INTRODUCTION

The concept of “health system governance” incorporates a wide variety of steering and rule-making functions carried out by governments in pursuit of policy goals. The “mixed health system model” – in which commercialized provision of health services in the private sector coexists with free or low-cost care in the public sector - is the norm in low- and middle-income countries (LMICs).¹ In this model, financial, managerial and performance gaps in the public sector combine with “market failures” in the private sector to exacerbate inequities in access and financial protection (see Box 1). Several leading global health agencies have noted that this is a model which calls for effective cross-sectoral approaches to health system governance. Some have called on LMIC governments to develop strategic options for private sector engagement (henceforth: PSE) and build capacity to implement these.²

However, the response to this call has so far been muted. Most LMIC governments focus most of their attention on the public sector – e.g. broadening the base of financing or addressing performance problems within organizations and facilities directly administered by the state - while the private sector is (usually) a more peripheral concern.

That is not to say that government are entirely inactive in this regard. Ministries of Health (MoH) usually have in force a small number of process-oriented regulations for the private sector – such as setting compulsory standards on premises, or certifying professional qualifications. However, far less attention is paid to actual performance – e.g. the range of products and services that are

²As reflected in the 63rd WHA, which passed a resolution on Strengthening the Capacity of Governments to Constructively Engage the Private Sector in Providing Essential Healthcare Services.
Box 1. “Failures” and other incentive problems in healthcare markets

It is a commonplace that markets in healthcare “fail” to maximize social welfare in a number of specific ways. Suppliers in markets distribute goods (products and services) to individuals according to their demand for them, a concept that includes willingness and ability to pay.

However, in healthcare, individuals may not have the information needed to make the “right” choices about what to buy, or how much to pay, and so they may have demand for the “wrong” things – e.g. goods that will not effectively prevent, diagnose, or treat illness. In some cases, demand for such goods may also be “induced” by suppliers, exposing the patient to health and financial risks.1

For example, the demand for some highly cost-effective goods is far lower than is optimal from a public health point of view – e.g. the demand for preventive health goods is much lower than is required to achieve key goals in relation to immunization, or the prevention of malaria or water-borne diseases, so that people are reluctant to pay even very low prices for them.1 In addition, patients are often unable to assess the safety, efficacy and quality of goods available from different providers, and make ill-informed decisions about where to receive care.

This means that low-quality providers can enter markets and sustain their activities (however damaging to the health interest) for long periods, as patients continue to purchase their products and services. And finally, of course, patients may be unable to access the health products and services they “need” - simply because they lack the funds to buy them or can do so only by foregoing other basic necessities (food, fuel, shelter etc.).

WHO Private Sector Roadmap) that can be regarded as the ‘software’ of PSE;4 as well as

2. design and implement new policy frameworks, incorporating novel tools and strategies, that will reliably influence the incentive and accountability environment in which the private sector operates - which can be regarded as the ‘hardware’ of PSE.

The aim of this report is to present a set of evidence-based principles that will help to influence (a) how stewardship behaviors are realized, and (b) how new policy frameworks and tools are

delivered in the private sector, the quality of the outputs delivered (e.g. their safety, appropriateness, efficacy and so forth), or their prices (which are usually paid by users directly). This represents a partial and inadequate approach to health system governance - especially when services are predominantly provided in the commercial market, as is the case for many critical service areas, in many countries.3

To address this gap, governments will need to develop or enhance their capabilities to:

1. adopt a set of relevant ‘governance behaviors’ (as outlined in the current

---

3Research shows that the private sector is the dominant source of treatment for children with diarrhea, fever or cough in a sample of 70 LMICs. See: Grepin, K. 2016. Private Sector An Important But Not Dominant Provider Of Key Health Services in Low- And Middle-Income Countries. Health Affairs 35, no.7. 1214-1221.

4The Advisory Group on the Governance of the Private Sector for UHC. Engaging the private health service delivery sector through governance in mixed health systems. December 2019. Impact for Health/WHO.
deployed to effectively serve the public health interest. Through a comprehensive document analysis, alongside a set of key informant interviews with senior staff in WHO departments, WHO regional offices, and key development partners and INGOs⁵ we identified four principles of effective PSE that should underpin such efforts:

- Principle (1) Well-functioning mixed health systems rely on strong governance
- Principle (2) Effective PSE approaches are defined by “problems” not “solutions”
- Principle (3) Successful governance of the private sector requires good data
- Principle (4) The private sector needs to be engaged in a meaningful dialogue

Below, each of these principles is outlined and explained in detail.

