

PRIVATE SECTOR ENGAGEMENT FOR IMPROVED CANCER CARE: A Strategic Guide



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EXECUTIVE SUMMARY

Private sector engagement is increasingly recognised as a critical pathway to improving access to cancer care, particularly in cities where public health systems face constraints in capacity, financing, and specialised service delivery. Across many health systems, private providers already play a substantial role in diagnosis and treatment. However, this engagement is often informal, fragmented, and reactive, lacking clear strategic direction or governance frameworks. As a result, opportunities to leverage private sector capabilities in support of equity, quality, and system sustainability may remain underutilised.

This strategic guide was developed by the City Cancer Challenge (C/Can) Foundation through a multi-stakeholder task force and informed by qualitative analysis across four cities: Tbilisi, Georgia; Greater Petaling, Malaysia; Leon, Mexico; and Nairobi, Kenya. These cities represent a range of health system contexts and levels of private sector involvement in cancer care. Stakeholder consultations with public authorities, private providers, and civil society revealed common challenges and recurring system-level gaps that affect how public and private actors collaborate in delivering cancer services.

The findings indicate that effective public–private engagement requires a shift from ad hoc arrangements toward structured, system-wide strategies. Key priority areas that shape the success of such engagement were identified: vision, governance, change management, human resources, health system regulations, clinical care, digitisation, contracting, payment and reimbursement, administration, and equipment. Together, these areas form an integrated framework for strengthening collaboration while safeguarding public interest and patient outcomes.

A clear vision is essential to articulate why and how private sector engagement supports national and city-level cancer priorities. Governance mechanisms must define decision-making authority, accountability, and transparent rules of engagement. Change management is critical to ensure that reforms are understood, accepted, and implemented by stakeholders across both sectors. Human resource strategies must address workforce shortages, preserve training capacity, and align incentives between public and private providers.

Regulatory frameworks, contracting practices, and payment systems must evolve to support value-based, patient-centred care. Private provider participation could be encouraged through contracts that are standardised, enforceable, and focused on quality and outcomes, with predictable and timely reimbursement mechanisms. Digitisation and equipment investments are strategic enablers that reduce administrative burden, improve care continuity, and strengthen monitoring and accountability across the system.

This guide does not prescribe a single model of public–private engagement. Rather, it offers adaptable principles and practical approaches that cities can tailor to their local health system context, regulatory environment, and market structure. By moving toward strategic, transparent, and coordinated partnerships, cities can better harness private-sector capabilities to expand access to cancer care, improve quality, and ensure long-term system sustainability centred on the needs of patients in all engagement efforts.

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INTRODUCTION

Private-sector engagement is increasingly cited as a critical pathway for advancing cancer control, particularly in settings where public systems face constraints in capacity, financing, and specialised service delivery. Across health systems, private actors already play a substantial role in cancer care provision. Yet despite this reality, engagement between public and private sectors is frequently ad hoc and reactive. In many contexts, there are no clear frameworks to guide when, where, and how private-sector engagement should occur, nor how such engagement can be structured to advance equity, quality, and system sustainability rather than exacerbate fragmentation or inefficiency.

Recognising this gap, City Cancer Challenge Foundation convened a multi-stakeholder task force of global experts to explore strategic approaches to strengthen local public-private engagement in cancer care at the city level. Four global cities with varying degrees and forms of private provider involvement in cancer care were selected. In each of these cities, stakeholder consultations in the private and public sectors were conducted to develop an understanding of the landscape, challenges, successes, and opportunities in each of the systems.

Building on the insights from these cities and considering their broader relevance to cities globally interested in improving cancer care in collaboration with the private sector, this document is intended as a practical strategic reference for city-level decision-makers seeking to strengthen public-private engagement in cancer care. It is not prescriptive, and does not promote a single model of engagement. Rather, it outlines strategic objectives, common challenges, and potential approaches that can be adapted to local health-system contexts, regulatory environments, and market structures.

The report aligns with previous strategic priority recommendations such as those set forth by the World Health Organization, which include convening political will, embedding governance, setting norms, and technical and learning support. This report goes further adapting and expanding on the recommendations so that they are better suited for the context of cancer care and its unique set of needs.

METHODOLOGY

Within the C/Can network, four cities were identified that capture varying degrees of private-sector provider involvement in the delivery of cancer care. The four selected cities reflect various geographies and city types; they are Tbilisi, Georgia; Greater Petaling, Malaysia; Leon, Mexico; and Nairobi, Kenya.

