BMJ Global Health

The governance behaviours: a proposed approach for the alignment of the public and private sectors for better health outcomes

David Clarke,[1] Gabrielle Appleford,[1] Anna Cocozza ,[1] Aya Thabet,[1,2] Gerald Bloom [3]

To cite: Clarke D, Appleford G, Cocozza A, *et al*. The governance behaviours: a proposed approach for the alignment of the public and private sectors for better health outcomes. *BMJ Glob Health* 2023;**8**:e012528. doi:10.1136/bmjgh-2023-012528

Handling editor Seye Abimbola

Received 6 April 2023
Accepted 29 August 2023

[1]Special Programme on Primary Health Care, World Health Organization, Geneve, Switzerland
[2]Health Systems, World Health Organisation Regional Office for the Eastern Mediterranean, Cairo, Egypt
[3]Health and Nutrition Cluster, Institute of Development Study, Brighton, UK

Correspondence to
David Clarke; Clarked@who.int

ABSTRACT

Health systems are 'the ensemble of all public and private organisations, institutions and resources mandated to improve, maintain or restore health.' The private sector forms a major part of healthcare practice in many health systems providing a wide range of health goods and services, with significant growth across low-income and middle-income countries. WHO sees building stronger and more effective health systems through the participation and engagement of all health stakeholders as the pathway to further reducing the burden of disease and meeting health targets and the Sustainable Development Goals. However, there are governance and public policy gaps when it comes to interaction or engagement with the private sector, and therefore, some governments have lost contact with a major area of healthcare practice. As a result, market forces rather than public policy shape private sector activities with follow-on effects for system performance. While the problem is well described, proposed normative solutions are difficult to apply at country level to translate policy intentions into action. In 2020, WHO adopted a strategy report which argued for a major shift in approach to engage the private sector based on the performance of six governance behaviours. These are a practice-based approach to governance and draw on earlier work from Travis *et al* on health system stewardship subfunctions. This paper elaborates on the governance behaviours and explains their application as a practice approach for strengthening the capacity of governments to work with the private sector to achieve public policy goals.

SUMMARY BOX

- ⇒ Governance is an essential and indispensable 'means' for achieving the Sustainable Development Goals (SDGs) health targets, including Universal Health Coverage and health security.
- ⇒ The SDGS are based on a strategy of governance by goal setting, goal achievement depends entirely on local implementation to translate global goals into actions at the local level.
- ⇒ It is acknowledged that achieving the SDGs requires partnerships between government, the private sector and civil society to pool resources and know-how.
- ⇒ The approach to implement this agenda must consider different governance structures, national realities, capacities and levels of development as well as respect national policies and priorities.
- ⇒ Plurality is a defining characteristic of most national health systems, with care provided by a mix of public and private providers.
- ⇒ The extent to which a government can work with the private sector for public purposes depends on how well the private sector is integrated into the institutional arrangements to set and implement national health policy priorities.
- ⇒ Because of the special microeconomic characteristics of how markets for healthcare function, governments must pay attention to the operation of the private sector. The special nature of the healthcare market—in which suppliers or providers of care have an unusually strong influence over demand and utilisation because of an extreme information asymmetry—together with other non-typical market characteristics, means that private interactions between consumers and providers cannot be relied on to achieve social outcomes. An unregulated healthcare market is acknowledged to be both inequitable and inefficient.

INTRODUCTION

In 2000, WHO introduced the concept of stewardship to clarify the practical components of a government's role in health systems.[1–3] In the World Health Report 2000, WHO identified stewardship as the core means of improving system performance. For WHO, stewardship is about how government actors take responsibility for the health system and the population's well-being, fulfil health system functions, assure equity and coordinate interaction with government and society.[1 3–5] This is reinforced in WHO policy statements which underscore that stewardship involves government actors exercising

- ⇒ There are many knowledge, policy and institutional gaps in the governance of health systems when it comes to forming partnerships with the private sector and steering healthcare markets towards social objectives such as the achievement of equitable, efficient and sustainable healthcare.
- ⇒ In practice, since reform processes are path dependant, addressing these gaps relies on grounding action in the contextual realities of each country.
- ⇒ The WHO recommends creating comprehensive national health policy frameworks inclusive of private actors and activities.
- ⇒ The reality of high levels of private provision means that governance arrangements between government and the private sector takes on a great salience. When governments lack regulation of and engagement with the private health sector, there is risk of governance failures—a threat to social objectives. Governments must build the capacity to 'steer' rather than to 'row' the health system. The shift from focusing primarily on providing services directly to guiding a health system that mixes public and private provision requires policy instruments and institutional capacity to achieve public policy goals.
- ⇒ WHO has adopted six governance behaviours (GBs) to provide a strategic approach to guide the process of implementing necessary governance reforms to steward the public and private sectors as one.
- ⇒ The GBs can be used as a diagnostic tool to identify and address gaps to help implement inclusive public health policies and support countries to develop the required policy frameworks and institutional capacities that make sense for their context.

