Core Area	Common Issues or Constraints	Desired Outcome	Potential Interventions
Service Delivery Goal: Increased access (geography and affordability) to qualified health care providers and facilities in the private sector	• Time and cost to get licensed • No or limited monitoring of licensing requirements • Strict and/or cumbersome re-licensing can lead to fewer access points for primary care	Qualification to practice • All private service providers meet minimum qualifications to practice • Private providers identifiable by appropriate licensing agency	• **Delegate authority to appropriate licensing body** to define qualifications for the profession. • **Streamline professional licensing/ relicensing procedures** to encourage market entry and prevent bottlenecks.

	• Limitation on kinds of services provided by types of providers can make task-shifting more difficult to achieve
	• Differences in scopes of practice between public and private sector providers creates unfair competition and restricts access points for primary care through the private sector
	• Confusion and overlap of scopes between different health cadres can make task-shifting more difficult to achieve
		Scope of practice
		• Easy access (geographic and price) to qualified private provider to deliver key health services
			• Establish **regulatory framework** governing scopes of practice including:
			  • **defining clear scopes** across cadres and consistent across sectors
			  • **delegating authority to appropriate licensing body** to define scopes of practice for the profession consistent with training and experience requirements
			  • **establishing a mechanism**(overarching council of allied medical professions) to resolve conflict when more than one profession claims sole right to carry out a particular activity or procedure
			  • **grant clear permission** for an individual to be licensed for private practice when working within agreed scope of practice.

	• Scopes of practice for pharmacists and related professionals are too vague or not clearly defined, leading to too much access to essential drugs • If prescribers (e.g. MD) also dispense, may create conflict between professions • Pharmacist requirement at all times prevents use of available pharmacy technicians • Without clear essential drug list and related staffing levels, drugs maybe abused or improperly used.	Qualification to practice • All private pharmacists meet minimum qualifications to practice • Private pharmacists identifiable by appropriate licensing agency Scope of practice • Easy access (geographic and price) to qualified private pharmacists and/or technician to deliver key health products	• To clarify scopes of practice for pharmacists and other related professionals, governments can: 1) **establish an essential drug list**, and 2) **define a drug list** for different levels of facility staffing and supervision. • To help increase access to drugs and qualified providers, 1) **require prescriptions i**f government has a system that can enforce, 2) if pharmacist is not available (e.g. rural areas) or health risk is low, allow pharmacist technicians to dispense, 3) allow technical supervision of facility by pharmacists without constant on-site presence, and 4) permit **franchise with a full-time pharmacists to supervise** a network of pharmacy shops staffed with full-time pharmacy technicians.
	• Existence (non) of regulations authorizing private sector provision of services • Cumbersome processes to get a license increases delays and costs • Public sector obligations required before being allowed to enter into private practice • NGOs restricted from charging feeds • Government control	Establishment of private practice and expansion of essential health services (e.g. PHC, FP/RH, HIV/AIDS, MCH) • All private providers meet minimum qualification to be in private practice • Private providers identifiable by appropriate licensing agency • Fair and competitive private sector service provision • Financially	• Utilize **dual practice** to incentivize retention of qualified HRH • **Limit waiting period** to enter private practice to no more than 2 to 3 years. • **Certificate of need** • **Contracting out** expands private sector coverage of particular services via government finance and may (through contract specification) improve quality of care. Contracting out can potentially improve efficiency and quality through competition. • **Vouchers** increase consumer choice and affordability of care from private sector providers through subsidy of goods or services. Reimbursement of vouchers is also a promising strategy to increase performance and assure quality. • **Networking providers** is an effective way to ensure a

	on prices • Difficulty accessing credit to establish and expand services and improve quality • Excessive requirements for liability and other types of insurance	sustainable private sector services • Retention of qualified health professional in local health market	standard of quality and price for given services. It also allows for the scale-up of essential services through individual private providers. • **Access to credit** for private providers
	• Absent, poorly defined, out-of-date service delivery standards • Different standards for public and private sectors • Quality uneven and inconsistent in private sector • No requirements for continuing medical education and/or re-licensing • Limited or no access to standards and guidelines • Limited or no access to medical updates and training • Limited or no quality supervision system	Quality assurance and monitoring • Sufficient numbers of well-trained private sector health care professionals mobilized to address public health priorities • Private providers apply national standards and guidelines and receive regular updates • Private providers supervised by appropriate government monitoring agency	• **Training–**through a variety of techniques including direct training, CME, and detailing–improves knowledge, skills, and quality of care of private providers. • Establishing **realistic CME policies and procedures** that 1) require proof of CME in license renewal, 2) ensure education requirements are realistic and take into account availability of training, and 3) link licensing to easy-to-comply disease reporting. • Given the rapid progress in drugs and diagnostics, allow greater flexibility in 1) in prescribing and dispensing protocols, permitting task-shifting, and 2) medical education and licensing guidelines to adjust to changes in new technologies and drugs • **Establish accreditation system** that defines performance benchmarks against pre-established quality standards to be applied consistently for specific types of providers and across sectors. • **Improve regulatory effectiveness** by 1) vesting authority in professional councils, 2) ensure adequate budget for inspectors and travel, 3) supervise inspectors to reduce graft, 4) include sanctions, 5) allow de-licensing by administrative action and 6) acknowledge supplementary peer review or accreditation. • **Strengthen inspection** by: 1) making same agency complete both sanitary and medical inspections at decentralized level; 2) requiring inspectors determine facility classification is appropriate, and 3) conducting

			interval, random quality checks of laboratory services as requirement for re-licensing.
	• Overly stringent infrastructure requirements can limit service delivery points, particularly in rural areas • Overly restrictive requirements on types of services provided at facility level • Limited or no quality system to inspect facilities	Facility registration and re-licensing	• Clearly state that **ALL facilities are subject to the same regulations.** Base licensing on facility classification irrespective of ownership. • Empower delegated agency the authority to update facility standards more frequently than the law, affording more flexibility. • Ensure facility **re-licensing occurs at least every five years** to continually maintain oversight. • Ensure facility licensing laws and regulations on staffing mirror the professional scopes of practice. • **Consider waivers or flexible arrangement**s for facility licensing in rural areas. Possibly adjust facility/staffing requirements to service level with a special category for rural areas. • Require approval for licensee to purchase selected equipment, particularly for expensive equipment that has limited public health impact.

Assessment to Action, USAID SHOPS Project led by Abt Associates (2014)