

Who governs when care is organised by digital platforms?

Governing digital platforms and AI in mixed health systems

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[Opens a monthly series](#)

KEY MESSAGES

- Digital platforms increasingly shape how people access health services, how care is organised and how it is paid for. Many of these decisions have long been made outside government. What is changing is that platforms bring them together, automate them and create new dependencies. Governments retain stewardship of the health system and remain responsible for public health objectives, including universal health coverage (UHC), but they increasingly rely on information and capabilities held by organisations they do not directly control.
- Governing does not mean making every decision. It means putting arrangements in place so that others' decisions support public objectives and can be examined, challenged and changed when necessary. The question is whether existing governance arrangements reach the decisions that digital platforms now make.
- Health law and regulation have largely developed around facilities, professionals, products and purchasing arrangements. Digital platforms cut across these boundaries, connecting services and decisions that are governed separately. Each part of a care pathway may comply with its own rules, while no one is responsible for examining how the pathway as a whole affects access, quality, equity and cost.

- Digital platforms, algorithms and artificial intelligence (AI) present related but distinct governance challenges. Many arise from how platforms organise services, control information and influence decisions, whether or not they use AI. AI can speed up and scale decision-making and make the basis for decisions harder to understand or challenge. WHO guidance calls for AI in health to be transparent, explainable and accountable, and for humans to remain in control of health care decisions (WHO, 2021a).
- Governments have responded most readily where digital activities fit existing regulatory categories, such as medical devices, prescribing, health information systems and pharmacies. Less attention has been paid to how platforms determine who receives care, where patients are directed, which services are made visible, how payments are organised and what happens when a platform changes or withdraws its services.
- The evidence on what works remains limited. In the literature examined for this paper, we found no evaluation showing whether governance arrangements for digital platforms or AI improved access, quality, equity or financial protection in a low- or middle-income country. This reflects the limits of the evidence identified, not necessarily the absence of relevant research or practice.
- Digital technologies can support progress towards UHC and stronger primary health care when they are governed in ways that put people's needs, equity and public accountability first. This is the vision WHO Member States endorsed in the Global Strategy on Digital Health (WHO, 2021b).

Why this matters

Digital platforms are changing how people enter health systems, find providers, obtain medicines and pay for care. An app can now suggest whether someone needs to see a clinician and how urgently. A platform can direct them to a provider or pharmacy. An insurer's software can decide what it will pay.

Increasingly, these decisions are made through systems run by companies that may not provide care themselves and may sit outside the arrangements traditionally used to govern it. AI adds to this, allowing more decisions to be automated, tailored and changed at scale.

For governments, the challenge is therefore broader than regulating new technologies. It is how to govern health systems in which important decisions, information and capabilities increasingly sit with organisations they do not own or directly control. Governments remain responsible for pursuing public health objectives even when the decisions affecting them are made elsewhere.

This is a familiar problem in mixed health systems, where private providers, pharmacies, insurers and other companies deliver much of the care and medicines people use. Private clinicians, insurers and intermediaries have long made decisions about referrals, prescribing and payment, and governments have always had to govern organisations they do not own through licensing, contracts, payment rules and professional regulation. They do not need to make every decision themselves. They do need arrangements that let them influence, examine and, where necessary, change the decisions others make. Platforms test whether those arrangements still work, because they change how decisions are made, bring together decisions previously made by separate actors, and create new forms of influence and dependence.

WHO's work on the governance of mixed health systems describes six governance behaviours that governments use for this purpose: delivering strategy, enabling stakeholders, fostering relations, building understanding, aligning structures and nurturing trust (WHO, 2020). Platforms put each of them under new strain.

Governance, as we use the term, concerns how decisions are made and influenced: who makes them, under what rules, using what information, and to whom they must answer. This paper sets the scene for a series on the Country Connector on Private Sector in Health on governing digital platforms and AI in mixed health systems. It draws on a rapid review of research, law and policy, sets out the questions the series will take up, and offers no policy recommendations. Service delivery gets most attention because the consequences for patients are most immediate there.

What platforms, algorithms and AI change

It helps to keep three things apart. Platforms organise interactions between patients, providers, purchasers and others, and their operators decide who takes part and how payments and data move. Algorithms apply rules to rank, sort, price and allocate, often without AI. AI adds prediction, content generation and automated decision-making, and raises questions about how models are trained, tested and monitored, and how their performance shifts in use. Throughout, we use platform broadly to mean the digital arrangements through which health services are organised, including clinical software, insurance algorithms and the infrastructure they run on, not just marketplaces that match patients with providers.

