Governance of the private sector in fragile, conflict-affected and vulnerable settings

Clearing house briefs series

World Health Organization

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ISBN 978-92-4-009719-3 (electronic version)
ISBN 978-92-4-009720-9 (print version)

Contents

Acknowledgements

The clearing house briefs series was developed by the World Health Organization (WHO) Systems' Governance and Stewardship Unit, under the leadership and coordination of David Clarke. The Systems' Governance and Stewardship Unit is part of the WHO Special Programme on Primary Health Care.

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

This brief was developed by Gabrielle Appleford (Special Programme on Primary Health Care, WHO headquarters), with Anna Cocozza and David Clarke (Special Programme on Primary Health Care).

Special thanks goes to Kavita Kothari (Quality Assurance Norms and Standards Department, WHO headquarters) for her invaluable support in refining the methodology and conducting the various search strategies.

Fundings:
WHO gratefully acknowledges the financial contributions to the development and production of this report provided by the United States Aid for International Development (USAID).

Abbreviations

CCPSH	Country Connector on Private Sector in Health
DCP	Disease Control Priorities 3
EPHS	essential package of health services
FCVs	fragile, conflict affected and vulnerable settings
HIS	health information systems
LIC	low-income countries
NGO	non-governmental organization
OECD	Organisation for Economic Co-operation and Development
UHC	universal health coverage
WHO	World Health Organization

Polio vaccinator is out on a polio vaccination campaign on the small islands around Kinshasa, Democratic Republic of the Congo © WHO / Eugene Kabambi

Abstract

Within fragile, conflict-affected and vulnerable settings (FCVs), health system governance arrangements have evolved in response to conflict, creating a complex foundation for service provision. Service provision is often pluralist in nature comprising state actors, foreign operators and local private-not-for-profit and for-profit providers. This brief focuses on this wide terrain of governance interaction and the effects this has on health service delivery and access for conflict-affected populations. It outlines three strategies for policy response and associated tools. Country cases reviewed for the brief have focused on well-known FCVs and those suffering from a confluence of crises related to security, humanitarian, political, and economic factors.

Key messages

- Within FCVs, policy response to private sector governance varies and is influenced by underlying health system attributes, capacities, and relational arrangements often shaped by conflict.

- Achieving a balanced response to health sector governance in FCVs requires navigating the complexities of immediate health service needs alongside long-term governance and capacity-building efforts.

- Opportunities for improvement lie in promoting state stewardship, integrating private sector actors into health system development, and leveraging governance interventions for improved health system performance.

- Policy tools such as regulation, service organization, contracting, information management, and coordination should be situated within broader policy response and serve to address service quality and access for conflict-affected populations.

On 25 November 2022, a boy plays with a kite on a hillside in Kabul, Afghanistan. © WHO / Kiana Hayeri

Background

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

This brief explores governance of the private sector in fragile, conflict-affected and vulnerable settings (FCVs). Literature on the governance of the private sector in FCVs was included under the "Align Structures" governance behaviour of the WHO's Strategy Report on "Engaging the private health service delivery sector through governance in mixed health systems", under the sub-assessment area "organizational arrangements". Countries were prioritized based on their feature and rank on the Fragile States List *(2)* and World Bank Classification of Fragile and Conflict-Affected Situations *(3)*. Selected papers broached the topic of governance of the private sector in FCVs from a wide range of perspectives, both state and non-state. 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.

Fragile, conflict-affected and vulnerable settings: what are they?

FCVs are multifaceted, and include states experiencing conflict, as well as those with high institutional and social fragility *(3).* Fragility is characterized by weak state capacity or weak state legitimacy, which, amongst other attributes, limits the provision of public services, including healthcare *(2).* State fragility may be accompanied by conflict, both civil and/or foreign in nature. Within these settings, health systems are also fragile and may be conflict-affected, underdeveloped and/or under-resourced, and unable to respond to the acute and growing needs of populations; their very fragility may contribute to an "immense and diverse disease burden" *(4)*. International support is often a central feature of health service delivery.

