Data for governance of the private sector in health

Clearing house briefs series

COUNTRY CONNECTOR ON PRIVATE SECTOR IN HEALTH

Contents

Abbreviations

CCPSH	Country Connector on Private Sector in Health
DHIS2	District Health Information Software 2
HIS	health information systems
LMICs	low- and middle-income countries
MFL	master facility list
SGS	Systems Governance and Stewardship
WHO	World Health Organization

COVID-19: Pakistan. 2020
© WHO / Blink Media - Saiyna Bashir

Abstract

Data generated through routine health information systems (HIS) has strategic, technical, and operational value, serving to provide the information required to translate policy intention and national priorities into health service delivery, positive health outcomes and user experience. Including the private healthcare sector within routine HIS is therefore important, particularly in contexts where private healthcare entities deliver a large proportion of health services. However, even where data and information are available from the private healthcare sector, these may not be used to govern or build understanding with component entities. This brief explores constraints to data capture and management within health systems and its use for decision making with specific focus on the governance of the contribution of the private sector in health to public health outcomes.

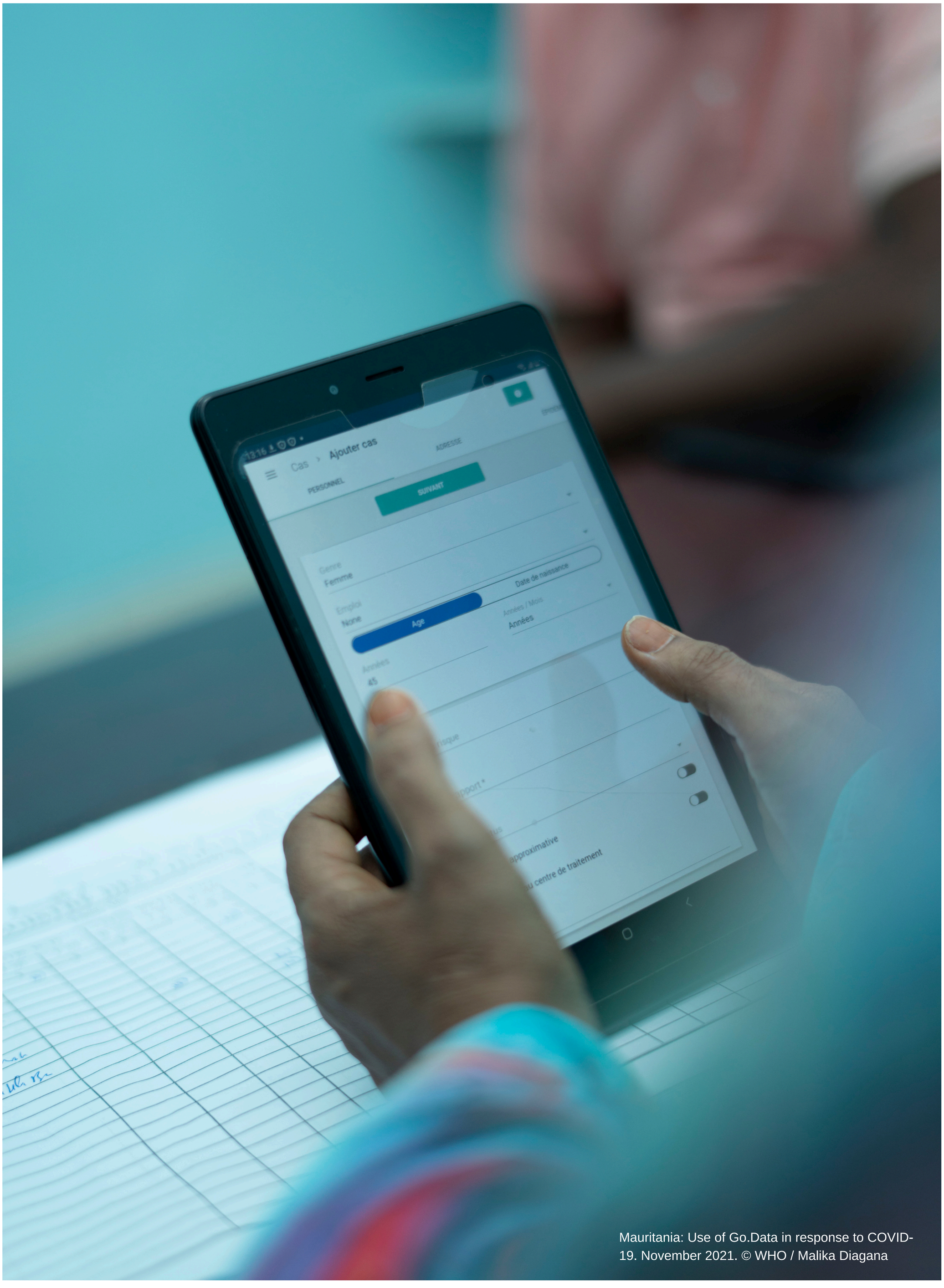
Key messages

- Barriers to the capture and management of data span both public and private sectors and different levels of the health system.

- More emphasis has been directed towards data collection and management (governance of data) in LMICs and less on how data are assimilated into practice (data for governance).

- Where data for governance is addressed in the literature, this has tended to focus on sub-national data use, and less on the inclusion of private healthcare entities.

- Policy response and related tools have tended to focus on technological solutions, and less on the organizational and behavioural determinants of data-informed decision making.



Mauritania: Use of Go.Data in response to COVID-19. November 2021. © WHO / Malika Diagana

Background

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

This brief explores data for governance of the private sector in health. Literature on health information and data use was included under the governance behaviour "Build Understanding" 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 data for decision making. Papers which included the private health sector were of specific interest however the literature covered health information and data use more broadly given the paucity of papers with specific focus on the private healthcare sector. While this brief embraces a broad notion of a health information systems (HIS), we focus on the inclusion of private healthcare entities in the collection and use of routine health data. More information on the methodology used to develop Clearing House briefs is available in **Annex 1**. The literature reviewed for the country case examples is included here.