Platforms are best distinguished by the decisions they control: some simply connect patients with clinicians, while others rank providers, allocate appointments, combine consultation, prescribing, dispensing and payment in one service, or supply the cloud services and AI models on which many other services depend. The same distinctions apply whether a platform is commercial, publicly operated or a hybrid.

Apart from general-purpose chatbots that people consult directly, on which WHO has issued separate guidance (WHO, 2024), AI rarely enters a health system on its own. It arrives inside platforms, clinical software, purchasing systems and supply chains that already influence care. It does not necessarily give a platform new authority. It changes how quickly decisions are made, how many people they reach, how hard they are to see into and how easily they can be altered, sometimes without those affected or public authorities knowing. Many governance problems therefore start with the platforms and software on which AI sits, and AI can make existing problems of authority, oversight and accountability harder to address.

Governing between the categories

Health law and regulation have largely developed around individual professionals, licensed facilities, approved products and specific activities, each with its own requirements and oversight. Platforms combine these activities within one service, often across several organisations, and the operator may not itself be licensed to provide care.

A single telemedicine service can assess a patient's symptoms, connect them to a clinician, issue a prescription, send it to a partner pharmacy and take payment. The product may be approved, the doctor registered, the pharmacy licensed and the data handled under an authorised system. Each part can satisfy its own rules while decisions about which clinician a patient sees, where a prescription goes and what it costs are made by the platform.

A pathway that is compliant at every point can still produce systematic problems in referral, prescribing, cost or continuity.

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The difficulty is not necessarily that the law is silent or that no regulator exists. Several authorities may have jurisdiction over parts of the service, yet none may be responsible for examining the combined effect of their separate decisions. Addressing this calls for coordination across ministries of health, medicines regulators, purchasers, and data protection, competition and consumer authorities, which WHO describes as a whole-of-government approach. That is a problem of governing the whole arrangement, not only a gap in regulating its components, and it means that a new AI law or a new regulator is not automatically the answer. The rest of this paper looks at where decisions are moving with that in mind.

Where decisions are moving

ENTRY INTO CARE

Symptom checkers and chatbots increasingly help patients decide whether they need care and how urgently. Their performance varies widely. A systematic review by Wallace et al. (2022) found that they listed the correct diagnosis first in only 19–38% of cases, and that the accuracy of their advice on urgency ranged from 49% to 90%, though the review rested on only ten studies and predates the current generation of AI chatbots.

Governments are also building these tools into public services. Schmude et al. (2026) describe how, in South Africa, an AI-based symptom checker developed by a commercial company was integrated into MomConnect, the government's WhatsApp-based maternal health platform, and report that physicians judged its advice safe in 98.4% of the cases they assessed. The study was observational, and several authors worked for the developer. Clinical accuracy is only part of the question. When a public service uses a commercial system to guide patients, someone must decide what advice it gives, what standards it must meet, how it is monitored and who answers if it steers people away from care they need.

IN THE CONSULTATION

AI is also entering the consultation itself. One of the more rigorous evaluations comes from Kenya, where Agweyu et al. (2026a) report a pragmatic cluster-randomised trial in 16 primary care clinics run by Penda Health, a private provider network, of a large language model embedded in the electronic medical record. The tool read clinicians' notes in the background and flagged possible problems with diagnosis or treatment. The trial enrolled 9,691 patients in 2025.

It found no reduction in treatment failure, a composite of unresolved symptoms, unplanned escalation of care and safety events within 14 days, and no serious adverse events judged to be related to the tool. The authors note that the trial was not powered to detect rare severe harms and that its results should not be read as evidence of equivalent safety (Agweyu et al., 2026a). An earlier review of records from the same network found that the tool's advice usually aligned with guidelines but was harmful in a small share of encounters, some of which made it into clinical records (Agweyu et al., 2026b). Neither study establishes how the system would perform over longer periods, in other settings or after changes to the underlying model.

The trial is valuable because it is rigorous, and it shows that finding no harm and improving patient outcomes are different things. But it provides evidence about the clinical performance of one AI-supported system, not about the arrangements governing its introduction or use. Tools like this are often introduced by private providers within their own networks, and not all are evaluated in this way. The wider governance questions apply to any such deployment: who authorises it, what information public authorities have, who can require changes if its performance deteriorates as the model is updated, and who answers for a harmful suggestion that a clinician follows?

