Governance of dual practice in the public and private health sectors

Clearing house briefs series

World Health Organization

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Contents

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

This brief was developed by Gabrielle Appleford (Special Programme on Primary Health Care, WHO headquarters), with Anna Cocozza and David Clarke (Special Programme on Primary Health Care). Substantial review and inputs were provided by Giorgio Cometto (Health Workforce Department, WHO headquarters).

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Abbreviations

CCPSH	Country Connector on Private Sector in Health
LMIC	low- and middle-income countries
MRI	magnetic resonance imaging
OPM	Oxford Policy Management
UHC	universal health coverage
WHO	World Health Organization

Close up of the artwork of Dairo Vargas painted at the Seventy-Second World Health Assembly. Geneva, Switzerland, 2023 © WHO / Violaine Martin

Abstract

Dual practice, the combination of public and private practice in the same or different sites, is ubiquitous in most national health systems. Within the literature, there has been more focus on the dual practice of physicians and specialists, although nurses, midwives and other health workers also engage in the practice. The adverse consequences of dual practice for universal health care vary by context, and evidence is largely descriptive and fails to quantify and analyse its effects. Governance response also remains inherently contextual and varies by level of implementation intensity and capacity. Overall, the effects of different governance tools in response to dual practice remain unexplored in the literature. Studies do not elicit much insight into the process of policy reform in response to dual practice.

Key messages

- Adverse incentives are created by dual practice, including misuse of public sector resources, diversion of patients into private treatment, and induced demand for unnecessary or low priority services
- Dual practice may also create or exacerbate other structural problems such as urban bias in service provision and loss of government control of the health market
- Three main strategies are available to governments in relation to dual practice, to ignore it, to manage it, or to ban it, alongside a logical set of policy responses; however, in general, some form of governance response is preferable, to ensure that dual practice remains within the regulatory and policy jurisdiction of governments
- Forthcoming regulation guidance from the WHO Health Workforce Department recommends regulation to facilitate positive outcomes from dual practice and mitigate its adverse or unintended effects, especially when there is a shortage of health practitioners

Artwork of Dairo Vargas at the Seventy-Second World Health Assembly. Geneva, Switzerland, 2022. © WHO / Laurent Cipriani

Background

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

This brief, the first in the series, explores dual practice in the public and private health sectors. Literature on dual practice was included under the "Enable Stakeholders" governance behaviour of the WHO's Strategy Report on "Engaging the private health service delivery sector through governance in mixed health systems", under the sub-assessment area of health worker regulation. Papers that included dual practice in the title and/or abstract were extracted and analysed for this brief. More information on the methodology used to develop clearing house briefs is available in the Annex. The literature reviewed for the country case examples is included here.

Dual practice: what is it?

Dual practice is ubiquitous in most national health systems. In simple terms dual practice, or dual job holding, is the combination of public and private practice in the same or different sites *(2)*. This may take a variety of forms: private practice provided outside, in a separate private facility; beside, private practice that is physically associated with a public facility; within, for example, private services offered in a public facility but outside of operating hours; or integrated, private services offered alongside standard public ones, often informally *(3).* The provision of private services through online platforms has also emerged, enabling patients to access care virtually *(4).* Of all forms of dual practice, "informal" provision of private services in the public sector are the most difficult to typologize as these may be "illegal, erratic, unregulated and unreported", depending on context *(5)*. Online practice also poses challenges as governments play regulatory catch-up with technology and varied models of virtual care.

Within the literature, there has been more focus on the dual practice of physicians and specialists, although nurses, midwives and other health workers also engage in the practice *(3) (6).* This brief focuses on physicians. Some studies further suggest that dual practice is engendered, with more male physicians engaged in some form of dual practice than their female counterparts *(4) (7) (8)*. Within the literature, there has been less attention paid to the impacts of physician dual practice on other health workers in terms of workload, morale, and behaviour. As described by a participant in a study on absenteeism in Kenya, it was understandable that physicians would seek to practice in the private sector, "they have to make money", but it was also deeply discouraging that a system would facilitate such behaviour *(6)*. Another study from Africa also noted a cascade of informal payments as part of integrated dual practice, starting with the physician, "then the nurse who attends the patient with me also asks for some payment, and so does the attendant. It is a whole set of undue payments" *(5)*.