leadership to 'ensure that a strategic policy framework exists and is combined with effective oversight, coalition building, regulation, attention to system design and accountability'.[6]

Most health systems are pluralistic, comprising a mix of public and private providers.[7] Effective governance of pluralistic systems depends on the integration of the private sector into contextualised institutional arrangements for the implementation of health policy.[8 9] Institutional gaps in governance arrangements compromise efficiency, quality and equity in healthcare delivery.[10] Addressing these gaps calls for that governments to ensure that all health system actors, whether public or private, respect the right to health and align towards national health goals.[11] To do so, governments must build their capacity to 'steer' rather than to 'row' the health system.[12 13] The shift from focusing primarily on providing services directly to guiding a health system that integrates and oversee private provision requires policy instruments and institutional capacity to achieve public policy goals, including Universal Health Coverage (UHC).[13]

Unregulated market competition will yield inefficient and inequitable results in the health sector, and when governments lack regulation of and engagement with the private sector, this threatens social objectives such as the achievement of equitable, efficient and sustainable healthcare. It also represents a lost opportunity to access resources that can help address the quality healthcare access gap through (a) financial instruments to close the financing gap, (b) expert capacities to close the innovation gap and (c) local development and increased number of available health providers to close the supply gap.

This paper provides a proposed approach for working productively with the private sector. We present six governance behaviours, an approach for addressing policy gaps and building institutional capacity for governing the private sector within pluralist health systems to deliver on public policy goals, including UHC and health security. The governance behaviours have been formulated through the work of the WHO's Advisory Group on the Governance of the Private Sector for Universal Health Coverage within the 2020 Strategy Report on 'Engaging the private health service delivery sector through governance in mixed health systems'.[14] The Strategy aims to guide and enable governance performance improvement, strengthen government stewardship, and subsequently improve health system performance in pluralistic health systems.

BACKGROUND

Governing pluralistic health systems

The private sector plays a critical role in providing access to healthcare, from private hospitals, non-governmental organisations-operated clinics to drug shops, informal providers and traditional healers serving remote geographies.[15–17] It forms a major part of healthcare practice in many health systems providing a wide range of health goods and services, with significant growth across low-income and middle-income countries. This contribution is estimated to range from 40% to 62% and varies across WHO regions.[18] Moreover, the private sector is perceived to be a strategic player in introducing product and process enhancements.[19] Innovations such as mHealth, telemedicine platforms and digital health are examples of the potential of the private sector to help expand health service coverage, including too hard-to-reach communities and populations. The private sector was also a critical source of care during the COVID-19 pandemic.[14 18 20–22]

While the private sector has increased access to healthcare, the question of its contribution towards quality, efficiency and equity is more contested.[23 24] It follows that the private sector represents a complex mixture of opportunities and threats for health policy objectives of access, quality, efficiency and equity. Evidence and experience have pointed to unfavourable behaviours and unprincipled procedures by some private (and public) providers within health systems, which undermines UHC and other public policy goals.[25 26] Accordingly, health policy needs to distinguish different elements of private sector initiative, to support and 'encourage the good' and redirect, curtail or 'eliminate the undesirable'.[9 27 28] Public policy goals remain the key aim, regardless of whether providers are public or private.

Ministries of health are frequently in a dilemma regarding how to guide or respond to unwanted