Data for governance: what is it?

Health data and information is critical - the fuel - to the function of national health systems. Health data can come from multiple sources while information is data that has been organized into a format that is meaningful. Health information is commonly understood as a 'tool of governance' for health service delivery and other health system functions *(2).* Many low- and middle-income country (LMIC) governments have increasingly addressed health information requirements through the collection, processing, and reporting of data through routine HIS. HIS may include data from different sources, including routine service statistics, population-based surveys, vital statistics, and facility registries, amongst others. Health information is intended to guide decisions and monitoring of health system performance, as such, HIS are "subsystems and subservient to health systems in any country and do not have lives of their own" *(3).*

Health data and information has strategic, technical, and operational value. Use cases vary and may include service and programme monitoring, strategy and policy development, operational planning and execution, evidence-informed practice, local decision making and accountability *(4) (5).* Within this continuum, data sits at the 'coalface' of implementation, serving to provide the information required to translate policy intention and national priorities into health service delivery, positive health outcomes and user experience *(2)*. Including the private healthcare sector within routine HIS is therefore important, particularly in contexts where private healthcare entities deliver a large proportion of health services.

Private sector data and use: what is the governance problem?

Alongside the development of routine HIS, efforts have been made to include data and information from private healthcare entities. However, even where data and information are available from the private healthcare sector, these may not be used to govern or build understanding with or about component entities. This situation is often set within wider constraints to data capture and management within health systems (governance for data) and its use for decision making (data for governance). Data may be absent or under-utilized; and, even when ownership of and access to good quality data does exist, it may not be used *(4).* Governance is therefore critical to data capture and management and use. In the literature, a similar distinction is made in terms of "data in principle" (as they are recorded), and the "data in practice" (as they are used) *(4).* Both are discussed in turn.