As suggested, motivations for dual practice, fundamentally come down to financial reward, particularly in low resource settings *(9)*. This is driven by gaps in professional and economic expectations. As illustrated by Russo et al., "If I were paid enough [by the government] don't you think I would gladly give up this life of hopping from one private practice to the other? This is not life!" *(5)*. Even within 'well salaried' health systems, financial reward remains an important motivation *(7)*. Other contributory factors include upholding public responsibility; enlarging professional contacts; access to information and the opinions of influential doctors; access to patients; building reputation and strategic influence; opportunities for professional development and teaching; control over work; social security benefits; and job security *(9) (8) (10)*.

Dual practice: what is the governance problem?

Dual practice presents a challenge for UHC and its associated outcomes, including access to health services, equity, efficiency, and quality of care. The adverse consequences of dual practice for UHC vary by context and evidence remains largely descriptive and fails to quantify and analyse its effects *(11)*. As such, dual practice is considered double-edged, with both negative and positive effects *(9)*. Cited effects found within the literature are outlined in **Table 1**; these may be overt or more subtle *(9)* and evolve over time, in response to the local health market (including out-migration opportunities).

Table 1. Dual practice negative and positive effects

Negative effects	Positive effects
• Longer wait times in the public sector • Lower quality in the public sector • Diversion of patients to private practice • Ignore poor/equity considerations • Contribute to absenteeism, and skimping on hours in the public sector • Contribute to urban bias	• Improve access in the public sector by shifting those with an ability to pay to the private sector • Improve overall productivity of physicians, e.g., number of hours worked • Retain physicians in the public sector • Address budget constraints through retention of physicians, e.g., moderate gap between professional and economic expectations and what public employment can offer • Reduce unofficial payments • Exposure to innovation and technology in the private sector, with the potential to bring this into the public sector

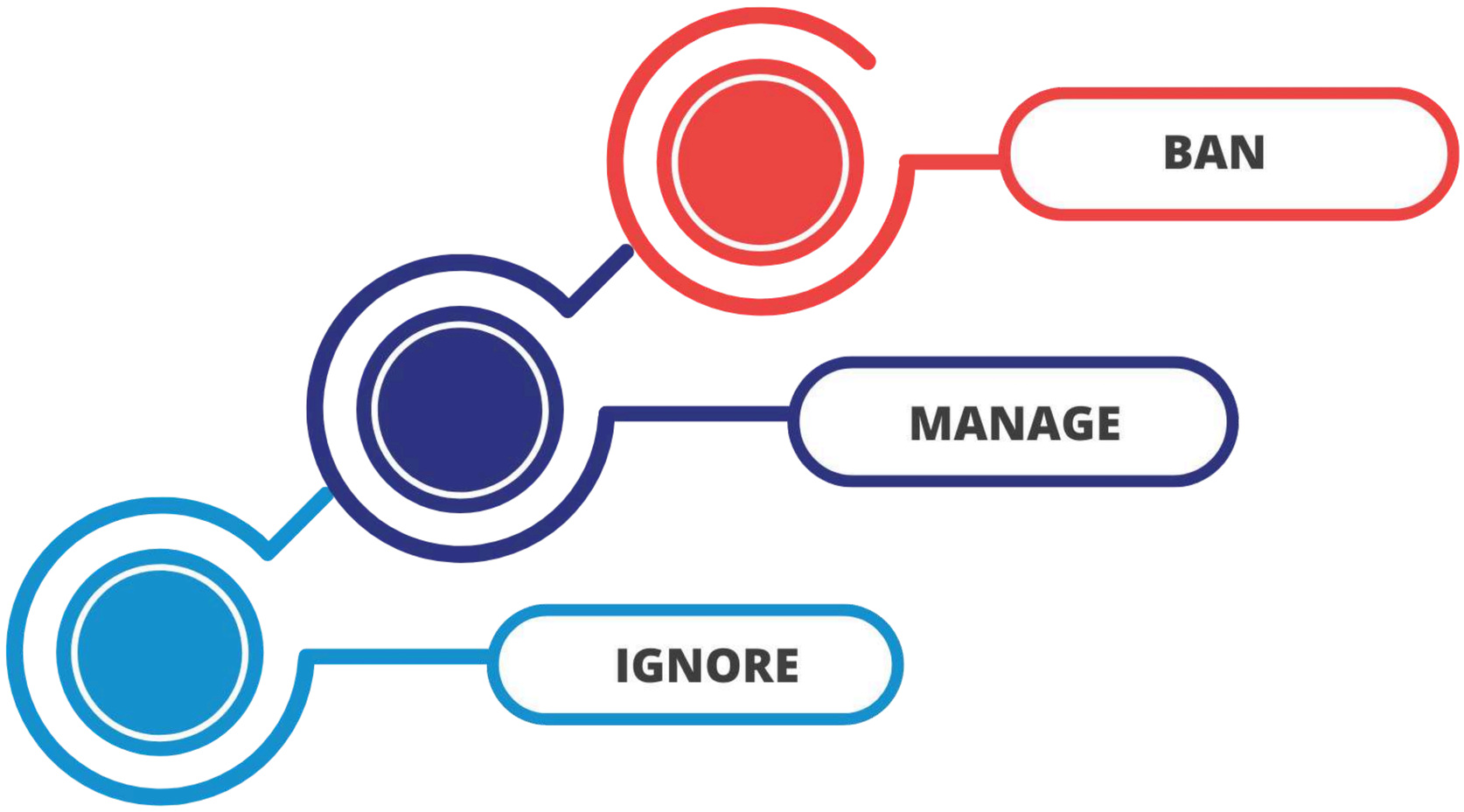
Illustrative of such dynamics, a three city study on dual practice described market contexts by physicians as ‘saturated’ in Praia, Cabo Verde (market covered based on current demand); ‘difficult’ in Bissau, Guinea Bissau (limited demand and uncertainty around recovering initial investment); and ‘aggressive’ in Maputo, Mozambique (increasing competition among physicians) *(5).*