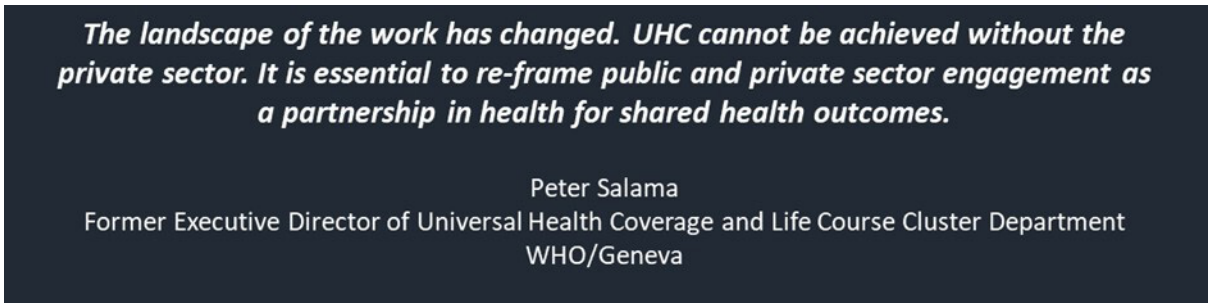

Figure 1 Changing landscape of global health.

behaviours in the health system. Where countries have had a recognisable policy towards the private sector, it has for a long time followed authoritarian practices such as banning or tightly restricting the scope for private practice or administering prices; increasingly, such policies have been found unworkable and have become discredited.[9 29] Due to the lack of data and knowledge about the scale of the private sector and its operations, and being wary of counter-productive policy positions, some governments have then preferred to ignore its recent growth.[30]

A growing public policy gap has opened because governments have lost contact with the private sector.[9 21] This situation creates significant challenges in meeting national health priorities, especially as the three dimensions of UHC—population coverage, access to essential services and financial risk protection—are unattainable without effective governance of all health actors.[8 31 32]

Closing this gap is essential (figure 1).[29 33–35] However, many health systems are underperforming because their current policy and implementation mechanisms do not effectively mobilise the whole health system. Instead, the private sector often operates in a parallel and separate system shaped by market forces rather than public policy goals such as UHC.[9 18 21] This is a serious problem because of the unique microeconomic characteristics of how markets for healthcare function, in which suppliers or providers of care have a powerful influence over demand and utilisation due to an extreme information asymmetry. Therefore, private interactions between consumers and providers cannot be relied on to achieve a socially satisfactory outcome. An unregulated healthcare market is acknowledged as inequitable and inefficient.[9] The absence of enabling environments for public–private collaboration further contributes to inefficient and inequitable results.[36 37] Therefore, the argument is not about the principle of intervention, but about its scale and form.

Accordingly, there is a need to develop public policies inclusive of the private sector, build implementation capability, improve the availability of data on the private sector, develop more evidence-based approaches, and better coordinate the work of global health actors working to support countries' efforts.[15]

Over the last two decades, various frameworks and strategies have been recommended, ranging from prohibition to encouragement of the private health sector.[27 33] Despite this acknowledgement, the health systems literature offers few solutions on how to effectively respond. This is because much of the work on health systems governance to date has concentrated on constructing long lists of principles and characteristics that constitute good governance in general, supplemented by lists of actions of particular concern for health systems.[38 39] These lists overlap and are seldom supported by empirical studies of how governance operates in practice.[38] As a result, there has been limited effort to operationalise governance frameworks.[40] For instance, Pyone *et al*[38] identified 16 health system governance frameworks, among which only 5 were in use. This has been attributed to the abstract nature of the principles, which limits their relevance for policymakers who look for actionable recommendations.[39] This situation is exacerbated by resource scarcity and multiple urgent competing priorities for political and policy action, system fragmentation and the conflict between development and donor agendas, focused on vertical programmes rather than on strengthening overall governance capacity for the whole system.[39]

Gilson *et al*[41] argue that 'governance is a practice, dependent on arrangements set at the political or national level, but which needs to be operationalised by individuals at lower levels in the health system'. For Bourdieu[42] and Giddens,[43] the concept of practice is essential to make clear that social structures such as rules and institutions do not simply 'exist' or influence actors 'from the outside'. They are produced and reproduced in practice by the interactions between actors and structures.

We argue that a focus on governance as a practice would help progress understanding from the general and theoretical to targeted analysis and the integration of governance into health policy and programme design. Practice has emerged as a critical concept for understanding central questions about how agency, structure, individual action and institutions are linked in social systems, cultures and organisations. We believe that a focus on practice helps progress understanding from the general and theoretical to a focus on process of local problem solving.

The advantage of the governance as practice approach is that it highlights that introducing new or strengthening existing governance arrangements should be approached as a change process. Existing rules, power structures, vested interests and incentives will impact governance

Box 1 The six governance behaviours and their intent statement

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 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).

reforms and likely mean that new rules and processes will need to be introduced over time with a concerted effort to assess and address bottlenecks. It follows that work on governance practice needs to consider the possibility of setbacks and the need to experiment, adapt, adjust and tailor approaches to local needs and circumstances.