A group of global experts was convened by C/Can to develop the scope, approach, and priorities of the analysis. The taskforce of experts was drawn from a wide range of sectors, including clinical care, hospital management, government administration, professional and industrial organisations, and development agencies. The scope focused on the role of the private sector in care delivery, beginning at diagnosis and included all aspects impacting care delivery with the exception of consumables.

Utilising a qualitative exploratory approach, literature reviews were conducted for each of the cities, focusing on the current structure, present and past financing approaches, and recent forms of private sector involvement in care delivery. C/Can City Managers were interviewed to provide an initial overview of the role of the private sector care provision and to support identification of key stakeholders to be interviewed within the private and public sectors. Stakeholders were selected based on their knowledge of the health system and the role of the private sector. Non-probability sampling techniques were used in the recruitment of initial stakeholders, and snowballing was used to identify further stakeholders based on the interviews.

Interviews were conducted virtually and adapted to the role and expertise of the interviewees. Interview questions were shared in advance, and informed consent was obtained. Interviews averaged 60 minutes. Summaries were shared with participants for validation, and findings were triangulated with additional interviews and literature sources.

The findings highlight the current structure, challenges, and opportunities for private sector care provision for each of the cities, along with common themes across the various cities were documented in an internal report and discussed by the taskforce. Through these discussions, thematic priority areas were identified, forming the structure of this strategic guide.

PRIORITY AREAS

Stakeholder interviews, literature reviews, and task force deliberations identified several health system components that appear particularly influential in shaping effective engagement between public and private cancer care providers.

These areas were prioritised based on their potential impact on access, quality, and outcomes of care. The focus was on systemic challenges affecting the broader cancer ecosystem rather than isolated institutional issues.

For each priority area, common challenges and potential strategic approaches were identified. The emphasis of this guide is on strengthening processes, governance structures, and coordination mechanisms, rather than proposing narrow or context-specific interventions.

By focusing on system-level capabilities and decision-making processes, cities may be better positioned to adapt solutions to their specific contexts while strengthening the overall resilience and responsiveness of their cancer care systems.

VISION

This refers to the message conveying future direction and intended outcomes. In this context, it should outline the vision for cancer management and the role of the private sector in cancer care provision. It should be sufficient to guide and inform strategy, governance, and contracting decisions and planning in the short to long term.

Strategic objective:

The clear articulation of the rationale, priorities, and intended direction of engagement with the private sector by the public sector may facilitate the investment and alignment by private actors to meet current and future health demands.

Challenges:

The clear articulation of the rationale, priorities, and intended direction of engagement with the private sector by the public sector may facilitate the investment and alignment by private actors to meet current and future health demands.

Across the health systems reviewed, high-level political statements supporting private sector collaboration were common, but these often lacked operational clarity regarding objectives, priorities, or implementation pathways.

As a result, private providers sometimes perceive such statements as symbolic or opportunistic rather than actionable, limiting their ability to plan investments or capacity development.

The lack of a clear strategic direction is compounded by the absence of documents that provide greater details or operational clarity on the direction and priorities derived from the high-level strategic statements. Many stakeholders identified procurement laws and regulations as the primary reference points, rather than broader strategic frameworks guiding engagement.

The private sector stakeholders indicated that there is difficulty in understanding and acting upon the government's strategy on private sector engagement in care delivery, as in addition to the statements often being high-level and vague, there is limited opportunity for clarification. Private providers experienced difficulty obtaining sufficient clarity regarding the short-, medium-, and long-term vision of the public sector to engage with the private sector that would allow them to plan and invest to be effective contributors and partners in this vision.

Approach:

- Internally, the public sector should identify the objectives and priorities associated with their strategy to engage with the private sector, providing the rationale for collaboration and alignment with other sector-specific strategic interests. Explicit identification of priority challenges is particularly beneficial in the cancer context given the multidimensional challenges associated with cancer such as financial toxicity, treatment complexity, social stigma, and social burden. Explaining why and how the private sector may be a strong partner to help achieve these goals would likely contribute to increased trust of the general public in these engagements, especially given the high costs associated.
- Publicly accessible reference documents outlining priorities, timelines, and engagement principles could help create a more transparent and competitive environment for private providers. Given the high cost and complexity of cancer management and the severity of the illness, there may be substantial opportunities for private providers to compete on the priority parameters. Information disparities where older or larger private providers are able to access this information places small and newer private providers at a competitive disadvantage.
- Structured engagement platforms between public authorities and private providers may facilitate dialogue, clarification of policy direction, and alignment of investments. This will reduce some of the risks to private providers prior to implementation. This may also encourage participation of the private sector as the high capital and investment cost associated with building cancer treatment capacity may carry higher risks if clarity is not sought earlier in the process.