Governance for data

Barriers to the capture and management of data span both public and private sectors and different levels of the health system. Typically, routine HIS are structured to collect and aggregate data from individual health facilities, a function that often sits with sub-national authorities whose capacity and/or interest may be limited. Private healthcare entity reporting may not be encouraged, mandated, or enforced. It may be limited to specific services or priority programmes. Such programmes may incentivize reporting on specific conditions or services, to the neglect or displacement of efforts to collect other routine data. This situation is reflective of early experience with HIS, which were modelled upon epidemiological surveillance systems, and the creation of vertical information systems *(3)*. Variation is reflected regionally, for example, in some contexts, more emphasis is given to private sector reporting on notifiable diseases while in other contexts routine HIS is more prevalent *(8).*

Irrespective of information system, private healthcare entities may not be trained to use or provided with reporting tools; and reporting itself may be cumbersome both in terms of submission but also due to the complexity of tools *(6) (7) (8).* Incentives for reporting may also change over time; and, as systems are digitized, they may create further reporting burden if such efforts are not interoperable or continue to require paper-based reports *(7).* Additionally, more, better, and different types of data pose costs for those collecting and managing data as well as those producing data, including private healthcare entities *(4).*

Data for governance

There may be limited interaction between those involved in data capture and its management and those intended to use data *(6),* referred to as a 'dichotomy' between 'data people' on the one hand and 'action people' on the other *(3).* Decision makers, a key target for data use, may consider the quality of data provided by routine HIS inadequate or irrelevant, it may be used symbolically or subject to strategic misrepresentation *(9).* Even when data of the right quality is available, "gaps in governance and coordination, resources and monitoring systems" may hinder analysis or action for governance *(10)*. There may also be specific private sector concerns with how data will be used to govern, in

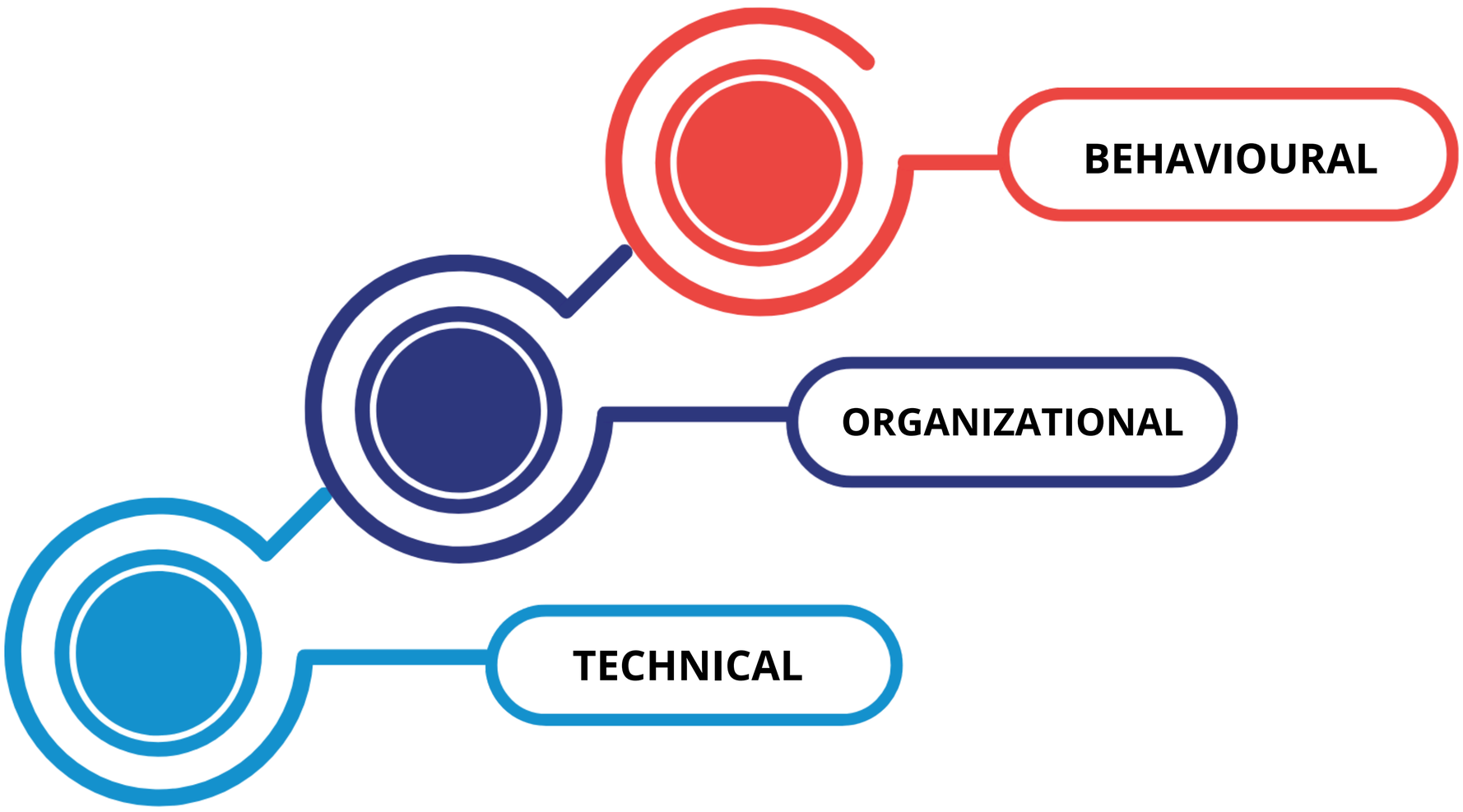
relation to more stringent regulation, auditing, taxation or sanction, for example *(6)*. This may act as a counterweight to efforts to capture data from private healthcare entities, even in contexts where this is encouraged or mandated.