WHO STRATEGY AND APPROACH

In 2020, the WHO's Advisory Group on the Governance of the Private Sector for Universal Health Coverage developed a Strategy Report on 'Engaging the private health service delivery sector through governance in mixed health systems' with six governance behaviours as its centrepiece (see box 1).[14] The strategy report aims to guide and enable governance performance improvement, strengthen government stewardship and subsequently improve health system performance.[14 44] The strategy was developed through an iterative process involving a series of in-person and virtual engagements with the experts members of the Advisory Group and other units within WHO. These engagements and the strategy were informed by a series of studies, compiled as a private sector landscape of mixed health systems.[18]

The strategy builds from the theoretical foundations of the WHO Report 2000 on health systems performance and by the work of Travis *et al*[2] on stewardship. Conceptually, the Advisory Group proposed reframing the stewardship subfunctions as behaviours in recognition of the need for a behavioural approach and a change management approach to govern the private sector within pluralistic health systems. As such, the governance behaviours presented in the strategy report seek to activate the governance building block and explicitly recognise the 'messy' and interconnected relationships within health systems. They follow a socioecological practice-based approach that conveys goal-oriented interaction between public and private health system entities and emphasises the leadership of government as stewards of health systems.[45] The governance behaviours further recognise that behavioural change is not a quick fix but a series of connected actions that should be approached consistently and with constancy.

The governance behaviours are thus proposed as the means and processes through which governments execute the governance function as part of their responsibility for the health and well-being of their population. The behaviours provide a strategic practice-based approach to unpack and implement necessary reforms and guide action for working with the private sector. They emphasise the importance of approaching governance as a practice, with necessary implementation activities determined through day-to-day decision-making and improvisation by actors at multiple levels.[41] However, they do not prescribe norms and values, as these should be contextually determined.

Deliver strategy and enable stakeholders focus on broader institutional arrangements for health system performance; these include setting health priorities and strategic direction, articulating principles and values, and deploying underlying policy and regulatory frameworks.

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 actors, and integration of entities within the health system's institutional arrangements.

Build understanding and foster relations consider the systems and interactive processes using information and engagement as levers for improving institutional and organisational (structural) performance.

Nurture trust considers how well this is done by exploring the quality of integrative engagement, power and responsibilities, and the centrality of population health, principles and values to sectoral roles and interactions.

The governance behaviours can thus be used to diagnose and guide action to address health system performance problems in which the private sector in health plays an important role (or could play one) and which can be mediated through governance intervention. This can be achieved through honing on performance issues in relation to the private sector in health, and identifying pathways to align behaviours. This form of diagnosis may then be used independently or feed into more extensive health systems performance assessments. Table 1 illustrates diagnostic questions for each governance behaviour. Since 2000, the WHO System's Stewardship