WHO PATIENTS REACH

Platform operators can decide which providers appear, how they are ranked and where patients are sent. Lu et al. (2025) found that on a Chinese online hospital platform, ratings and reviews affected whether patients travelled to another region for treatment. Dahlstrand (2026), studying Swedish online primary care, estimated that matching high-risk patients with doctors better at keeping patients out of emergency departments could cut those visits by 4.4% compared with existing allocation. Neither study is about governance, but together they show that how platforms present and allocate providers affects where patients go and what happens to them. These decisions need not involve AI, and operators usually set the criteria rather than the authorities responsible for the system. A government may regulate every clinician on a platform and still have little say over how patients are directed to them.

PAYING FOR CARE

Algorithms are also changing how care is paid for. Digital insurers use them to assess claims, detect fraud and set payments, and public schemes are moving in the same direction. In May 2026, India's National Health Authority and the IndiaAI Mission showcased hackathon winners developing AI to automate claims adjudication under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), the country's publicly funded health insurance scheme, and officials said the solutions could be considered for use (PIB, 2026).

A government may decide which services its scheme covers while software decides how those rules apply to each claim. If the software's criteria are opaque, or can be changed without public oversight, decisions about what gets paid for may drift beyond the scrutiny of those responsible for the scheme. For people, the consequence can be a denied or delayed claim and unexpected out-of-pocket payments. This is why claims algorithms matter for financial protection, one of the two dimensions of UHC, which countries monitor through SDG indicator 3.8.2.

WHEN A PUBLIC SERVICE DEPENDS ON ONE PLATFORM

The stakes rise when a public health service relies on a single platform. In Rwanda, Babyl, a subsidiary of the UK company Babylon Health, provided digital primary care under a ten-year agreement with the government signed in 2020. It had more than two million registered users and had handled 3.9 million consultations, three-quarters of them covered by community-based health insurance. When the parent company entered administration in August 2023, the Ministry of Health began contingency talks, and Babyl Rwanda reportedly ceased operations in September (The EastAfrican, 2023; The New Times, 2023). Rubuga et al. (2026) found that demand for common conditions moved back to health facilities after the service closed.

The contract was an important means for the government to govern the relationship, but its terms were not public, and we found no published account of what was agreed about ending the service, transferring patient records or continuing care. Such provisions may have existed, but without a public record we cannot assess how the arrangement was governed. The wider lesson, for any country, is that exit and continuity provisions matter as much as the terms of entry.

Dependence goes beyond any one contract. Platforms collect information about patients, providers and transactions, often in more detail than ministries of health hold, and many run on cloud infrastructure and AI models supplied by a handful of global companies. A government can pay for a digital service without controlling how its data are used, where they are stored or how the software changes. Formal authority may remain with government even when the information, technical expertise or practical alternatives needed to exercise it are held elsewhere. The Lancet and Financial Times Commission warned that concentrated control over health data and digital infrastructure also concentrates economic and political power (Kickbusch et al., 2021).

How governments are responding

Governments have made most progress where digital services and AI fit activities their laws already cover. Few have legislated for AI in health as such. When Townsend et al. (2023) mapped 12 African countries, none had regulation written specifically for AI; its use was shaped instead by laws on data protection, digital health, consumer protection and intellectual property.

Medical products are the most developed area because AI diagnostic and decision-support tools often fall within device law. The harder question is what happens after approval, when products are updated or retrained and their performance drifts. WHO's Regulatory considerations on artificial intelligence for health set out areas regulators can address across the product life cycle, including documentation, risk management, data quality and post-market monitoring (WHO, 2023). Regulators in the United States, Canada and the United Kingdom have agreed principles for planning changes to machine learning-enabled devices (FDA, Health Canada and MHRA, 2023), and in October 2026 the UK's MHRA opened applications for the third phase of its AI Airlock sandbox, which focuses on overseeing products once they are in use (MHRA, 2026).

Evidence available at approval is thin. In a review of 692 AI-enabled devices authorised in the United States, Muralidharan et al. (2024) found that only 3.6% of approval records reported participants' race or ethnicity, and 9% included a prospective study for post-market surveillance. That matters for countries whose regulators rely on approvals granted elsewhere. Reliance on trusted regulators is a sound and efficient practice that WHO promotes (WHO, 2021c), but it works best when the evidence behind those approvals is relevant to local populations.