FCVs are increasingly a dominant global feature. A recent Organisation for Economic Co-operation and Development (OECD) report referred to the present-day as the "age of crises" in recognition of multiple, concurring crises taking place globally *(5)*. The same report featured 60 multi-dimensional fragile contexts, estimating that these account for almost a quarter of the world's population and nearly three-quarters of people living in extreme poverty worldwide *(5)*. While many FCVs are indeed poor, classified as low-income countries (LICs) based on World Bank evaluation, higher income contexts also feature.

Humanitarian response varies, based on the form and complexity of fragility and conflict. Response itself has become more complicated and long-lasting. It may take place on a national scale or be more geographically confined. Contexts deemed chronic humanitarian situations, may be layered with other acute crises (e.g., floods, droughts, displacement), including wider impacts of climate change.

This brief employs the term FCVs but recognises the diversity of contexts that may belie classification lists. Diversity extends to FCVs health systems, which are often pluralist in nature, either in response to, or predating crises. In addition to state actors, health system entities may include private-not-for-profit and for-profit providers, faith-based providers and networks, foreign operators, and a range of informal providers, including traditional birth attendants, informal drug outlets, traditional healers, and self-care/treatment. The World Health Organization (WHO) operational definition recognizes such diversity in service delivery and defines the private health sector as including "all individuals and organizations that are neither owned nor directly controlled by government and are involved in the provision of health care and services" *(6)*.

Country cases reviewed for the brief have focused on well-known FCVs, characterised in the literature as some of the worst humanitarian situations in modern history *(6) (9-11)*. These include Somalia, Yemen, South Sudan, and Afghanistan. Other FCVs, also included in this brief, similarly suffer from a "confluence of crises" *(10)* related to security, humanitarian, political, and economic factors. These include Iraq, Cameroon, Chad, and the Democratic Republic of Congo.

The private sector within fragile, conflict-affected and vulnerable settings: what is the governance problem?

Health systems governance, like FCVs, is multifaceted, and refers to the processes, structures and institutions that are in place to oversee and manage a country's healthcare system *(11)*. Discussed here are governance of external and local private sector actors within evolving service delivery contexts. Roles are not static; for example, local private sector actors may have grown in response to conflict (e.g., Somalia, Chad and Afghanistan) or pre-exited conflict (e.g., Yemen). Local private sector actors may have a long history of interaction with the public health sector (e.g., Cameroon and the Democratic Republic of Congo) and play an instrumental role in the management and delivery of services *(10) (12).*

Within FCVs, health system governance arrangements may have evolved in response to conflict, creating a complex foundation for service provision. This may be due to the separation of territories under different administrative and political structures, with health systems following suite. For example, Somalia has three governments: the Federated States, Somaliland, and Puntland each with their own ministries of health; Yemen has two different ministries of health, each stewarding policy and service provision; within Iraq, the Kurdistan Republic of Iraq health system also operates independently of the Ministry of Health of Iraq. As in other contexts, service delivery may be devolved to sub-national level (e.g., governorate, county, state or province), which may operate in isolation of, or with little direction from, the central level *(13)*.

Health system fragmentation, widely referenced within FCVs literature, is often associated with external intervention. Within FCV, there is a recognized tension and offset of roles between government on the one hand, and external actors, on the other *(4) (8) (10)*. While not always defined within the literature, a Yemeni case study is illustrative, where fragmentation is understood as the

presence of “many different health systems” and service providers, operating in the same territory, with their own agenda for delivering healthcare *(8)*. Within this and other contexts, attention may be focused on governance of external actors (or the fragmentation resulting from external intervention), and less on local private sector actors. For example, uncoordinated health aid is seen as having contributed to the fragmentation of the Chadian health system, with little analysis provided on local private sector roles within the system *(14).*

There is a small, but growing literature that has specifically looked at the role of local private sector actors within FCVs health systems. Of the reviewed cases, the literature included Somalia, Cameroon, the Democratic Republic of Congo, and Afghanistan. Local private service delivery actors were characterised in different ways in these contexts:

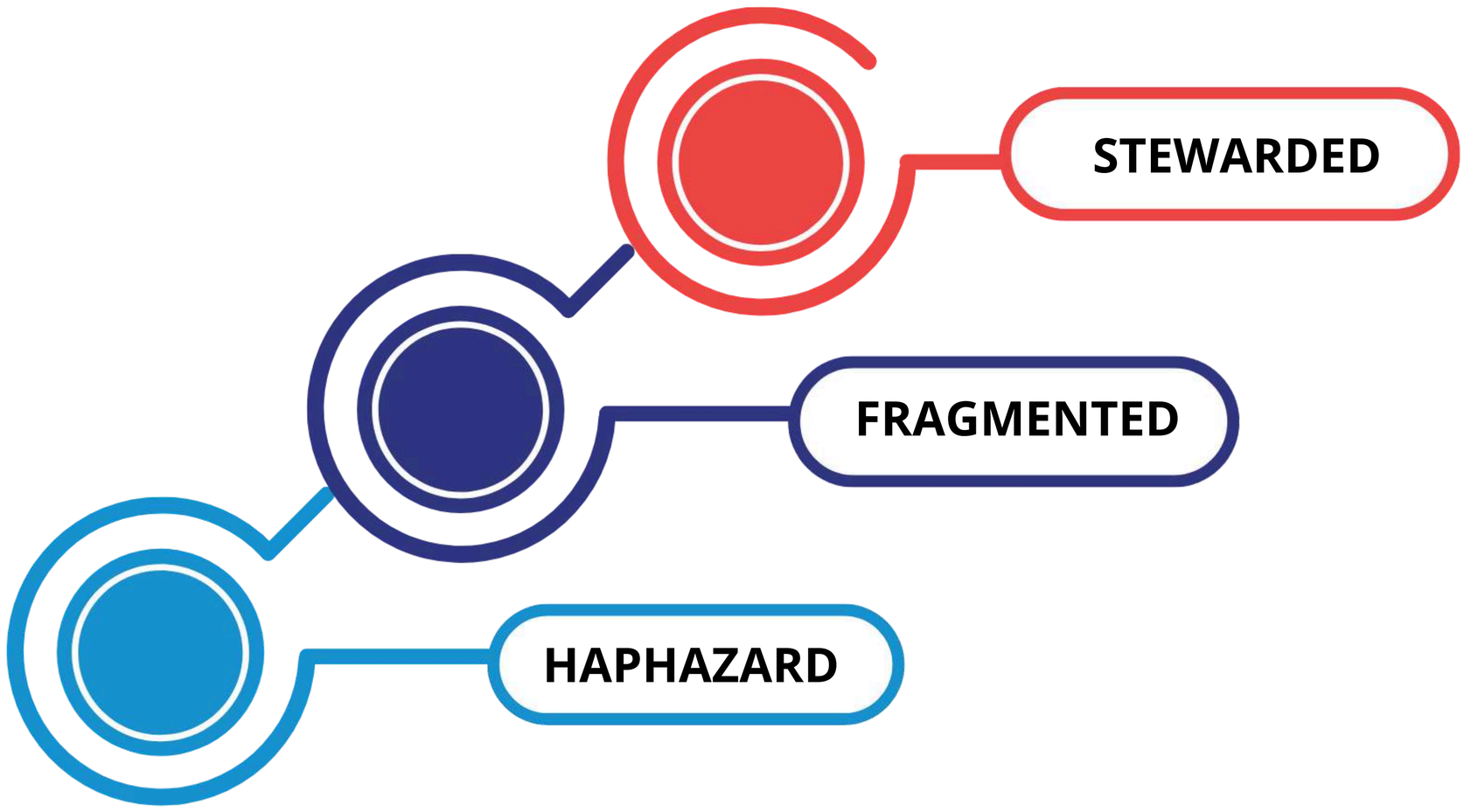
- as beneficiaries of conflict, exploiting the collapse of the public health system and the void left by the state in the provision of health services *(7);*
- as co-opted contractors, haphazardly engaged by external donors as a means of side-stepping an authoritarian state *(12);*
- as legacy managers, where state authorities have been historically weak, and service delivery mandated to non-state actors at sub-national level *(10);*
- as an untapped source for the delivery of standardized health services under the auspices of state health authorities *(15).*

This brief focuses on this wide terrain of governance interaction with the private sector in health and the effects this has on health service delivery and access for conflict-affected populations.

Strategy: what is the policy response to the private sector in health within fragile, conflict-affected and vulnerable settings?