THE PRINCIPLES OF ENGAGEMENT

Principle (1) Well-functioning mixed health systems rely on strong governance

As Box 1 highlights, without government intervention, markets in healthcare fail to provide the “right” range of services, to the “right” people, at the “right” price. Governments need to intervene in health markets to correct such failures - and, more generally, ensure that incentives and activities in the market are aligned with health policy goals, such as UHC.

There are a number of well-functioning health systems in which policymakers have learned how to do this – how to govern markets in the health system in ways that reliably address key failures.

This approach to indirect governance (i.e. governance over parts of the health system legally outside of the state) is based on the routine deployment of private sector-focused ‘tools of government’ (see Box 2).

Tools of government, then, are mechanisms used by policymakers to shape the incentive and accountability environment in which market actors operate. In well-functioning health systems, governments tend to deploy such tools as a ‘package’, which influences different aspects of a market’s operation simultaneously. For example, a financing tool (vouchers or insurance) can be used to strengthen demand for essential health services, while a regulatory tool (accreditation or licensing) can ensure that demand is addressed only by competent providers. Demand-side information can also be used, e.g. to inform patients’ decisions about what to ‘buy’ (and from whom), while market information can be provided so that providers understand patient demand and preferences, shaping key decisions regarding investment and promotion.

Our review of the institutional arrangements that exist in well-functioning mixed health systems reveals a pattern: some service areas are more market-oriented than others

⁵See the acknowledgments section for a list of the experts consulted in the research. The authors are fully responsible for any inaccuracies in this report, and it is not necessarily the case that the experts consulted endorse the analysis herein.
Box 2. Stewardship of the private sector using ‘tools of government’
In the public policy literature, mechanisms used by states to influence the behavior of individuals and organizations in response to a defined problem (e.g. reducing financial barriers to access; enhancing the supply of products and services; enhancing the level of demand for qualified medical knowledge; ensuring that only safe, effective and appropriate care is available to the population) are called tools of government. First, Financing Tools - such as grants, loans, voucher payments and contracts - are used to increase consumption of goods that would be under-utilized in a ‘free’ market. Second, there are several Regulatory Tools that rely on the state’s power to compel certain behaviors, and/or prohibit others, or use information to ‘nudge’ actors’ behaviors towards alignment with policy goals.

Figure 1. The tools of government for indirect governance of the private health sector

<table>
<thead>
<tr>
<th>Financing Tools</th>
<th>Regulatory Tools</th>
<th>Information Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand-side (vouchers, insurance) Supply-side (contracts, grants, loans)</td>
<td>Social (licensing, certification, accreditation) Economic (anti-trust)</td>
<td>Demand-side (patient information) Supply-side (market information)</td>
</tr>
</tbody>
</table>

This variation between services is widely recognized, even if the reasons for it are less understood. Experts point to two key features of service-specific markets that seem to influence governance approaches: (i) the degree of “contestability” in the market (i.e. how competitive it is) and (ii) the “measurability” of the related product(s) (i.e. how easy it is to specify what we ‘want’, and verify whether this is being obtained). For example, the pharmacy sector tends to be highly competitive because barriers to market entry are low; and, also, the required ‘products’ are relatively easy to specify and verify. Therefore, a limited package of regulatory tools – often focusing on licensing, as a means of ensuring that only qualified providers are able to operate in the market – have in practice

---

Most retail pharmacies in France are privately owned and operate in a competitive market, in which patients are free to choose from whom they buy their medicines. However, the incentive and accountability environment in which providers operate is highly regulated. To maintain their license and be eligible to receive social insurance reimbursement, pharmacists must abide by a range of regulations relating to key aspects of provision, including dispensing, opening hours, and quality standards. In addition, pharmacists must maintain their registration with the relevant professional body. Prescription prices are standardized, based on outcomes from a process of public-private dialogue institutionalized under a government commission. Patients are reimbursed for the majority of their costs under the social insurance scheme (mostly funded via income-based contributions, topped up by general government budgets), and make a co-payment only if they request a branded drug rather than a generic equivalent.

In this market, a combination of financing and regulatory tools are being deployed to:

- Create the rules in which retail pharmacies are legally obliged to operate (economic regulations), enabling public agencies to influence both the nature and extent of provider-patient interactions;
- Enforce quality standards (social regulations) and encourage the retail pharmacy sector to take additional responsibility for quality assurance via co- and self-regulation; and
- Facilitate voucher-style payment to pharmacies (i.e. social insurance reimbursement for eligible providers) (financing), supporting access, and ensuring that money follows the patient.

The result is that, while the retail pharmacy sector in France is largely owned by the private sector, the government is able to create an incentive and accountability environment that safeguards quality of care, value for money, and, to a large extent, equity of access (at least for the insured population).