Rules on professional practice settle who makes the final clinical decision. India's 2020 Telemedicine Practice Guidelines, issued by the Board of Governors in supersession of the Medical Council of India, bar AI-based platforms from counselling patients or prescribing: AI may support a registered medical practitioner, but the practitioner must give the final advice or prescription. Platforms must verify the practitioners they list and provide a grievance mechanism, and may be blacklisted (Board of Governors, 2020). In China, national rules issued in 2022 for medical institutions providing internet-based care state that AI may not generate prescriptions, a ban Beijing restated in draft rules in 2023 and Hunan's healthcare security administration applied to insurance-designated pharmacies in 2025 (National Health Commission, 2022; Global Times, 2023; China Daily, 2025). These measures say little about how to test, monitor or hold to account the software that shapes clinical decisions.

Kenya provides a relatively comprehensive legislative example. Its Digital Health Act 2023 created a Digital Health Agency, and regulations introduced in April 2025 require digital health solutions, including telemedicine platforms, to be certified before providers may use them. Certificates last two years, and changes to a system's functionality trigger a fresh audit (Kenya, 2023, 2025). The legislation establishes formal authority. How it is used in practice, and whether certification examines the performance of AI within the tools, is less clear. In Ghana, Nyarko et al. (2026) describe arrangements in which authority for digital health is shared among several bodies, none of which yet holds comprehensive stewardship or enforcement powers. In their assessment, the main task now lies in putting governance into practice rather than in developing a strategy.

Online pharmacies show both progress and its limits. When Miller et al. (2021) examined India, Kenya and Nigeria in 2018, none had rules specifically designed for online pharmacies. A 2026 review of 12 countries found that only Kenya's and the United Kingdom's regulations covered all 15 basic provisions on the authors' checklist, which measured minimum standards rather than enforcement, and none explicitly mentioned AI (Satheesh et al., 2026). The stakes are high because WHO recognises online sales as one of the routes by which substandard and falsified medicines reach patients (WHO, 2017). Platforms that list many sellers become part of the medicines supply system whether or not they dispense anything themselves, and how they verify sellers and products is a governance question in its own right. In Thailand, telepharmacy moved from pandemic flexibility to formal standards under the Universal Coverage Scheme, while independent pharmacies struggled to afford access to certified platforms (Tapchaisri and Theeraroungchaisri, 2026), a reminder that market-entry terms can shape who participates.

Throughout, it is worth keeping apart whether governance arrangements exist, whether they operate as intended and whether they improve health-system outcomes. The examples above mostly establish the first. The literature reviewed provides much less evidence about implementation and almost none about effects on health-system outcomes.

The governance questions that follow

The underlying question is whether governments keep the practical means to govern services and markets increasingly organised through privately controlled software. That depends on more than formal legal powers.

It depends first on **authority**: who can set and change the rules a platform applies, and whether public bodies can require changes when those rules conflict with public objectives.

It depends on **information**: whether anyone outside the operator can see how decisions about ranking, routing or payment are made and what results they produce.

It depends on **accountability**: whether operators must explain their decisions and whether patients and providers can challenge them. It also includes whether communities and civil society have a voice in how these systems are designed and overseen, which the World Health Assembly recognised as part of UHC in its 2024 resolution on social participation (World Health Assembly, 2024). In the United States, people in Medicare Advantage can appeal prior authorisation denials. In 2024 just over one in ten denials was appealed, yet more than eight in ten appeals led to the denial being partly or fully overturned (Biniek et al., 2026). A formal right of appeal may offer limited protection if people cannot understand or exercise it, and in many low- and middle-income countries whether comparable remedies exist is poorly documented.

And it depends on **capability**: whether governments have the technical expertise, data and institutional capacity to monitor these systems, intervene and keep services running if a supplier leaves. The studies reviewed repeatedly point to gaps here in low- and middle-income countries (El-Naggar et al., 2026; Nyarko et al., 2026). This is not new with AI. A WHO-led review of 738 digital health interventions in sub-Saharan Africa found only 0.4% addressing leadership and governance (Karamagi et al., 2022).

Private ownership is not itself the problem. A privately owned platform may be subject to effective public oversight, and a publicly run one may be opaque and unaccountable. What matters is how authority, incentives, information and capability are distributed. Commercial incentives may favour patient acquisition, transaction volume, particular providers, higher-value services or lower claims costs. These are not necessarily at odds with public objectives, but they are not automatically aligned with them either.

Two questions follow for any operator: why would it act in ways that support health-system goals, and can it?

Governance arrangements need to answer both. Authority, information and accountability bear on the first by setting what an operator may and must do, making its conduct visible and attaching consequences. Capability, on the operator's side and the government's, bears on the second. Xiao et al. (2026), studying Chinese platforms selling medical-aesthetics services, whose operators act as both businesses and quasi-regulators of the providers they list, describe the resulting conflict between platform growth and public health compliance.