Irrespective of the net effect of dual practice, adverse incentives exist. These include the potential for misuse of public sector resources; diversion of patients into private treatment; and induced demand for unnecessary or low priority services. Dual practice may also create or exacerbate other structural problems such as urban bias in service provision and loss of government control of the health market. In Iran, for example, dual practice was associated with an influx of technology, “we noticed that suddenly the country has become full of magnetic resonance imaging (MRI)” *(12)* with implications for overall functionality and patient trust in the health system. Given this, some form of governance response is indicated as is greater empirical evidence on the effects of dual practice.

Dual practice: what is the policy response?

Three main strategies are available to governments in relation to dual practice, to ignore it, to manage it or to ban it **(Figure 1)**. These strategies have a logical set of policy responses: (i) take no action; (ii) ban or significantly limit dual practice, and (iii) allow dual practice but regulate behaviour in public and private spheres *(3)*.

Figure 1. Strategies in response to dual practice



Banning dual practice is feasible in contexts where private sector competition is weak, public and private care are sufficiently close substitutes and there is regulatory implementation capacity *(13)*. However, these contexts are likely to be few in practice. Within the literature, Canada is one country mentioned which resembles this scenario. In this context, physician dual practice is deemed 'contrary to official regulations' *(13)*, however this is provincially determined, and more recent evidence suggests that dual-practice models are increasingly deployed, including in virtual-care settings *(14)*. Other countries where the practice has been highly controlled include China, Greece, and some Indian states with a similar loosening of restrictions over time or in response to the adverse reactions of physicians.in Greece, and Mumbai, India, for example, banning of dual practice resulted in exodus of physicians and specialists from the public sector *(13)*. The Islamic Republic of Iran also imposed a complete ban on dual practice, which subsequently created the "dilemma of enforcing [national] law but not strictly following it" *(15)*.

In many contexts, strict controls on dual practice presents risks in terms of brain drain of health professionals to other countries, or from the public to the private sectors *(8) (10) (16).* It may also encourage growth of the informal private sector and informal payments within the public sector *(9) (17)*. In resource constrained settings, governments may simply choose to ignore the practice, through either lack of recognition or regulation. In general, some form of governance response is preferable, to ensure that dual practice remains within the regulatory and policy jurisdiction of governments *(9)*. Understanding the basis of strategies is recommended *(13)*, free of ex-ante value judgement of the 'rights and wrongs' of dual practice *(9)*.

Dual practice: what governance tools are deployed?

Governance response remains inherently contextual and varies by level of implementation intensity and capacity. Governance tools also vary, may be deployed singularly or in concert, to either limit the adverse effects of dual practice and/or reward public service. **Table 2** provides examples of governance tools and forms that these may take. On balance, higher income countries have a wider array of limiting and rewarding governance tools at their disposal *(7)*.

While definitive evidence of effectiveness is lacking, the literature describes implementation experience with governance tools.