As alluded within the literature, policy response varies with regards to governance of the private sector in health. In part, response is reflective of underlying health system attributes, capacities and relational arrangements that may have predated or emerged from conflict. Response may also reflect the humanitarian imperative, and underlying tensions between building or bypassing the state in the interests of urgency *(16).* Three policy responses – haphazard, fragmented and stewarded – are discussed here (**Figure 1**). Each one is exemplified in turn. In practice, these responses are mutable, and subject to change over time. Case study examples should be considered in this vein.

Figure 1. Policy responses to governance of the private sector in health



Haphazard response

Even within protracted FCVs, humanitarian intervention may remain the paramount response. For example, in Somalia, since 2000, an influx of humanitarian actors have been providing basic services, including healthcare; in 2020, these actors were estimated to be 328 operating within the country *(17)*. A key driver of humanitarian response has been the health of women and children, as Somalia has been described by international actors as the "worst place in the world to be a mother" and has one of the highest under-5 mortality rates in the world *(17).*

Humanitarian intervention in the Somali context remains haphazard, based on the ebb and flow of emergency funding and the operational landscape. Emergencies include on-going and active conflict with Al Shebab, drought and famine, amongst others. Within this landscape, donors are said to determine priorities, "for twenty years down the line organisations are still trapped on humanitarian delivery of service" *(17).* This situation exists despite the availability of national health sector strategic plans (three for the Somalia Federated States, Puntland and Somaliland) and an essential package of health services (EPHS). Within this context, local private-for-profit health providers remain on the periphery of donor response *(7) (17) (18).*

Fragmented response

In many FCVs (Somalia included), donors have supported policy to strengthen health systems and public health. This is often reflected in the availability of national health sector strategic plans and EPHS amongst other policy interventions. However, despite the availability of policy, there remains a "priority-setting problem" between state and international actors in some contexts.

- As described within the context of South Sudan, priority setting is often “ad hoc, rather implicit, and materializes through a haphazard series of opaque choices, which reflect competing interests of governments, donors, and other stakeholders”(4).Furthermore, central policy may not trickle to the peripheral level which may be guided more by donor funded activities, often vertically delivered.
- In the Cameroon study, motivation behind policy may be more reflective of donor requirements for a framework from which to engage, more so than a strategy for local healthcare actors. Engagement was notionally framed under the Cameroon health sector partnership strategy (2007–2015), intended to strengthen collaboration between state and non-state actors. The strategy was reported to have ignored previous arrangements between the government and faith-based organizations, and imposed a new and top-down strategy *(12)*.
- Fragmented policy response has also been found in other contexts, such as Yemen, where civil society organizations have been engaged in service delivery, as they are “responsive to donor interests” *(19).* In this context, weak coordination between the state health authorities and international and civil society actors has led to “a lack of streamlining key priorities, resulting in expensive and inefficient interventions” *(19)*. Despite references to the private-for-profit sector, there is very little narration of how this sector is involved in such arrangements.

Examples further suggest that a narrow range of international and local health actors are engaged by donor-funded programmes, further contributing to system fragmentation as part of response design *(4) (12).*

Stewarded strategy

The literature reflects aspiration towards state stewardship of the humanitarian and development nexus, as part of policy response *(8) (10) (12).* As highlighted in South Kivu, in the Democratic Republic of Congo, the state aspiration was for a paradigm shift towards institution building, however, support remained humanitarian in nature. For example, of the over 100 international non-governmental organizations (NGOs) engaged in the health sector in South Kivu in 2014, only four were reported to work on health systems strengthening using a more developmental approach *(10).*

In contrast, the Kurdistan Republic of Iraq was able to agree on a stewarded response for the development of primary health care, “albeit with differing strategies and goals” amongst state and non-state actors *(20).* Policy response in this context was reported to have increasingly incorporated a “market-led development praxis” in which private health providers were viewed as development actors with roles envisaged for both public sector services and private providers in family health care as the foundation of the health system *(20).*

In Afghanistan, a governance intervention using a quasi-experimental design, implemented a provincial health governance intervention that consisted of action planning, implementation, and self-assessment of governance performance before and after the intervention *(21).* The intervention had a statistically and practically significant impact on six indicators; it further served to engage stakeholders, including local private healthcare providers and set a shared strategic direction. Despite

promising results, interventions such as this are infrequently used as a lever to improve health sector and health system performance *(21).* Another study on Afghanistan also described a more holistic approach to governance intervention in relationship to the for-profit private health sector. Amongst issues identified were dependency on external funding and assistance for development of institutional and regulatory systems for governing the private sector *(15).*

As with FCVs, there is both context and history involved in humanitarian response. A new deal was proposed in 2012 for engagement in fragile states, calling for renewed focus on the contribution of health care to stabilisation and state building, and the need to balance immediate health service needs with building governance and capacity of healthcare systems *(22).* In many contexts, this balancing act remains fragile and response haphazard and fragmented.