Box 3. Regulating retail pharmacies to ‘harness’ market forces for the public interest

Most retail pharmacies in France are privately owned and operate in a competitive market, in which patients are free to choose from whom they buy their medicines. However, the incentive and accountability environment in which providers operate is highly regulated. To maintain their license and be eligible to receive social insurance reimbursement, pharmacists must abide by a range of regulations relating to key aspects of provision, including dispensing, opening hours, and quality standards. In addition, pharmacists must maintain their registration with the relevant professional body. Prescription prices are standardized, based on outcomes from a process of public-private dialogue institutionalized under a government commission. Patients are reimbursed for the majority of their costs under the social insurance scheme (mostly funded via income-based contributions, topped up by general government budgets), and make a co-payment only if they request a branded drug rather than a generic equivalent.

In this market, a combination of financing and regulatory tools are being deployed to:

- Create the rules in which retail pharmacies are legally obliged to operate (economic regulations), enabling public agencies to influence both the nature and extent of provider-patient interactions;
- Enforce quality standards (social regulations) and encourage the retail pharmacy sector to take additional responsibility for quality assurance via co- and self-regulation; and
- Facilitate voucher-style payment to pharmacies (i.e. social insurance reimbursement for eligible providers) (financing), supporting access, and ensuring that money follows the patient.

The result is that, while the retail pharmacy sector in France is largely owned by the private sector, the government is able to create an incentive and accountability environment that safeguards quality of care, value for money, and, to a large extent, equity of access (at least for the insured population).
contentious, markets through indirect governance.

In well-functioning mixed health systems, governments have managed to do so. For example, they have built and sustained the organizational capabilities (underpinned by substantial public financing) required to specify and verify required standards of primary health care. Hence, health systems in these countries are able to take advantage of the benefits of private provision (e.g. greater responsiveness to patient preferences and strong incentives to manage costs) while ensuring that patients’ interests are protected, in essential health services (see Box 4).

In contrast, governments typically find it more difficult to adequately specify and verify the range of services provided in more complex service areas, such as acute inpatient care. Effective governance in such areas requires a far more interventionist approach (and therefore much stronger government capacity). Indeed, even in many well-functioning mixed health systems, governments have taken steps to ensure that most acute inpatient care providers (i.e. hospitals) are predominantly owned by the public sector and/or not-for-profit organizations.

Figure 2. The balance between public and private provision varies across service areas
Box 4. Indirect governance of health markets through using a ‘package’ of tools of government

In the majority of OECD member states, primary care services to the population through a large number of small-scale clinics – operating as SMEs. As Table 1 (below) shows, primary care is in this sense predominantly a small-scale private sector ‘industry’, in most OECD countries. However, it is an industry that is heavily regulated by governments – indeed, to such an extent that it resembles in many respects a public sector ‘industry’ (and may be perceived as such by patients!). These OECD countries rely on indirect governance (i.e. deployment of a range of tools) to ensure that private provider actions are aligned to public health objectives:

- Delegate authority to professional bodies with the legal power to control entry into the ‘industry’ and the responsibility to assure members continuously quality meet standards in providing goods/services (social regulations);
- Provide grants and service contracts to address spatial inequities in access (supply-side financing); and
- Facilitate voucher-style payment to clinics (i.e. government/insurance reimbursement for eligible providers) supporting access and ensuring that money follows the patient (demand-side financing).

Table 1. Predominant form of ownership and the share of total primary care provision accounted for by the private sector ‘segment’ in 26 OECD countries