Table 2. Governance tools and examples

Governance tools	Examples
Regulatory controls	• Private sector entry requirements • Caps on service earnings, quantity and types of services, service hours, location of services • Restrictions on the use of public sector resources for private profit • Employer codes of conduct, and requirements to seek permission from principal employers before engaging in dual practice
Reward/payment systems	• Exclusive contracts for public service • Increase public sector salaries • Establish contracts with private physicians for public service • Performance-based contracts for public service
Information and monitoring	• Patient information/charters, e.g., opening hours, fees and charges, including free-of-charge services, responsibilities towards patients and clients • Information on workplaces in the registry of private practitioners • Monitoring and evaluation of data on practitioner performance or complaints, by consumers or third parties, e.g., civil society, consumer representative forums, insurers or government • Self-regulation by professional bodies, e.g., accreditation, certification, and other means of performance assessment

Regulatory controls

As previously mentioned, outright banning of dual practice is seldomly enacted or implemented and may only be viable under specific market conditions. This option was considered in a country in the Mediterranean region in 2014 alongside proposals to increase health workers' salaries, close existing private clinics and not approve new licenses, and ban private hospitals from hiring public sector employees *(16)*. However, before proceeding, the Ministry of Health, with World Bank support, undertook an analysis of the potential impacts of the proposed reforms and found that an outright ban on dual practice would not have the intended policy outcomes. A key reason for this was financial, as dual practice reform had not been budgeted for; secondly, the proposed measures did not consider compensation plans for nurses and paramedical staff. The study itself provided an opportunity for consulting those most directly impacted by such reforms, health workers themselves.

In lieu of outright bans, restrictions on dual practice are more common; and, if governed well, they have been shown to shape patterns of dual practice. The three-city study from Africa *(5)* is instructive. In Praia, Cabo Verde, where governance was considered strong, there was evidence of the protection of the "public characteristics of services within time and space boundaries"; private sector activity was 'outside' of public space (in terms of both time and space) where it was formally recognized as dual practice. In contrast, in Bissau, Guinea Bissau, there was greater ungoverned practice as this was integrated within public space (in terms of both time and space). This situation was also reflective of the market conditions found in Guinea Bissau where there was lower patient ability to pay, and therefore limited potential profitability for 'outside' private practice.

Studies from Southeast Asia also suggest more regulated forms of dual practice. In Viet Nam, for example, dual practice is promoted by government as a means of addressing current and projected shortages of physicians in the country *(8)*. In this context, a variety of choices of dual practice are available for public hospital physicians with the government actively encouraging the development of 'outside' practice in private health facilities. In Cambodia, the Ministry of Health estimated that just over two thirds of physicians operate or work in private practice; this was based on the number of consultation cabinets, clinics, polyclinics, and private hospitals in the country with the majority of patients utilizing these services *(10)*. In this and neighbouring countries including Viet Nam and Indonesia, dual practice is often carried out after public working hours *(11)* and therefore restricted.

Reward/payment systems

Reward/payment systems are a feasible option in higher income contexts and have been employed in a number of countries. These can take different forms, such as exclusive contracts, which entail payments to public sector staff in return for their agreement not to engage in private practice. These may be combined with regulatory controls on dual practice or applied singularly. In the Norwegian context, where dual practice is not banned or regulated, dual job holding declined by thirty percent over the period 2001 to 2009 *(7)*. This was attributed to increasing the hourly rate for extended working hours in hospitals, a policy that was instituted in 1996 to ensure a sufficient labour force *(7)*.

This achievement was in the context of a largely publicly financed health system with strong regulation of patient and health worker rights. Other countries that have introduced exclusive contracts include Spain, Portugal, Italy, Thailand, and some Indian states, with varying effects *(11)*. In low- and middle-income country (LMIC) contexts, income satisfaction through exclusive contracts and competitive salaries may be prohibitively costly; rough estimates suggest that salaries would need to multiplied by at least a factor of five to be competitive with what is offered in the private sector *(11)*. Reward/payment policy tools may also neglect other cadres, such as nurses, and create friction between professional groups *(9)*.

Output or performance-related pay, as an alternative to fixed salaries, were also referenced, however, these were not a primary focus in the literature reviewed for this brief. Of mention, were the performance-based contracting schemes, introduced in Cambodia in 2009-2010 and funded through donor programmes, which included 'golden rules' (e.g., basic rules of reciprocity) as a means of discouraging private practice *(10)*. However, it is uncertain if these so-called golden rules continue to influence dual practice, nor is it recommended that performance-based contracting replace fixed salaries.