As highlighted in the literature, more emphasis has been directed towards data collection and management (governance for data) in LMICs, "with evaluations of these systems focusing more on statistical data processes and data quality, and less on how data are assimilated into practice" *(4)*. Where data for governance is addressed in the literature, this has tended to focus on sub-national data use, in some instances noting concerns about 'non-reporting actors' such as those from the private healthcare sector (*2, 9, 11-15*).

Strategy: what is the policy response to private sector information and use?

Policy response sits on a continuum of data capture, management and use. Conceptually, this is framed in relation to the technical, organizational and behavioral determinants of data-informed decision making *(3, 5)*. Strategies to improve private sector data and use have been positioned within these determinants (see **Figure 1**). While determinants focus on routine HIS performance, this is intended to drive health system performance *(3)*.

Figure 1. Data use determinants



Technical

Since the late 1990s, many LMICs have embraced technology as part of the development of routine HIS. However, HIS pre-date computers *(16)* and some remain paper-based *(3).* Despite wide recognition of the need a more holistic approach to data use, technology 'fixes' remain at the fore of policy response *(4).* A recent systematic review found that technical challenges were the least commonly raised issues in the literature, but strategies that incorporated technical components were the most prevalent *(16).* In contrast the same review found limited strategies to address other data use determinants.

A key focus of technology has been on data quality using routine HIS. Data quality is concerned with the overall value and usefulness of data and information and is one of the most proximate interventions to improving the use of data in decision making *(6).* Data quality has several dimensions, including relevance, completeness, accuracy, and timeliness, but may be due to other proximate factors such as poor HIS design, complex reporting forms and indicators *(3).* Difficulties with capturing routine data from healthcare entities may contribute to the perception of poor data quality, in relation to its completeness and representativeness. As noted in Senegal, "the private [facilities] are configured in the DHIS2 platform but unfortunately their data are not captured"*(15).* Very few studies have considered data capture from the perspective of the private healthcare sector nor is data capture been designed with such users in mind, which may limit relevancy (an often neglected aspect of data quality) *(3).*