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PREDOMINANT OWNERSHIP</th>
<th>PRIVATE SEGMENT %</th>
<th>COUNTRY</th>
<th>PREDOMINANT OWNERSHIP</th>
<th>PRIVATE SEGMENT %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Private</td>
<td>89</td>
<td>Japan</td>
<td>Private</td>
<td>-</td>
</tr>
<tr>
<td>Austria</td>
<td>Private</td>
<td>80</td>
<td>Korea</td>
<td>Private</td>
<td>-</td>
</tr>
<tr>
<td>Belgium</td>
<td>Private</td>
<td>75</td>
<td>Luxembourg</td>
<td>Private</td>
<td>-</td>
</tr>
<tr>
<td>Canada</td>
<td>Private</td>
<td>52</td>
<td>Netherlands</td>
<td>Private</td>
<td>54</td>
</tr>
<tr>
<td>Denmark</td>
<td>Private</td>
<td>-</td>
<td>New Zealand</td>
<td>Private</td>
<td>52</td>
</tr>
<tr>
<td>Finland</td>
<td>Public</td>
<td>88</td>
<td>Norway</td>
<td>Private</td>
<td>-</td>
</tr>
<tr>
<td>France</td>
<td>Private</td>
<td>65</td>
<td>Portugal</td>
<td>Public</td>
<td>100</td>
</tr>
<tr>
<td>Germany</td>
<td>Private</td>
<td>76</td>
<td>Spain</td>
<td>Public</td>
<td>97</td>
</tr>
<tr>
<td>Greece</td>
<td>Private</td>
<td>60</td>
<td>Sweden</td>
<td>Mixed</td>
<td>-</td>
</tr>
<tr>
<td>Iceland</td>
<td>Public</td>
<td>95</td>
<td>Switzerland</td>
<td>Private</td>
<td>-</td>
</tr>
<tr>
<td>Ireland</td>
<td>Private</td>
<td>-</td>
<td>Turkey</td>
<td>Public</td>
<td>-</td>
</tr>
<tr>
<td>Israel</td>
<td>Public</td>
<td>-</td>
<td>UK</td>
<td>Private</td>
<td>90</td>
</tr>
<tr>
<td>Italy</td>
<td>Private</td>
<td>65</td>
<td>United States</td>
<td>Private</td>
<td>90</td>
</tr>
</tbody>
</table>

Source: Data is from primary care and outpatient specialist services from OECD Health System Characteristics Survey 2012 and 2016. Analysis by Mirja Sjoblom, Senior Economist, World Bank

As Table 1 makes clear, OECD countries have achieved private provision of private health care through different paths based on the selection and combination of the tools of government. Regardless of the path chosen, the majority of public and private primary care clinics are reimbursed for the cost of service-delivery through social insurance (sometimes referred to as the Bismarck Model) or by government directly in NHS-style system (also referred to as the Beveridge Model), and face a range of regulations they must comply with to remain eligible for such payments.
Principle (2) Effective PSE approaches are defined by “problems” not “solutions”

Development partners play an important role in providing technical support to MoHs in LMICs. Officials tend to view development partners as sources of objective, evidence-based advice. However, development partners’ advice can be influenced by organizational priorities, or swayed by the latest development ‘fad’ in PSE. If there is over-reliance on pre-designed solutions – a process called “isomorphic mimicry” – this can lead to negative impacts from PSE (see Box 5).

Indeed, the history of health system strengthening in high-income countries highlights this key attribute of effective PSE: the focus on problems as the driver of solutions. After the Second World War, governments in western Europe, Canada and Japan faced a common set of problems. However, each country responded in a unique way, according to an in-depth

Box 5. Avoiding “Maslow’s Hammer”

“I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail.” Abraham Maslow, The Psychology of Science, 1966.

The concept known as “Maslow’s Hammer” is a form of cognitive bias that stems from over-reliance on an available tool. Increasingly, LMICs are establishing specialist public private partnership (PPP) units, and are drafting legal and regulatory reforms that encourage health authorities to undertake specific forms of PPP. In this context, Ministries of Health are armed with a hammer – a highly complex tool that bundles together in a single contract an extensive range of complex services – and they need only to find a suitable nail. The consequences of this process – finding a problem to match a solution - can be dire. In 2008, the government of Lesotho procured a PPP project incorporating the part-financing, construction and operation of a 425-bed hospital, a gateway facility and three ‘filter’ clinics in Maseru. The transaction was modeled on PPP contracts undertaken for similar infrastructure in high-income countries – though it was more ambitious in terms of the range of activities transferred to the private sector – which included primary, secondary and tertiary care services. The Ministry of Health in Lesotho had limited capacity to plan, procure, manage and pay for this deal, leading to a monopolistic procurement process (there was only one bidder), errors in the payment mechanism (the failure to share demand risk with the private sector) and severe affordability problems, leading to a distortion of government resources to acute care and, ultimately, a series of creditor defaults (as delays in payment undermined the ability of the contractor to meet scheduled debt payments).

understanding of the problems to be addressed and an objective appraisal of existing governance capabilities.

A key development across these countries was the attempt to insulate people from direct healthcare costs. Most governments explored a range of strategies and introduced some form of financing tool: in some cases, a voucher-style payment to individuals (i.e. insurance), and/or direct ownership of the public health delivery system. These reforms reduced the direct individual costs of service use, thereby enhancing equity of access and financial protection. However, these reforms also created new “problems” – the increased demand for, and the rising cost of, healthcare. Accordingly, several countries introduced new tools of government aimed at containing costs without reducing quality of care – a goal that included an increase in government ownership in some service areas (especially acute care) but, in most other areas, a strengthening of indirect governance capabilities, and a shift from ‘passive’ to ‘strategic purchasing’ approaches with respect to the (often quite extensive) private sector.