Tools: what policy tools are deployed in response to the governance of the private sector in health within fragile, conflict-affected and vulnerable settings?

The literature featured common policy tools[1] of relevance to the governance of the private sector in health in FCVs. Policy tools are understood as the means by which strategy – or policy response – is implemented. This distinction recognizes that policy tools can be used in multiple ways to pursue different strategic objectives (so are not fixed to one strategy) *(23).* **Table 1** provides examples of tools cited in the papers reviewed for this brief.

Table 1. Governance tools and examples

Policy tools	Examples
Regulation	Facility and health worker licensing
Service organization	Essential package of health services
Financing	Contracting
Information	Health information systems Bespoke studies and research
Dialogue	Coordination mechanisms

[1] As planning was discussed in relation to policy in the literature, these are not featured separately in the tools section.

Regulation

The Disease Control Priorities 3 (DCP-3) project recognized the range of regulatory tools and incentives needed to engage private healthcare providers in service delivery within focal contexts, including FCVs. Those specified included better statutory control to prevent unlicensed practice, self-regulation by professional bodies to maintain standards of practice and accreditation of large private hospitals and chains *(24).* However, in many FCVs, the private healthcare sector remains under-regulated. While there may be a focus on specific regulatory tools, “to control the private sector" these often are not implemented *(7).* As highlighted in Somalia, even the most basic regulatory systems for licensing and registration of health facilities do not exist, with “service exploitation” symptomatic of other regulatory failures related to private healthcare education; in this context, health workers may seek return “on investment in medical education through over pricing and the provision of unnecessary services” *(7)*. In other contexts, regulatory systems may be more developed and tools tailored to counter adverse practice albeit with challenges with implementation and compliance. For example, in the Kurdistan Republic of Iraq, financial incentives have been introduced for hospital staff, particularly in operating theatres, to reduce waiting times and counter dual practice between private practice and public service *(20).*

Service organization

EPHS normatively outline a standard service package and treatment guidelines for a comprehensive range of health services *(17)*. They have been developed across a range of FCVs. For example, the DCP-3 project has supported EPHS development in Afghanistan, northern Syria, Somalia and Yemen, with the engagement of development agencies and donors *(25).* Often this was for the purpose of emergency funding or contracting with non-state actors. As noted, “while these reasons justify the need for the service package, the definition of the EPHS in the six countries has a broader objective and serves as a major milestone for the realisation of Universal Health Coverage (UHC)” *(25).* However, despite such aspiration, EPHS may not guide priority setting or service delivery due to a lack of “prerequisite institutional capacity and domestic financing” *(25).*

Contracting

Despite institutional shortcomings, EPHS have been used as a basis for contracting and were the favoured tool for some post-conflict states such as Cambodia and Afghanistan (in the early 2000s). In Afghanistan for example, the EPHS was delivered using NGO contacts in 31 of the 34 Afghan provinces (and by the government in three provinces) *(9).* Post-independence (2007) this tool was also introduced in South Sudan, where it was considered “the only way to finance the health services compared to previous short-term humanitarian approaches” *(26).*

Contracting was also the main tool featured in the Cameroon study. Within this context, it was considered instrumental, divorced from its strategic intent, “they treat us like a business, but we are doing the job of the government” *(12).* While reference was made to a legally binding framework for collaboration, between government and faith-based organizations, in practice this served donor engagement requirements for selected large-scale programmes *(12).*

As the examples illustrate, contracting has typically involved international and local NGOs, using donor resources. Local private-for-profit providers remain largely peripheral to contracting, even in contexts where they may play a dominant service delivery role. In Somalia for example, the EPHS describes four levels of service delivery, from primary to first referral (district) and regional hospital. As described in one district case study, because of a lack of public primary hospitals, health workers refer patients directly to regional referral hospital, despite the availability of ten private primary hospitals and private provider interest in being contracted *(18).*