Organizational

Organizational determinants for using and sustaining HIS include the availability of resources (e.g., financial, physical and human), as well as underlying rules, values and practices (e.g., existence of procedures for data collection and transmission, and consequences for not following such procedures) *(3).* As reported in a recent systematic review, strategies to address organisational determinants are not well documented, despite this being a widely cited challenge *(16).*

Legislative mechanisms for routine reporting by the private healthcare sector often exist but may not be operationalised or enforced, with minimal consequences for individual entities *(6).* In Uganda, for example, submission of HIS reports was linked to private entity license renewal, with filing of 'missing reports' to the HIS district office considered part of this process *(17).* This suggests that lags in routine reporting were permissible (the study indicated that only 25% of private facilities submitted reports), with reporting playing a procedural, not performative role. Furthermore, there was recognition of uneven support for reporting at district level, with greater attention to organizational determinants in public health facilities, such as supervision and training. In Kenya, where compliance with reporting requirements was largely observed, an increase in the use of technology within the public and private sectors has not replaced the need for paper-based reporting of routine services, suggesting that the incentives for reporting by the private healthcare entities is not monitored over time *(7).* Such considerations may not be at the fore of national digital health strategies, even in contexts where private healthcare entities deliver a large proportion of health services.

Behavioural

Behavioural determinants entail how users "react to and use information systems for problem solving or self-regulating their performance" *(3).* In general, this is considered a neglected area of routine HIS processes, with limited knowledge of the usefulness of routine data a major factor in low data quality and use *(3).* In part, limitations may be fuelled by 'perceptions of use' with much data collection done for procedural reasons, such as reporting upwards *(4).* Data may also be viewed as a form of 'control at a distance' rather than the basis of building understanding between health system entities *(4).* This was observed in Uganda where there was a strong perception of the promotion of data use, which was not reflected in practice *(3)*. In South Africa, two modes of data use were observed, one based on a transactional mode and the other on a co-production mode of governance, with the latter facilitating collective learning and reflective practice *(2).*

Part of the reason for neglect of data use, is difficulty in its measurement and explains a primary focus on data quality given relative ease in monitoring *(4).* It may also be perceived as the only data action available at local level as decisions, both strategic and operational, may be made at higher levels of the health system. A recent scoping review concluded that there has been no rigorous study on data use and, in particular, on data use in relation to DHIS2, despite its widespread adoption *(4).* The review highlighted the informational capabilities needed for data use such as communication, information literacy and knowledge sharing *(4),* reflecting the interdependencies with other determinants of data use and governance more broadly.

Country research projects in India, Nigeria and Ethiopia have sought to address data use through a structured decision-making process, "bringing together key data from the public and private sectors on inputs and processes" with a specific focus on service delivery *(13).* However, as concluded, there was "no standardized process for data-based district level decision-making, and substantial obstacles in all three countries" *(13).* India, considered the most amenable of the three countries to data use, had an underlying challenge of the absence of an effective legal framework for engagement with the private healthcare sector *(11).* In these and other country cases, the relationship between routine HIS performance defined as 'improved data quality and continuous use of information' and health system performance was difficult to establish in practice *(3).*

Tools: what policy tools are deployed to facilitate private sector data, information and use?

HIS, while highly contextual, have been heavily influenced by international donors *(3).* This extends to the introduction and use of policy tools including those used for routine HIS (see **Table 1**).