There were some common features in the responses. For example, in the retail pharmacy sector, all countries required service providers to be licensed and/or contracted by state agencies. However, there were important differences in the range of tools deployed. For example, in the United States, government agencies achieved downward pressure on prices largely through incentives and requirements put in place by insurance companies (including social insurance organizations), thereby impacting whole supply chains, while in Canada, and in western Europe, government achieved equivalent effects through centralized price regulation.

These experiences highlight how effective PSE activity needs to be founded on how the market system needs to change to address a prioritized problem. The solution to be implemented needs to match that problem (i.e. what actors and actions are implicated in the problem; how can incentives be re-shaped to change related behaviors, and what capabilities - e.g. what skills, what data, what dialogue platforms - are needed to implement the required tools of government). As such, they provide a useful source of information to guide the future PSE efforts of LMICs without encouraging direct mimicry or adoption of pre-defined solutions.

**Principle (3) Successful governance of the private sector requires good data**

Designing sound policy to harness private sector capacity to advance UHC objectives requires sound data.

How, for example, can a government enter into contracts with a network of primary care providers without knowing some basic facts, such as how many providers the network includes, and where they are located? How can you determine if quality is good or bad in the network without data on the

---


quality standards in use, or the status of self- or peer-regulation in the field? All LMIC governments collect (at least some) equivalent data for public sector providers – and often, also, faith-based and non-governmental organizations (FBOs and NGOs). However, data on the private sector, in particular the for-profit sector - are often lacking.\textsuperscript{10} This has not prevented Ministries of Health in LMICs from designing health policies and regulations that have a material effect on private sector activities – for better or worse.

Box 6 illustrates how such well-intended policies and programs can go wrong in this context.

Data on the private sector is typically poor in LMICs, for several reasons:
• Government’s attitude that the private sector is ‘someone else’s problem’ means that it is not regarded as a priority to collect data on it.
• Development partners do not recognize the private sector’s contribution to healthcare supply, and therefore do not routinely collect data on related activities.
• Government agencies may not have the systems or staff to undertake the necessary data collection.
• LMICs Ministries often lack the capacity to analyze data, particularly market data, on private sector activities.
• On the private sector side, private providers do not report to the Ministry of Health for fear of increased taxation and other forms of state scrutiny.
• Lack of reciprocity (i.e. MOHs often do not consistently share information - particularly on policy reforms and regulatory changes).

There is a growing experience in

\textsuperscript{10}Based on USAID and World Bank experience of conducting over 36 private health sector assessments.
collecting data on the private health sector in LMICs (NB. our focus here is on local data collection approaches). There are different types of research approaches and they fall into four broad categories: (i) Sector Analysis; (ii) Health Market Analysis or feasibility studies that relate to a specific sub-market or a market related to a particular procurement; (iii) Provider Research; and (iv) Consumer Research (see Figure 3).

Each of these approaches aims to address basic facts about the market, including:
- The scale and composition of the private health sector;
- The product/service areas it works in;
- The consumer groups for which they perform these activities;
- Any geographical locations and urban/rural division;
- Their approaches to revenue collection, and the prices being charged; and
- Policy-relevant aspects of demand (e.g. preferences and price/income elasticities).

The following is a brief description of each approach outlined in Figure 3.

- **Private health sector assessment (PHSA).** The PHSA is considered the “gold standard” in this research area because it allows policymakers to explore the full range of market actors relating to a specific product or service area. The PHSA draws on existing data sources – both international (Demographic Health Surveys, National Health Accounts, World Bank Statistics), domestic sources (MOH service statistics, legal frameworks and regulations, and national health sector and financing strategies) as well as

---

**Figure 3. Types of data collection exercises relating to the private health sector in LMICs**

**Sector Analysis**
Private Health Sector Assessment

**Health Market Analysis**
Market Scoping Exercise; Project-Specific Analysis

**Provider Research**
Facility Census; Provider Knowledge, Attitudes, Perceptions (KAP) Research

**Consumer Research**
Patient Pathway Analysis; Consumer Health Seeking Behavior and KAP Research

---

\[11\] The PHSA approach was developed with support from USAID and World Bank. Consult [https://assessment-action.net/](https://assessment-action.net/) for more information on the methodologies employed.
the published literature. However, primary data is also collected in-country. For example, stakeholder interviews are conducted with a broad range of public and private stakeholders in both urban and rural settings to complement the review of secondary sources. Box 7 illustrates the types of data generated by the PHSA.