Table 1 Description and key diagnostic questions for the governance behaviours

Governance behaviour	Rubric options
Align structures. Government takes the required actions to align public and private structures, processes and institutional architecture to create a fit between policy objectives, organisational structures and culture.	
Are private sector entities integrated into health system organisational arrangements? (formal, informal health actors, as well as digital self-care models of care, etc)	A. No evidence of integration
	B. Limited integration (eg, larger urban entities)
	C. Moderate integration (eg, a base of large, medium and small providers)
	D. Full integration of private entities in the health system
	E. Do not know
Do private sector entities deliver a publicly defined essential healthcare package?	A. No essential benefits package
	B. Essential benefits package defined but not used to align/engage the private sector
	C. Essential benefits package defined and partially delivered by private sector entities
	D. Essential benefits package is fully aligned and delivered by private sector entities
	E. Do not know
Are systems used to align public and private providers? (eg, referral, quality assurance, supervision)	A. No systems used
	B. Systems used on an ad hoc basis
	C. Systems used but coverage is limited
	D. Systems used across a range of public and private entities
	E. Do not know
Deliver strategy. Government establishes strategic public policy framework which sets out the vision, priorities, principles and values for the health system, and works out how to translate these priorities, principles and values into practice.	
Does national health policy/strategy include the private health sector?	A. Private sector is not mentioned in national health policy
	B. Private sector is included in national health policy but vaguely referenced
	C. Private sector is included in national health policy with some specificity on entities and roles
	D. Private sector is included in national health policy with clear identification of entities and roles
	E. Do not know
Is national health policy/strategy used to guide the private sector towards public health goals?	A. National health policy is not used to guide the private sector
	B. Limited use of national health policy (not reflected in operational plans)
	C. Moderate use of national health policy (reflected in operational plans but limited implementation)
	D. Demonstrated use of national health policy (operationalised plan/roadmap and tools)
	E. Do not know
Is there an inclusive process for national health policy review? (eg, formal review as part of the policy cycle)	A. No policy review
	B. Policy review (public sector only)
	C. Policy review (selective participation of private and civil society)
	D. Policy review is inclusive of private sector entities and civil society
	E. Do not know
Are there defined national health policy monitoring mechanisms in place that include the private sector?	A. No monitoring mechanism
	B. Monitoring mechanism defined, but no evidence of use
	C. Monitoring mechanism used in a limited way (eg, at time of policy review, or only by the public sector)
	D. Monitoring mechanism used consistently
	E. Do not know
Build understanding. Government facilitates information-gathering and sharing about all elements of service provision in the health system to provide intelligence to contribute to better health system outcomes.	
Are private sector entities included in national health information systems (HIS)?	A. No private sector reporting in HIS
	B. Limited private sector reporting in HIS (eg, larger facilities, faith-based facilities)
	C. Moderate private sector reporting in HIS (eg, wider spectrum of entities)
	D. Universal reporting by private sector entities (eg, meets WHO threshold of 80%)
	E. Do not know
How confident are health actors in using private sector data from national HIS? (eg, completeness, timeliness, quality and consistency of information)	A. No confidence in private sector data
	B. Limited confidence in private sector data
	C. Moderate confidence in private sector data (efforts in place to improve quality)
	D. Confidence in private sector data (eg, routine data quality review/assurance)
	E. Do not know

Continued

Table 1 Continued

Governance behaviour	Rubric options
Are other sources of private sector data/information available and used? (eg, surveys, assessments, research)	A. No other data sources available
	B. Other sources available but not recognised/used
	C. Other data sources partially recognised/used
	D. Evidence of triangulation of information sources and their use
	E. Do not know
Foster relations. Government should establish mechanisms that allow all relevant stakeholders to participate in policy-making and planning and forge partnerships.	
Is the private sector organised for public sector engagement?	A. No private sector organisation
	B. Limited private sector organisation (eg, parts of the private sector)
	C. Moderate private sector organisation (wider membership)
	D. Organised private sector (wide and active membership)
	E. Do not know
Is the public sector organised and resourced for private sector engagement?	A. No public sector organisation (for PSE)
	B. Limited public sector organisation for PSE (eg, limited resources, role and reach)
	C. Moderate public sector organisation (eg, investment in resources, roles and reach)
	D. Public sector organisation for PSE (eg, established/adequate resources, roles and reach)
	E. Do not know
Are there public–private coordination platforms?	A. No coordination platform
	B. Coordination platform(s) available but not formalised/used
	C. Coordination platforms formalised and used on an ad hoc basis
	D. Coordination platform(s) formalised and consistently used
	E. Do not know
Enable stakeholders. Government ensure that tools exist for implementing health policy to authorise and incentivise health system stakeholders and, where necessary, impose sanctions to align their activities and further leverage their capacities, towards national health goals.	
What regulations are in place for the private sector? (eg, licensure, accreditation)	A. No regulations in place
	B. Limited regulations in place
	C. Regulations in place but some gaps
	D. Comprehensive regulatory framework
	E. Do not know
Do public financing arrangements include the private sector? (eg, grants, in-kind, contracting)	A. No public financing of the private sector
	B. Limited public financing options (eg, training, access to commodities)
	C. Wider availability of public financing instruments but not widely used (eg, grants or contracts to specific entities only)
	D. Public financing instruments available and cover a range of private sector entities
	E. Do not know
Is there adequate public sector capacity to ensure compliance with regulations and rules?	A. No capacity to monitor or enforce
	B. Limited capacity to monitor/enforce (eg, ad hoc, selective)
	C. Moderate capacity to monitor/enforce (eg, procedures in place but not fully implemented)
	D. Monitoring and compliance systems fully implemented
	E. Do not know
Nurture trust. Government leads the establishment of transparent, accountable and inclusive institutions at all levels to build trust ensuring that all health system actors, public and private, are accountable for their actions to a country's population.	
How central are patient/civic interests to private sector engagement?	A. Patient/civic interests not mentioned as part of PSE
	B. Patient/civic interests mentioned broadly as part of PSE
	C. Patient/civic interests with some specificity as part of PSE (eg, some analysis of gaps)
	D. Patient/civic interests specified as part of PSE (eg, analysis considers gender, diversity, equity)
	E. Do not know
Do measures exist to manage competing and conflictive sectoral interests?	A. No measures in place
	B. Measures in place but not used for mitigation
	C. Measures in place but require pressure to prompt mitigation (eg, via media or civic intervention)
	D. Measures in place and used to mitigate and manage interests
	E. Do not know