Table 1. Policy tools and examples

Policy tools	Examples
Data legislation	Digital health strategies, operational guidance
Data capture	DHIS2, master facility list
Data use	Data displays, structured assessments/tool kits

Data legislation

A focus on technology and innovation has prompted the development of national digital health strategies in recognition of the plethora of digital activity that sits within and outside of routine HIS. Often this remains "uncoordinated, fragmented and not integrated" leading to duplication and lack of scaling of interventions, limiting the potential benefits of digital health innovations *(18).* National digital health strategies are intended to set a clear vision for how digital technology will improve healthcare access, provide direction for stakeholders across the health system, and establish a supportive, predictable operating environment for solution providers[1]. Given the nascency of many of these strategies, there is little evidence on how well digital health strategies do this in practice. Strategies ideally would guide innovation and the use of digital technologies in the private healthcare sector as well as provide clearer operational guidance, such as the use of standardised case definitions and reporting standards, and their communication to reporting entities, including those in the private healthcare sector *(16).*

Data capture

While there are many digital HIS platforms, the District Health Information System 2 (DHIS2) has been widely adopted. DHIS2, developed by the University of Oslo, is a comprehensive web-based application for compiling data across different levels of a health system into a central storage point, using data warehouse principles and a modular structure, that allows for customization to distinct needs of different health systems *(14).* As of 2020, DHIS2 had been introduced in at least 73 LMICs, of which 60 used the application as the basis for their routine HIS *(6).* Some countries have introduced or piloted direct, online accounts in the national DHIS2 instance to allow private healthcare entities to report directly *(6)* which could reduce reporting burden and improve data capture. This has been done in Senegal for example which, according to key informants, has significantly improved the way they collect, transmit and use data but has not been extended to the private reporting entities *(15).*

[1] https://www.weforum.org/agenda/2019/08/6-ways-digital-technology-can-transform-healthcare-in-africa/

Alongside data capture through DHIS2, master facility lists (MFL) have also been introduced in a range of contexts. A MFL is a comprehensive listing of public and private health facilities with a set of attributes to uniquely identify each, including basic information about facility services and capacities *(19).* Like HIS, they are considered an important tool for planning, coordination, and delivery of health services. They are considered particularly useful in LMIC contexts, including fragile and conflict-affected settings. For example, a MFL was developed in Haiti as part of the earthquake response in 2010. This employed a web-based repository which has been updated and improved upon over time, forming the basis for the present national service delivery and infrastructure status database *(19).*

More recently, other technologies have also been introduced; for example, the use of health information exchange environments to address interoperability between information sources, including from the private healthcare sector; advanced analytics using machine learning and artificial intelligence techniques are also increasingly available and being tested in LMICs as part of a broader toolkit of tech solutions, often supported through international donors.

Data use

Increasingly there has been greater use of automated data displays to facilitate access to information in a format that is meaningful to decision makers/data users. However, more research is needed to understand shifts in data "agency", from data custodians of HIS, to intended users of information, who may have more limited access and analytic capacity to engage with routine HIS. Feedback mechanisms are also an important use function, recognised as integral to "identifying problems for resolution, for regulating and improving performance at individual and system levels" *(3).* As highlighted in case material from India and Africa, there is need to engage in "conversations around data" and ensure that technology solutions are integrated within health system processes and practices *(4).* This suggests less emphasis on audit-like tools and more emphasis on knowledge exchange *(2).* In this regard, additional guidance and criteria could be developed to help users objectively assess whether data are employed to inform key decisions *(5).*

In several countries (Kenya, Ghana and Uganda), digital health strategies have been informed by assessment using an HIS interoperability toolkit. Interoperability refers to the capacity for different information systems to meaningfully exchange data. This has been guided by multistakeholder working groups, including those from the private sector. As found in Kenya, despite a robust technological environment there was a clear bias towards the technology that facilitates interoperability with neglect of other assessed domains, specifically leadership and governance, and human resources *(18).* Structured assessment has the potential to rebalance focus on "data in principle", and the "data in practice" – in other words, the relationship between HIS performance and health system performance.