- **Health Market Analysis.** Many approaches are used to provide a descriptive account of a health market’s core characteristics (e.g. Box 8 shows the type of data generated from Market Scoping Exercises). Such methods can serve to make the private sector more ‘legible’ to policymakers, thereby providing a starting point for diagnosing problems, identifying the most promising opportunities for leveraging the private sector, and ensuring that the right organizations are ‘at the table’ when defining PSE policies and/or implementing them in the market. International consulting firms, such as PricewaterhouseCoopers and KPMG, have developed standardized approaches to market-scoping, based on methods used in other sectors. Development Banks have also developed similar tools to determine the viability of private investments in specific health markets/businesses, alongside methods for conducting financial and economic analysis for public-private partnerships.

- **Provider Research.** Both qualitative and quantitative methods are used to collect data on private sector providers, their location, their capacities and interests. In high-income countries, a lot of useful data is collected through routine regulatory systems (e.g. facility licensing, HR certification, accreditation, facility inspections and capital planning processes). In contrast, LMICs do not always have these tools in place - and if they do, they do not collect the data systematically. Moreover, the private sector under-report to DHIS – health information system widely used in LMICs. To compensate for this gap, an increasing number of LMICs are investing in master facility lists, facility census and GIS mapping. The quantitative data is combined with qualitative data to
assess: (i) what the private sector can feasibly offer in terms of PSE (e.g. its clinical skills, infrastructure, quality standards, etc.), (ii) its willingness to partner with government, and (iii) the key barriers to partnership (e.g. regulatory, market conditions, access to capital, business skills, etc.).

- **Consumer Research.** In high-income countries, larger healthcare groups will tend to collect data on key aspects of consumer behavior and preferences, including the service and product attributes most valued by consumers, and how these differ among consumer groups (e.g. different demographic, socioeconomic, education and gender groups). This type of research assists businesses to adapt their resource allocation and marketing decisions to expand their market share and revenues. In most cases, they hire marketing firms that specialize in healthcare. Key actors in the global health community, through implementing partners such as Population Services International and Johns Hopkins Population Center, have leveraged traditional consumer research methodologies in OECD markets and applied them to health in LMICs. Of the three methodologies most used, focus groups and exit interviews are the most common while opinion polls and consumer surveys less so. Box 9 shows the type of data collected.

While not specifically designed to focus on the private sector, the Patient Pathway Analysis (PPA) method is also relevant as a methodology to understand patient use of public and private services. This approach describes the steps that individuals with a specific need, like treatment for tuberculosis, or maternity care, take between their initial presentation of their symptoms to cure. The results of a PPA reveals key gaps in care-seeking, diagnosis, treatment initiation, and continuity of care (whichever sector such gaps relate to), and can be used as inputs into an evidence-based process of identifying and developing private sector engagement actions to address gaps in patient care.

Collecting data on the private health sector is expensive. The cost can range from as little as $25,000 for a small-scale

<table>
<thead>
<tr>
<th>Box 8. Data generated by market research</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Market size</td>
</tr>
<tr>
<td>• Effective demand</td>
</tr>
<tr>
<td>• Market segments</td>
</tr>
<tr>
<td>• Market trends</td>
</tr>
<tr>
<td>• Market barriers</td>
</tr>
<tr>
<td>• Market competition</td>
</tr>
<tr>
<td>• Cost</td>
</tr>
<tr>
<td>• Price</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Box 9. Data generated by consumer research</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Current demand</td>
</tr>
<tr>
<td>• Potential demand</td>
</tr>
<tr>
<td>• Consumer preferences for providers / products</td>
</tr>
<tr>
<td>• Consumer ability to pay</td>
</tr>
<tr>
<td>• Consumer willingness to pay</td>
</tr>
</tbody>
</table>
market scoping exercise, to $150,000 for a comprehensive PHSA, and even $500,000 for a large-scale project such as a nationwide facility census. However, governments should not shy away from making such investments. So long as a government is clear about what the research is for, how it will be used, and how this will help contribute to strategic objectives, the research is likely to generate significant net returns in better problem-identification and policy design. In addition, data can also help to raise awareness of the private sector as a cause of, and a potential source of solutions to problems that have been prioritized by local actors. Indeed, both PHSA and Patient Pathway Analysis have helped, and are helping, to raise policymakers’ awareness of problems with regard to the private sector. Box 8 offers guidance in selecting which research to undertake.

Principle (4) The private sector needs to be engaged in a meaningful dialogue

In the past two decades, a new development paradigm has emerged. Increasingly, development partners, governments, and private health sector alike agree that sustainable development requires all key players to work together for change. Several factors have contributed to this change in view:

- The long history of failed development approaches that focus exclusively on strengthening the state and its administrative apparatus.
- The increasing emphasis governments place on participation and dialogue as methods for bolstering their legitimacy, fostering transparency and strengthening accountability.

