide performance?
- What effects does existing policy have on the performance problem and public-private mix of health products and services?
- Are there unintended effects of existing policy?
- Do the relevant policy stakeholders view the policy as acceptable?

Policy analysis should focus on the most important policies in relation to the health system performance problem. In short, it is important to understand where the policy vacuum is, and how to address this.

As referenced in Figure 1, policy instruments are tools intended to influence the incentives or capacities of health system entities to deliver public health policy. Examples of policy tools include licensure, accreditation, communication, and information systems. The policy analysis considers the tools in place to deliver public health policy and their degree of implementation. While a range of tools are outlined in the **Excel tool**, we suggest focusing on those most critical to the performance problem. Performance change often requires the use of more than one tool and a change in one tool is likely to have an effect on the performance of other tools. In considering the tools' analysis, some tools should be considered as key enablers of other tools and performance more broadly, such as information and communication systems.

Behaviour diagnosis (governance)

As previously introduced, governance behaviours are the means and processes through which governments execute the governance function, as part of their responsibility for the health and wellbeing of their population. The behavioural analysis uses prompts to guide diagnosis of governance behaviours. The **Excel tool** provides a rubric from which you can select one of four criteria. These are colour-coded (red-orange-yellow-green) to provide a visual cue of where behaviours (and behavioural problems) lie. Policy intervention should be guided by the overall behavioural context as well as the performance of individual governance behaviours.

Solution (vision for the future)

For the solution, we suggest developing a vision statement that responds to the health system performance problem. This can serve as a similar communication and coherence function to the problem diagnosis; a 'rally cry' to build consensus and inform people of policy intent.[15] The vision will guide the changes needed in each of the diagnostic domains: service delivery, policy, tools, and behaviours.

For each diagnostic domain, consider:

- What change is needed
- The entity or entities responsible for implementation
- The financial resource implications of change and who should pay
- How equity and inclusion have been factored into the change needed
- The role of public and private sector entities in facilitating change

We suggest being modest with the envisaged change as it is better to build engagement incrementally as 'successful agreements' provide foundation for further intervention and improvement.[15]

CONCLUSION

The policy ‘how-to’ brief is part of a technical workstream on governance of the private sector in health. The workstream employs a collaborative and iterative process for the design of interim ‘modular’ products. This is one such product housed within the Research and Learning channel of the Country Connector on Private Sector in Health. These technical products are ‘draft for discussion’ intended to be used as a basis for engaging global, regional and country stakeholders in the process of guidance refinement and/or further inquiry. The quality of engagement will ultimately be reflected in the utility and application of the technical resource.

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REFERENCES

1. *Clarke D, Doerr S, Hunter M, Schmets G., Paviza A. The private sector and universal health coverage. Bull World Health Organ 2019;97:434–435 (http://dx.doi.org/10.2471/BLT.18.225540.*
2. *WHO Terminology Information System [online glossary] https://www.who.int/healthsystems/Glossary_January2011.pdf*
3. *WHO, 2008. Tallin Charter: Health System for Health and Wealth. WHO European Ministerial Conference on Health Systems: “Health Systems, Health and Wealth”, Tallinn, Estonia, 27 June 2008*
4. *Mackintosh, M, Channon, A, Karan, A, Selvaraj, S, Zhao, H and E. Cavagnero, 2016. What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. The Lancet http://dx.doi.org/10.1016/S0140-6736(16)00342-1, page 1.*
5. *https://www.ccpsh.org/*
6. *https://www.who.int/health-topics/health-systems-governance#tab=tab_1*
7. *Cross, H, N Jewell and Karen Hardee. 2001. Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs POLICY Occasional Paper. No. 7. Washington DC: The Futures Group International, POLICY Project*
8. *World Health Organisation, 2020. Private Sector Utilization: Insights from Standard Survey Data in Private Sector Landscape in Mixed Health Systems. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.*
9. *GRC20/20, 2019. Policy Management Maturity Model Journey to an Agile Policy Management Programme. Strategy Insight: Governance, Risk Management & Compliance Insight. GRC20/20 Research, LLC.*
10. *World Health Organisation, 2020. Private Sector Landscape in Mixed Health Systems. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.*
11. *World Health Organisation, 2007. Everybody's business -- strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization https://apps.who.int/iris/handle/10665/43918*
12. *World Health Organisation, European Observatory on Health Systems and P, Papanicolas I, Rajan D, Karanikolos M, Soucat A et al. Health system performance assessment: a framework for policy analysis. Geneva: World Health Organization https://apps.who.int/iris/handle/10665/352686.*
13. *Kingdom, J, 1984. Agendas, Alternatives and Public Policies. Boston: Little Brown & Co.*
14. *Cairney, P, 2019. Understanding Public Policy: Theories and Issues: 2. London: Bloomsbury Publishing.*
15. *Roberts, MJ, Hsiao, W, Herman, P and MR. Reich, 2004. Getting Health Reform Right: A guide to improving performance and equity. Oxford University Press.*

ADDITIONAL REFERENCES

Cairney, P, 2019. Understanding Public Policy: Theories and Issues: 2. London: Bloomsbury Publishing.

Clarke D, Doerr S, Hunter M, Schmets G., Paviza A. The private sector and universal health coverage. Bull World Health Organ 2019;97:434–435 (http://dx.doi.org/10.2471/BLT.18.225540.

Cross, H, N Jewell and Karen Hardee. 2001. Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs POLICY Occasional Paper. No. 7. Washington DC: The Futures Group International, POLICY Project

GRC20/20, 2019. Policy Management Maturity Model Journey to an Agile Policy Management Programme. Strategy Insight: Governance, Risk Management & Compliance Insight. GRC20/20 Research, LLC.

Howlett M, Ramesh M, 2003. Studying public policy: policy cycles and policy subsystems. Toronto (ON):Oxford University Press.

Kingdom, J, 1984. Agendas, Alternatives and Public Policies. Boston: Little Brown & Co.

Mackintosh, M, Channon, A, Karan, A, Selvaraj, S, Zhao, H and E. Cavagnero, 2016. What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. The Lancet http://dx.doi.org/10.1016/S0140-6736(16)00342-1.

Roberts, MJ, Hsiao, W, Herman, P and MR. Reich, 2004. Getting Health Reform Right: A guide to improving performance and equity. Oxford University Press.

World Health Organisation, 2007. Everybody's business -- strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization https://apps.who.int/iris/handle/10665/43918

World Health Organisation, 2008. Tallin Charter: Health System for Health and Wealth. WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth", Tallinn, Estonia, 27 June 2008

World Health Organisation, 2020. Private Sector Landscape in Mixed Health Systems. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.

World Health Organisation, European Observatory on Health Systems and Papanicolas I, Rajan D, Karanikolos M, Soucat A et al. Health system performance assessment: a framework for policy analysis. Geneva: World Health Organization https://apps.who.int/iris/handle/10665/352686.

ABOUT THE COUNTRY CONNECTOR ON THE PRIVATE SECTOR IN HEALTH

WHO's Country Connector provides a platform to support countries to manage the private sector's contribution to the response consistent with national health priorities. The Country Connector shares experiences across countries, connects countries to the resources, tools and guidance needed for stronger health system governance and better public policy toward the private sector in health

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