Conclusions

Data for governance of the private sector in health is premised on access to information, its conversion into intelligence and situational awareness. To do this, governments must act to ensure that the private health sector is integrated into routine HIS, that data is converted to information and organised in a way that facilitates data-informed strategic and operational decision-making. However, due to aggregation, data may not distinguish the contribution of private sector to health system performance as information needs on the private healthcare sector may not be defined or demanded for decision making. The WHO Systems Governance and Stewardship (SGS) Unit has developed a data protocol to identify what data and information is currently being collected by governments and how this is used for governance of the private sector in health *(20).* The WHO Progression Pathway on the Governance of the Private Sector in Health further provides a practice-based approach that can be employed to situate HIS performance within the wider context of health governance and system performance.

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.

References

1. Wong G. Getting to grips with context and complexity - the case for realist approaches. Gac Sanit. 2018;32(2):109–10. doi: 10.1016/j.gaceta.2017.05.010.

2. Scott V, Gilson L. Exploring how different modes of governance act across health system levels to influence primary healthcare facility managers' use of information in decision-making: experience from Cape Town, South Africa. International Journal for Equity in Health. 2017 Sep 15;16(1):159. https://doi.org/10.1186/s12939-017-0660-5.

3. Aqil A, Lippeveld T, Hozumi D. PRISM framework: a paradigm shift for designing, strengthening and evaluating routine health information systems. Health Policy Plan. 2009 May;24(3):217-28. doi: 10.1093/heapol/czp010. Epub 2009 Mar 20. PMID: 19304786; PMCID: PMC2670976.

4. Byrne, E., Sæbø, J.I. Routine use of DHIS2 data: a scoping review. BMC Health Serv Res 22, 1234 (2022). https://doi.org/10.1186/s12913-022-08598-8.

5. Nutley, T and M. Li, 2018 (June), Conceptualizing and Measuring Data Use: A Review of Assessments and Tools: Working Paper. MEASURE Evaluation and USAID. Avilable at: https://www.measureevaluation.org/resources/publications/wp-18-214.html

6. Mangone, Emily and Sarah Romorini. 2021. Private Sector Engagement in National Health Management Information Systems: Barriers, Strategies, and Global Case Studies. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates Inc. Available at: https://marketbookshelf.com/wp-content/uploads/2022/03/PrivateSectorEngagementinNationalHMIS_BarriersStrategiesandGlobalCaseStudies.pdf

7. Appleford G, Mumbia D, Emmart P. Incentives and disincentives to private sector reporting on family planning in Kenya: why these matter, and how they may change over time. Gates Open Res. 2023 Aug 7;6:124. doi: 10.12688/gatesopenres.13909.2. PMID: 37766755; PMCID: PMC10520241.

8. Private health sector engagement in the journey towards Universal Health Coverage in Private Sector Landscape in Mixed Health Systems. Geneva: World Health Organization; 2020. https://iris.who.int/handle/10665/353170 Licence: CC BY-NC-SA 3.0 IGO.

9. Wickremasinghe D, Hashmi IE, Schellenberg J, Avan BI. District decision-making for health in low-income settings: a systematic literature review. Health Policy Plan. 2016;31 Suppl 2(Suppl 2):ii12-ii24. doi:10.1093/heapol/czv124

10. Kruk, ME, Gage, AD, Arsenault, C, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. Lancet Glob Health. 2018 Nov;6(11):e1196-e1252. doi: 10.1016/S2214-109X(18)30386-3.

11. Gautham M, Spicer N, Subharwal M, et al. District decision-making for health in low-income settings: a qualitative study in Uttar Pradesh, India, on engaging the private health sector in sharing health-related data. Health Policy Plan. 2016;31 Suppl 2(Suppl 2):ii35-ii46. doi:10.1093/heapol/czv117.

12. Bhattacharyya S, Berhanu D, Taddesse N, Srivastava A, Wickremasinghe D, Schellenberg J, et al. District decision-making for health in low-income settings: a case study of the potential of public and private sector data in India and Ethiopia, Health Policy and Planning, Volume 31, Issue suppl_2, September 2016, Pages ii25–ii34, https://doi.org/10.1093/heapol/czw017.