- Changing expectations about the role of non-state actors in policy processes, demanding greater transparency and accountability between governments and those actors.

The experience of high-income countries suggests that successful collaboration in the health sector requires effective engagement and dialogue. High-income countries have a long tradition of working with the private health sector through established, formal mechanisms to tackle difficult issues - such as physician reimbursement, benefit packages and quality assurance. For example, in France, as we have seen, prescription prices are standardized, based on outcomes from a public-private dialogue (PPD) platform organized under a government commission. Similarly, in Germany, the fixed “per case” prices of hospital services are negotiated between sickness funds

Box 11. Definition of PPD

“PPDs are structured mechanisms – both temporary and permanent – anchored at the highest practical level, coordinated by a light secretariat, that facilitates a process involving a balanced range of public and private sector actors to identify, filter, prioritize, accelerate, implement, and measure policy reforms and actions.”

(Adapted from Herzberg, 2011)
and hospital organizations through a dialogue platform that brings together a wide range of stakeholders (providers, insurers, unions, employers, and state actors) at the national level. In primary care, high-income countries have a variety of procedures in place but, in each case, a platform exists in which key stakeholders – including professional associations – participate to agree on outputs, standards and/or prices.

Figure 4 illustrates six key attributes of successful public-private dialogue. These are:

1. leadership by a core group of local public and private sector champions who “own” and “drive” the PPD process;
2. balanced representation between and within sectors;
3. organizational structures including budgetary resources and staffing to ensure the capacity exists to manage day-to-day operations;
4. a common agenda that aligns partners and is focused on delivery;
5. shared metrics that use data to make decisions, inform the dialogue process, demonstrate results and hold partners accountable for their (in)action; and
6. mutually reinforcing activities that harness the collective actions of all stakeholders.

Where PPD forums exist in LMICs, they tend to not possess these attributes. There is still considerable mistrust between the public and private sectors due to the lack of understanding of the private health sector’s intentions.

Figure 4. The six key attributes of an effective public-private dialogue platform

15The work of Herzberg and Wright (2006), on which these good practices are based, is the product of a comprehensive review of case studies and synthesis research papers on techniques for promoting successful dialogue, including major studies by the World Bank, DFID, and the OECD Development Centre.
and suspicion of the profit motive. Also, deep rooted philosophical beliefs and negative personal experiences are cited as major barriers to interactions between public and private stakeholders (see International Finance Corporation 2011). In many developing countries, interactions between the public and private health sectors are punitive, with LMIC MOH regulations and guidelines implemented more strictly than in other sectors. The lack of understanding between the two main players in health systems burdens the very population groups who need the services the most (see Box 12).

**Box 12. African Health Markets for Equity (AHME)**

Many LMICs have embraced social health insurance (SHI) as a mechanism for achieving UHC. By giving private providers the right to be reimbursed under SHI, governments can increase access to health services for covered populations while enabling private providers to grow their businesses. Realizing this potential is difficult, especially in primary care, a sector that tends to be highly fragmented. The African Health Markets for Equity (AHME) project - financed by DfID and the Bill and Melinda Gates Foundation - worked to address these challenges in Nigeria, Kenya and Ghana. The project aimed to help poor people enroll in SHI schemes. AHME also has worked with small-scale private providers to assist them to become accredited so that they could provide free services to poor people and be reimbursed under SHI. While the quantitative analysis of enrollment outcomes achieved under the project is still being undertaken at the time of writing, extensive qualitative research on the project has been completed. This research has shown that, while some poor people were successfully enrolled under the AHME project, most failed to renew scheme membership. The costs of renewal were seen by many as poor value, given that accredited service providers were often hard to access. Two reasons emerged why there were few private providers participating in SHI. First, the process of accreditation was complicated and poorly understood by providers. Second, SHI payments to smaller facilities were often delayed, if they arrived at all, and small providers did not have the working capital to provide services based on unpredictable payments. In this context, it is no surprise that many providers were charging patients at the point of demand – undermining the UHC principles at the heart of the scheme. Governments and regulators involved in the SHI scheme did not understand the constraints faced by small-scale providers which ultimately, lead to the project’s failure to address the obstacle. AHME project supported a PPD platform to facilitate dialogue to address these implementation as they arose. But large healthcare businesses dominated the dialogue process and the voice of small-scale providers was not adequately heard. Although in one small case, the AHME project’s efforts highlight the need to ensure PPD processes follow the best practices. A more balanced and representative number of private sector providers as well as clear leadership of champions may have headed off the political capture of the strong interest group. Moreover, the lack of information and buy-in from the affected providers ultimately undermined the project’s success.