Information and monitoring

The lack of information on physician dual practice, has been a major focus of studies. This is in recognition that a failure to understand "why, how and to what extent health workers engage in dual practice" *(3)* limits understanding of health system effects and the effectiveness of governance response. Within the reviewed literature, only the Norwegian context drew on routine health information, via a hospital physician registry, as the basis for longitudinal study. Other forms of information and monitoring were referenced but not elaborated in the literature reviewed for the brief. Some, such as self-regulation by professional bodies and monitoring through third parties, were noted to have been used with good effects, including in LMICs *(9)*.

Tools with teeth

Overall, the effects of different governance tools in response to dual practice remain unexplored in the literature. Studies do not elicit much insight into the process of policy reform in response to dual practice. Notable exceptions include a Hungary study which explored health policy reforms introduced in 2020 to counter shortages of health professionals, low public financing, and informal payments in the public sector *(17)*. This reform was 'pressurized' by the COVID-19 pandemic and pushed through hastily with limited consultation. It introduced physician employment status akin to that of the armed forces, alongside a 120 per cent salary increase and criminalization of informal payments. The reform met with strong resistance from the medical fraternity and wider society (highlighting the active role patients play in perpetuating dual practice). As concluded in the paper, *"indispensable legitimacy [of reform] is unlikely to be established without wide and meaningful social consultations involving all stakeholder groups" (17)*.

In contrast, the analysis described in the country in the Mediterranean region was instigated by Ministry of Health to inform policy on dual practice. The conclusions from this work provided for a more measured response. Specifically, that reform be sequenced over time, be piloted and monitored, retain flexibility over design, be executed in the context of broader sectoral reforms, take into account intrinsic and extrinsic motivations of health workers, and be costed and feasible within the available fiscal space *(16)*.

Conclusions

Many ministries of health have defined models of care for their populations; these outline how services should be delivered, including the processes of care, the organization of providers, and the management of services. Dual practice has implications for models of care (both conceptually and in practice), in particular, referral care pathways. Dual practice may also be leveraged as part of models of care (again both conceptually and in practice). However, this is only feasible if there is some form of governance response, as part of the regulatory and policy jurisdiction of governments. This is mission critical in many contexts, in light of human resources for health crises and health worker migration. More case studies on policy interventions on dual practice in different contexts are needed as well as greater understanding of the 'why, how, extent and effects' of governance responses to dual practice, and its evolution over time.

Forthcoming regulation guidance from the WHO Health Workforce Department recommends regulation to facilitate positive outcomes from dual practice and mitigate its adverse or unintended effects, especially when there is a shortage of health practitioners *(18)*.

About the Clearing House

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

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Annex. Methodology

Contributors

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Introduction

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

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

Strategic frame

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

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

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

Box A1. Governance behaviours definitions

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

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

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

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

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

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

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

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

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

Search strategy development

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

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

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

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

Guiding questions, sub-assessment areas and key terms

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

Deliver Strategy

Guiding questions

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

Sub-assessment 1. Private sector inclusion within NHPSPs

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

Sub-assessment 2. Policy reform/processes

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

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

Align Structures

Guiding questions

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

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

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

Sub-assessment 2. Priority public health programmes

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

Sub-assessment 3. Quality of care and referral systems

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

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

Enable Stakeholders

Guiding questions

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

Sub-assessment 1. Facility registry and licensing

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

Sub-assessment 2. Training institutions

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

Sub-assessment 3. Registration and licensing of health professionals

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

Sub-assessment 4. Pharmacy licensing

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

Sub-assessment 5. Anti-trust/economic regulation

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

Sub-assessment 6. Private health insurance

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

Sub-assessment 7. Purchasing and contracting

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

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

Build Understanding

Guiding questions

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

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

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

Sub-assessment area 2: routine service statistics

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

Sub-assessment area 3: data for decision making

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

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

Foster Relations

Guiding questions

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

Sub-assessment 1: Private sector organization

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

Sub-assessment 2: Public sector organization

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

Sub-assessment 3: Coordination platforms

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

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

Nurture Trust

Guiding questions

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

Sub-assessment 1. Conflicts of interest

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

Sub-assessment 2. Role of intermediaries

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

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

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