Continued

Table 1 Continued

Governance behaviour	Rubric options
What is the role of brokers/champions in sectoral engagement?	A. No broker/champion
	B. Broker/champion used on an ad hoc basis with limited effect
	C. Brokers/champions used more routinely to facilitate engagement
	D. Brokers/champions consistently engaged to facilitate engagement and build trust across sectoral entities
	E. Do not know
Is there any sharing of resources, capacities, skills for establishing trust between sectors?	A. No sharing of resources, capacities, skills
	B. Ad hoc sharing of resources, capacities, skills
	C. Externally driven sharing of resources, capacities and skills
	D. Cooperative models of sharing of resources, capacities and skills
	E. Do not know

and Governance team has tested the approach in a range of contexts, during COVID-19 and postpandemic recovery[22 46 47]; some of this work is reflected within this *BMJ* special edition.

CONCLUSION

With this article, we have taken a behavioural approach to the governance of the private sector in health, drawing on the WHO strategy on the topic. We see the need for this, as the aim is to help governments better understand and solve their health system performance problems, harnessing the private sector in health to achieve UHC. We argue that the six governance behaviours offer an approach for guiding the practice of governing pluralistic health systems focused on anchoring public values and outcomes and drawing on exploratory and behavioural approaches to design and implement localised inclusive policy frameworks and governance operating models. The governance behaviours are intended to support countries to take a bottom-up approach to fill knowledge, policy and governance gaps when it comes to this long-neglected area of health systems strengthening.

In recognition that all complex systems—such as health systems—are made up of experiential learnings, held by diverse actors within or across various parts of the system, we acknowledge that this paper presents a learning approach for governance to document success and redress failures in working with the private sector in health. Learning enables governments to adapt and improve their regular practices to perform their stewardship functions more effectively and it has various benefit for health systems, from correcting errors to build greater self-reliance.[48] The governance behaviours model is still in the process of validation. Nevertheless, we hope that our reflections on health system governance in pluralistic health systems will contribute to and support much-needed operational discussion among health policy-makers and researchers.

To effectively fill the literature gap on practices for governing pluralistic health systems, the governance behaviours and policy reform frameworks need to account for the maturity of specific national political and health systems. In this regard, research sponsored by WHO, and anticipated in other articles in this supplement, is focusing on the development of a progression model of governance capacities to steward the private sector in health. This work reinforces the preliminary standpoint proposed in this article to accurately measure and diagnose performance of private sector governance capacities with the aim to inform policies and prioritisation, build institutional capacity as well as to scale-up examples of effective governance practice.

Acknowledgements The paper benefited a lot from the critical comments and review provided by Joe Kutzin.

Contributors All authors have accepted responsibility for the entire content of this manuscript and approved its submission.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Disclaimer The authors alone are responsible for the views expressed in this article and they do not necessarily represent the views, decisions or policies of the institutions with which they are affiliated.

Competing interests None declared.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data sharing not applicable as no datasets generated and/or analysed for this study.

ORCID iDs

Anna Cocozza http://orcid.org/0000-0002-0591-4341
Gerald Bloom http://orcid.org/0000-0002-7047-2412

REFERENCES

1 World Health Organization. The world health report 2000: health systems: improving performance. Geneva: World Health Organization; 2000. Available: https://apps.who.int/iris/handle/10665/42281
2 Travis P, Egger D, Davies P, *et al*. Towards better stewardship: concepts and critical issues. Geneva: World Health Organization; 2002. Available: https://apps.who.int/iris/handle/10665/42281