---

CONCLUSION

In this report, we have presented a set of evidence-based principles we believe can support LMIC policymakers to establish sustainable improvements in mixed health system governance. Collectively, our four principles highlight the importance of building government’s capabilities to engage the private sector in pursuit of its key objectives. Markets cannot deliver the equity of access and financial protection that is called for by the UHC ideal. Governments need to intervene – and by doing so in an informed, evidence-based way, they can leverage the advantages of the market while protecting the public health interest.

This means a new way of doing ‘governance’ that is more inclusive, and can deliver the key governance behaviors outlined in the WHO’s Private Sector Roadmap. Key principles that underpin this are:

- the need to taking account of experiences in well-functioning mixed health systems, but not seeking to mimic these, or adopt wholesale a particular instrument or method;
- the importance of focusing PSE on problems that are prioritized by actors in the local context (and therefore command the support of key policy actors);
- placing emphasis not on particular interventions but on the set of organizational capabilities needed to deploy tools of government as a matter of routine; and
- building solutions from prioritized problems by accessing good data on the private sector delivery system – its operations in different service areas, its sources of revenue and the prices it levies, and the nature of demand for its services.

All of these goals are more readily achievable when there is a real, live, functioning dialogue between the government, development partners and the private sector. Over time, as such platforms are institutionalized, such that policy processes routinely include data on the private sector, and its interests and motivations, there is likely to be a profound and positive impact on the effectiveness of mixed health system governance.

---

17 As a rule of thumb, defining which challenges/problems can be regarded as priorities can be done by examining key policy statements, such as National Health Sector Strategies, or National Health Financing Strategies. Ensuring that strategic options for, and capacity-building linked to, PSE is likely to be a sensible approach.
ABOUT THE PROJECT

For more information about the work, please contact Dave Clarke, clarked@who.int

This document was commissioned by the World Health Organization and recommended by the Advisory Group on the Governance of the Private Sector for UHC as part of its ongoing work to develop a strategy for the World Health Organization and member states to effectively engage the private sector for the governance of mixed health systems.

Additional documents in this series include the following:
- International Organizations and the Engagement of Private Healthcare Providers
- Measuring the Size of the Private Sector: Metrics and Recommendations
- Private Sector Accountability for Service Delivery in the Context of Universal Health Coverage
- Private Sector Utilization: Insights from Standard Survey Data
- Engaging the Private Health Sector to Advance Universal Health Coverage: WHO Eastern Mediterranean Region Case Study

The Advisory Group on the Governance of the Private Sector for UHC was convened in February of 2019 to act as an advisory body to the WHO about developing and implementing governance and regulatory arrangements for managing private sector service delivery for UHC. The group was formed with the primary goal of providing advice and recommendations on the regulation and engagement with the private sector in the context of the WHO GPW goal of 1 billion more people benefiting from Universal Health Coverage, and in particular outcome 1.1.4 of this goal – “Countries enabled to ensure effective health governance”. Members of the Advisory Group include: Dr. Gerald Bloom, Mr. Luke Boddam-Whetham, Ms. Nikki Charman, Dr. Mostafa Hunter, Mrs. Robinah Kaitritimba, Dr. Dominic Montagu, Dr. Samwel Ogillo, Ms. Barbara O’Hanlon, Dr. Madhukar Pai, Dr. Venkat Raman, and Dr. Tryphine Zulu.

The authors of the document would like to thank the following people for sharing their insights as part of this research: David Clarke, Gerry Bloom, Luke Boddam-Wenham, Susan Rae Ross, Amit Thakker, David Elliot, Charles Dalton, Chris McCahan, Andrew Myburgh, Andreas Selter, Benjamin Loevinsohn, Sneha Kanneganti, Cicely Thomas, Nikki Charman, Andrea Bosman, Jane Canningham, Hannah Monica Dias, Deirdre Dimanesco, Hassan Salah and Phyllida Travis. The authors would also like to thank David Clarke and Aurelie Paviza from WHO and Cynthia Eldridge and Samantha Horrocks from Impact for Health International.

WHO also thanks those who were involved in commenting on this document. Financial support for this work was provided by the European Union as part of its support for the UHC Partnership.


© World Health Organization, 2019 All rights reserved. This document may not be reviewed, abstracted, quoted, reproduced, transmitted, distributed, translated or adapted, in part or in whole, in any form or by any means without the permission of the World Health Organization. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines, for which there may not yet be full agreement. The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions are excepted, the names of proprietary products are distinguished by initial capital letters. All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.