Equity is not only a question of whether digital services reach disadvantaged groups or whether algorithms perform equally well across populations. It also depends on whose needs count when platforms decide which services to offer, which providers to promote and which patients to prioritise. A platform may improve average access while worsening it for some groups, or cut costs while shifting financial risk to patients. Digital services may make care easier to reach for some while shutting out others because of connectivity, language, digital skills, gender, age, disability or cost, and software trained on unrepresentative populations may perform differently across groups. Bangla et al. (2026), reviewing India's national digital programmes, found that digital-by-default delivery risked pushing aside people who relied on other routes, and that accountability for exclusion was weak. WHO's guidance on AI for health makes inclusiveness and equity one of six core principles, alongside protecting autonomy, promoting well-being and safety, ensuring transparency, fostering accountability and promoting responsive and sustainable AI (WHO, 2021a).

Power matters too. Large technology companies, insurers and platform operators may control the information, infrastructure and expertise that governments depend on. This can limit what governments can realistically require of them, even when their legal powers remain unchanged.

Governments have several routes to influence: licensing and certification, purchasing contracts, payment rules, interoperability and data access requirements, competition and market oversight, and service-continuity arrangements. The guidance available says more about adopting technology than about acting on problems once it is in use; in a review of frameworks for implementing AI in clinical settings, Khan et al. (2024) found that only a quarter covered changing or improving a system in response to what was learned. The question for the series is less which instruments exist than whether, together, they reach the decisions that matter.

What we know and what we don't

The evidence describes the governance problems far better than it shows how to solve them. Much of the research is recent, small, based on hypothetical cases or carried out by technology developers. Evidence on how patients challenge decisions, and on how governments buy and oversee these systems, comes largely from high-income countries. Much of the available guidance comes from elsewhere too: a systematic review of 19 frameworks for governing AI in health systems found that half were developed by authors in North America and only a third were derived from primary studies (Alami et al., 2026).

The sources also establish different things. A randomised trial can show whether an intervention changed patient outcomes, but not whether the arrangements governing it worked. Legal analysis shows what powers exist, not whether they are used. News reports record events but seldom explain them. We have tried to keep what the evidence shows separate from what it suggests.

QUESTIONS THE SERIES WILL RETURN TO

These are largely unanswered.

- How far are platforms already shaping access to care in mixed health systems, and for whom?
- Do governments know which platforms, algorithms and AI systems influence triage, referral, prescribing and payment?
- How do patients learn that software has influenced a decision about their care or coverage, and how can they challenge it?
- When a public service depends on a private platform, what happens to patients, their records and the service if the company withdraws or fails?
- When governments buy or use these systems, who monitors performance, who can require changes and who decides when a system should be withdrawn?
- Which approaches work where public resources and technical capacity are limited?
- How can people and communities, including those least likely to use digital services, take part in decisions about how these systems are used?

Looking ahead

Digital platforms and AI can help health systems reach more people, improve services, strengthen primary health care and use resources better, but their contribution to universal health coverage cannot be judged by technical performance alone. It also depends on who decides how they are used, whose interests those decisions serve, what information is available to scrutinise them and whether those affected can seek redress. The task is therefore not only to regulate AI or license platforms. It is to ensure governments retain the practical means to govern their health systems as the organisations and technologies through which care is delivered change. This series sets out to explain what those means are and how countries can build and use them.

The series will appear monthly on the Country Connector, and later articles will refer to this paper rather than repeat its background. The first turns to medicines. Pharmaceutical companies and other commercial actors already use AI to promote, price, procure, distribute and monitor medicines, and governments have long-standing ways of governing these activities through rules on promotion, competitive procurement, health technology assessment and pharmacovigilance. The article asks how far those arrangements reach decisions now made or shaped by AI.

Readers working on these questions in their own countries are invited to share examples, including arrangements that have worked and those that have not.

NOTE ON METHODS

This paper draws on a rapid narrative review, carried out in October 2026, of research, law, regulation and policy on governing digital platforms, algorithms and AI in mixed health systems, with particular attention to low- and middle-income countries. Sources were chosen for relevance to the questions examined, not through a systematic search. Where we report that no evidence was found, none was identified in the sources reviewed; that does not mean none exists. The sources include peer-reviewed studies, preprints, legal texts and news reports, which differ in what they can reliably establish. The review will be updated as the series proceeds.

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