3 Brinkerhoff DW, Cross HE, Sharma S, *et al*. Stewardship and health systems strengthening: an overview. Public Adm Dev 2019;39:4–10. 10.1002/pad.1846 Available: https://onlinelibrary.wiley.com/toc/1099162x/39/1
4 Lagomarsino G, de Ferranti D, Pablos-Mendez A, *et al*. Public stewardship of mixed health systems. *Lancet* 2009;374:1577–8.
5 Veillard JHM, Brown AD, Barış E, *et al*. Health system stewardship of national health ministries in the WHO european region: concepts, functions and assessment framework. *Health Policy* 2011;103:191–9.
6 World Health Organization. Everybody's business -- strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007. Available: https://apps.who.int/iris/handle/10665/43918
7 Böhm K, Schmid A, Götze R, *et al*. Five types of OECD healthcare systems: empirical results of a deductive classification. *Health Policy* 2013;113:258–69.
8 Clarke D, Doerr S, Hunter M, *et al*. The private sector and universal health coverage. *Bull World Health Organ* 2019;97:434–5.
9 Kutzin J, Sparkes SP. Health systems strengthening, universal health coverage, health security and resilience. *Bull World Health Organ* 2016;94:2.
10 Nishtar S. The mixed health systems syndrome. *Bull World Health Organ* 2010;88:74–5.
11 San Giorgi M. *The Human Right to Equal Access to Health Care*. Antwerp: Intersentia, 2012.
12 World Health Organization and the United Nations Children's Fund (UNICEF). Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF); 2020. Available: https://www.who.int/publications/i/item/9789240017832
13 Ruef F, Ejderyan O. Rowing, steering or anchoring? Public values for geothermal energy governance. *Energy Policy* 2021;158:112577.
14 World Health Organization. Strategy report: engaging the private health service delivery sector through governance in mixed health systems. Geneva: World Health Organization; 2020. Available: https://www.who.int/publications/i/item/9789240018327
15 De Costa A, Diwan V. Where is the public health sector?' public and private sector Healthcare provision in Madhya Pradesh, India. *Health Policy* 2007;84:269–76.
16 Bloom G, Standing H, Lucas H, *et al*. Making health markets work better for poor people: the case of informal providers. *Health Policy Plan* 2011;26 Suppl 1:i45–52.
17 Sudhinaraset M, Ingram M, Lofthouse HK, *et al*. What is the role of informal healthcare providers in developing countries? A systematic review. *PLoS One* 2013;8:e54978.
18 World Health Organization. Private sector landscape in mixed health systems. Geneva: World Health Organization; 2020. Available: https://www.who.int/publications/i/item/9789240018303
19 Strong J, Lattof SR, Maliqi B, *et al*. Experiences of private sector quality care amongst mothers, newborns, and children in low- and middle-income countries: a systematic review. *BMC Health Serv Res* 2021;21:1311.
20 Mackintosh M, Channon A, Karan A, *et al*. What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. *Lancet* 2016;388:596–605.
21 Siddiqi S, Aftab W, Venkat Raman A, *et al*. The role of the private sector in delivering essential packages of health services: lessons from country experiences. *BMJ Glob Health* 2023;8:e010742.
22 World Health Organization. *Private Sector Engagement to Deliver Maternal, Newborn, Child Health and Family Planning Services During COVID-19 in Pakistan*. Geneva: World Health Organization, 2023.
23 Basu S, Andrews J, Kishore S, *et al*. Comparative performance of private and public healthcare systems in low- and middle-income countries: a systematic review. *PLoS Med* 2012;9:e1001244.
24 Rao KD, Petrosyan V, Araujo EC, *et al*. Progress towards universal health coverage in BRICS: translating economic growth into better health. *Bull World Health Organ* 2014;92:429–35.
25 David Williams O, Yung KC, Grépin KA. The failure of private health services: COVID-19 induced crises in low- and middle-income country (LMIC) health systems. *Glob Public Health* 2021;16:1320–33.
26 Lal A, Erondu NA, Heymann DL, *et al*. Fragmented health systems in COVID-19: rectifying the misalignment between global health security and universal health coverage. *Lancet* 2021;397:61–7.
27 Montagu D, Goodman C. Prohibit, constrain, encourage, or purchase: how should we engage with the private health-care sector? *Lancet* 2016;388:613–21.
28 Governance of the private sector in health: a public health policy framework approach. 2022. Available: https://www.ccpsh.org/research/governance-private-sector-health-public-health-policy-framework-approach [Accessed 31 Mar 2022].