Information

As in other settings, FCVs lack reliable health information. Routine health information systems (HIS) remain nascent or fractured in FCVs, and information, where available, may be extractive and siloed, used for specific programs or purposes. In the Kurdistan Republic of Iraq, for example, surveys are conducted by national and international agencies, but considered to be "generally outdated and poorly disaggregated, and...of limited present value" *(20).* In Yemen, NGOs reportedly have a better understanding of the health terrain than government, with the provincial health department referring to non-state demographic health records to get "an image of what the situation looks like" *(19).*

In most FCVs, there has been limited attention paid to the processes, interests, and institutions that shape priorities and interventions *(4).* Even less attention has been paid to the heterogeneity and composition of health service delivery actors. One scoping study highlighted the importance of understanding the effects of temporary donor funded health services on the development and sustainability of local private providers *(27).* In recognition of this lacuna, there have been more systematic efforts to map and assess the contribution of the private sector *(17) (28)*.

Coordination

Coordination is often framed in relation to other policy tools, such as EPHS and contracting. For example, in South Sudan, coordination structures are established at national and sub-national level, between donors and government, and government and implementing partners, creating "a web of accountability mechanisms" *(26).* These are principally focused on contracting for the EPHS. Similar elaborate coordination mechanisms are described in other contexts, and they are similarly purpose built. Within this coordination milieu, engagement of the private sector has been limited, especially when considering its role in the provision of primary health care services *(25).* As suggested by the reviewed studies, coordination mechanisms may not address wider aspects of governance as part of their deployment nor do they necessarily adhere to the Paris Declaration on Aid Effectiveness *(10) (14)*.

Conclusions

FCVs health systems have different attributes, histories, and capacities. Some have existing health system governance functionality while in others this may be virtually non-existent due to years of conflict. Health systems are not static, they have been progressively “made and remade”; understanding health systems therefore requires an appreciation of “their trajectory of institutionalization, policy making and patterns of inter-organizational interaction” *(10)*. This level of appreciation needs to be considered alongside the humanitarian imperative. While the FCVs narrative may be changing to one of a humanitarian-development nexus, the heterogeneity of local healthcare actors may be overlooked within such a nexus. Within this context, tools may continue to be introduced without coherent and coordinated strategy, and not stewarded by government.

A forthcoming WHO Progression Pathway on the Governance of the Private Sector in Health provides a practice-based approach that can be employed to build FCVs governance capacities to work productively with the private sector in health as part of building resilient and responsive health systems.

About the Clearing House

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

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Annex. Methodology

Contributors

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Introduction

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

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

Strategic frame

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

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

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

Box A1. Governance behaviours definitions

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

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

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

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

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

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

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

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

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

Search strategy development

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

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

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

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

Guiding questions, sub-assessment areas and key terms

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

Deliver Strategy

Guiding questions

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

Sub-assessment 1. Private sector inclusion within NHPSPs

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

Sub-assessment 2. Policy reform/processes

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

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

Align Structures

Guiding questions

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

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

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

Sub-assessment 2. Priority public health programmes

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

Sub-assessment 3. Quality of care and referral systems

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

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

Enable Stakeholders

Guiding questions

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

Sub-assessment 1. Facility registry and licensing

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

Sub-assessment 2. Training institutions

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

Sub-assessment 3. Registration and licensing of health professionals

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

Sub-assessment 4. Pharmacy licensing

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

Sub-assessment 5. Anti-trust/economic regulation

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

Sub-assessment 6. Private health insurance

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

Sub-assessment 7. Purchasing and contracting

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

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

Build Understanding

Guiding questions

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

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

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

Sub-assessment area 2: routine service statistics

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

Sub-assessment area 3: data for decision making

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

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

Foster Relations

Guiding questions

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

Sub-assessment 1: Private sector organization

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

Sub-assessment 2: Public sector organization

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

Sub-assessment 3: Coordination platforms

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

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

Nurture Trust

Guiding questions

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

Sub-assessment 1. Conflicts of interest

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

Sub-assessment 2. Role of intermediaries

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

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

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A makeshift camp at Charsadda Sports Complex, where people displaced by the floods are housed and provided with medical treatment. Pakistan, 2022. © WHO / Mobeen Ansari

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