13. Avan BI, Berhanu D, Umar N, Wickremasinghe D, Schellenberg J. District decision-making for health in low-income settings: a feasibility study of a data-informed platform for health in India, Nigeria and Ethiopia. Health Policy Plan. 2016 Sep;31 Suppl 2(Suppl 2):ii3-ii11. doi: 10.1093/heapol/czw082. PMID: 27591204; PMCID: PMC5009223.

14. Odei-Lartey EO, Prah RKD, Anane EA, Danwonno H, Gyaase S, Oppong FB, Afenyadu G, Asante KP. Utilization of the national cluster of district health information system for health service decision-making at the district, sub-district and community levels in selected districts of the Brong Ahafo region in Ghana. BMC Health Serv Res. 2020 Jun 6;20(1):514. doi: 10.1186/s12913-020-05349-5. PMID: 32505209; PMCID: PMC7275484.

15. Muhoza, P., Saleem, H., Faye, A. et al. Key informant perspectives on the challenges and opportunities for using routine health data for decision-making in Senegal. BMC Health Serv Res 21, 594 (2021). https://doi.org/10.1186/s12913-021-06610-1

16. Hoxha K, Hung YW, Irwin BR, Grépin KA. Understanding the challenges associated with the use of data from routine health information systems in low- and middle-income countries: A systematic review. Health Inf Manag. 2022 Sep;51(3):135-148. doi: 10.1177/1833358320928729. Epub 2020 Jun 30. PMID: 32602368.

17. Wandera, S.O., Kwagala, B., Nankinga, O. et al. Facilitators, best practices and barriers to integrating family planning data in Uganda's health management information system. BMC Health Serv Res 19, 327 (2019). https://doi.org/10.1186/s12913-019-4151-9

18. Nyangena J, Rajgopal R, Ombech EA, et al. Maturity assessment of Kenya's health information system interoperability readiness. BMJ Health Care Inform 2021;28:e100241. doi:10.1136/bmjhci-2020-100241.

19. Rose-Wood A, Heard N, Thermidor R, Chan J, Joseph F, Lerebours G, Zugaldia A, Konkel K, Edwards M, Lang B, Torres CR. Development and use of a master health facility list: Haiti's experience during the 2010 earthquake response. Glob Health Sci Pract. 2014 Aug 5;2(3):357-65. doi: 10.9745/GHSP-D-14-00029. PMID: 25276595; PMCID: PMC4168633.

20. Protocol: using data to drive governance. Geneva: World Health Organization. 2023 https://iris.who.int/handle/10665/375724. License: CC BY-NC-SA 3.0 IGO

Annex. Methodology

Contributors

SGS private sector team: David Clarke (DC), Unit Health; Anna Cocozza (AC), Technical Officer; Gabrielle Appleford (GA), Private Sector Consultant

Information specialist: Kavita Kothari (KK)

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.

References

1. The private sector in health service delivery: an operational definition. World Health Organization. https://iris.who.int/handle/10665/375133 License: CC BY-NC-SA 3.0 IGO.

2. Patouillard, E, Goodman, CA, Hanson, KG, Mills, AJ. Can working with the private for-profit sector improve utilization of quality health services by the poor? A systematic review of the literature. International Journal for Equity in Health 2007;6:17. https://doi.org/10.1186/1475-9276-6-17

3. Wiysonge,CS, Abdullahi,LH, Ndze,VN, Hussey,GD. Public stewardship of private for-profit healthcare providers in low- and middle-income countries. Cochrane Database of Systematic Reviews 2016, Issue 8. Art. No.: CD009855. DOI: 10.1002/14651858.CD009855.pub2

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

5. Governance of the private healthcare sector in low- and middle-income countries: a scoping review of approaches, effectiveness, and enablers. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO. [Forthcoming]