29 Preker AS, Harding AL. Private participation in health services. health, nutrition and population. Washington, DC: World Bank; 2003. Available: https://openknowledge.worldbank.org/entities/publication/f6f79915-7c62-5a9d-8825-c956c7ebae17
30 Understanding the private health sector: in the Eastern Mediterranean Region. Cairo: WHO Regional Office for the Eastern Mediterranean; 2021. Licence: CC BYNC-SA 3.0 IGO.; 2022.
31 Morgan R, Ensor T, Waters H. Performance of private sector health care: implications for universal health coverage. *Lancet* 2016;388:606–12.
32 Nabyonga-Orem J, Nabukalu JB, Okuonzi SA. Partnership with private for-profit sector for universal health coverage in sub-Saharan Africa: opportunities and caveats. *BMJ Glob Health* 2019;4:e001193.
33 Peters DH, Mirchandani GG, Hansen PM. Strategies for engaging the private sector in sexual and reproductive health: how effective are they? *Health Policy Plan* 2004;19 Suppl 1:i5–21.
34 Lagomarsino G, Nachuk S, Kundra S. Public stewardship of private providers in mixed health systems: synthesis report from the Rockefeller foundation—sponsored initiative on the role of the private sector in health systems. Washington, DC: Results for Development Institute; 2009. Available: https://www.r4d.org/wp-content/uploads/Public-Stewardship-of-Private-Providers-in-Mixed-Health-Systems.pdf
35 Bennett S, Hanson K, Kadama P, *et al*. World health organization. evidence and information for policy C. Working with the non-state sector to achieve public health goals. Geneva: World Health Organization; 2005. Available: https://apps.who.int/iris/handle/10665/69202
36 Stibbe D, Prescott D. THE SDG PARTNERSHIP GUIDEBOOK: A practical guide to building high impact multi-stakeholder partnerships for the sustainable development goals. 1st edn. The Partnering Initiative and UNDESA; 2020. Available: https://sustainabledevelopment.un.org/content/documents/26627SDG_Partnership_Guidebook_0.95_web.pdf
37 Siddiqi S, Masud TI, Nishtar S, *et al*. Framework for assessing governance of the health system in developing countries: gateway to good governance. *Health Policy* 2009;90:13–25.
38 Pyone T, Smith H, van den Broek N. Frameworks to assess health systems governance: a systematic review. *Health Policy Plan* 2017;32:710–22.
39 Hamra R, Siddiqi S, Carmel E, *et al*. Assessing the governance of the health policy-making process using a new governance tool: the case of Lebanon. *Health Res Policy Syst* 2020;18:66.
40 Wu X, Ramesh M, Howlett M, eds. Policy capacity and governance. In: *Assessing governmental competences and capabilities in theory and practice*. 1st edn. Palgrave Macmillan Cham, 2018.
41 Gilson L, Lehmann U, Schneider H. Practicing governance towards equity in health systems: LMIC perspectives and experience. *Int J Equity Health* 2017;16:171.
42 Bourdieu P. *Outline of a theory of practice*. Cambridge: Cambridge University Press, 1977. Available: https://www.cambridge.org/core/books/abs/outline-of-a-theory-of-practice/contents/2087FF361B2A4078123E3658B889D70B2087FF361B2A4078123E3658B889D70B
43 Giddens A. *The constitution of society: outline of the theory of structuration*. Cambridge: Polity Press, 1984. Available: https://www.ucpress.edu/book/9780520057289/the-constitution-of-society
44 Salmon J, Hesketh KD, Arundell L, *et al*. Changing behavior using ecological models. In: Hagger MS, Cameron LD, Hamilton K, et al., eds. *The Handbook of Behavior Change*. Cambridge, United Kingdom: Cambridge University Press, 2020: 237–50. Available: https://research.usq.edu.au/item/q6xy8/changing-behavior-using-ecological-models, https://www.cambridge.org/core/books/handbook-of-behavior-change/BD76D0E53DB1BC2EE8C53C1603D45E6A
45 Managing Markets for Health (MM4H). Online course massive open online course: global financing facility. 2018. Available: https://m4h.sps.ed.ac.uk/
46 World Health Organization. Equitable access to COVID-19 tools: aligning the private sector with national response efforts. Geneva: World Health Organization; 2022. Available: https://www.who.int/publications/i/item/9789240046481
47 World Health Organization. Towards better engagement of the private sector in health service delivery: a review of approaches to private sector engagement in Africa. Geneva: World Health Organization; 2022. Available: https://www.who.int/publications/i/item/9789240047273 [Accessed May 2022].
48 Sheikh K, Peters D, Agyepong IA, *et al*. Learning is a means to progress and empowerment for health systems. *BMJ Glob Health* 2022;7:e010572.