GOVERNANCE

The set of structures and rules that guide engagement between the public and private sectors in cancer care provision, facilitating engagement, authority and accountability structures, decision-making processes, public interest integration, and enforcement.

Strategic objective:

Clarify decision-making processes for engaging with the private sector, with appropriate rules for engagement and oversight.

Challenge:

There are limited stewardship structures that exist within countries to promote or govern interactions with the private sector, limited primarily to procurement regulations. Clear processes guiding when and how to engage private providers are often absent, including how to select, coordinate, and evaluate private partners as providers.

Governance with regard to clinical aspects is less defined, including how to assess clinical care quality and value of care, as well as the role of national agencies and documents in setting or enforcing national guidelines.

Decision-making authority may be distributed across multiple administrative levels, creating coordination challenges between national policy, regional financing decisions, and facility-level contracting practices.

Approach:

- Establish clear authorized bodies within the public sector responsible for guiding engagement with private providers. Clear, transparent criteria and processes to be applied when inviting, considering, and evaluating private sector provider partners would lessen the influence of personal networks in resource allocation and allow smaller or newer institutions to be more competitive.
- Develop complementary digital and private sector engagement strategies in tandem. This could involve the establishment of a digital governance structure that addresses the potential role for private technology companies to act as providers, investors, or both, and how data and any insights from it can be accessed or used.
- City-level coordination platforms or advisory bodies may help bridge gaps between national strategy and facility-level implementation. Opportunities for in-depth and informed deliberation among stakeholders in neutral platforms could support sustainable decision making, reduce shocks and need for course correction. Sufficient guardrails and decision-making mechanisms should be in place to ensure no groups have undue dominance and that public and patient interest remain at the core of the process.

CHANGE MANAGEMENT

This refers to structured processes to support the preparation, engagement, guidance, and implementation of reforms impacting the cancer management ecosystem.

Strategic objective:

Leverage changes to expand and drive system-level reforms, through a transition process that is equitable, beneficial, and with minimal disruptions to care provision.

Challenge:

The stakeholders from the various health systems all considered their healthcare system to be undergoing significant transformation, though the degree and type of change varied greatly. In most cases, policies were developed primarily within government institutions, with private stakeholders involved only after implementation, even in situations where private sector providers were expected to be the main groups either affected by or implementing the new policy. The expectation is that once the policy has been implemented, the private sector can push and advocate for the necessary reforms to be considered.

This limited participation sometimes contributed to uncertainty among private providers, leading to some adopting a cautious approach toward engagement with public sector initiatives. The extent to which this results in withholding of participation with the public sector, constituting an opportunity cost is unclear.

Approach:

- Reform processes may benefit from broader review of related system components, rather than isolated policy changes, to reduce prolonged uncertainty.
- Transparent communication of proposed reforms, timelines, and consultation opportunities could support greater stakeholder engagement and smoother implementation. This would give stakeholders the opportunity to provide feedback on their perspective on the impact and feasibility of suggested reforms.

HUMAN RESOURCES

This involves the planning, management, and development of the workforce needed for delivery, oversight and sustainability of cancer care. It includes personnel working in the private sector, public sector, or both. The main aim is to align the people, skills, and responsibilities with the most appropriate roles.

Strategic objective:

Ensure sufficient workforce capacity and capability to meet current and future demand for cancer care.

Challenges:

There is a persistent shortage of health care providers of multiple cadres across the various health systems. The preference among healthcare providers is to transition to private sector employment from the public sector, primarily citing improved pay and working conditions. Even in systems where providers are permitted to practice concurrently in both private and public facilities (dual clinical practice), such arrangements tend to be short-term before providers fully transition into the private sector.

Across systems with some degree of private and public provider mix, private institutions were more likely to recruit senior and experienced personnel, creating short- and long-term challenges. In the short term, public institutions lose part of their investment in the training of these individuals and experience reduced treatment capacity. In the longer term, public institutions lose training capacity, which limits their ability to attract and train junior professionals. In all systems the training of healthcare personnel remains overwhelmingly within the public sector at the undergraduate level, postgraduate level, and residency programmes. A shortage of personnel with the capacity and experience to educate and train junior personnel would be expected to result in long-term instability in the health workforce pipeline. Attempts at hybridised models in the public sector, where services are offered at higher pay points but still lower than the private sector, in exchange for certain privileges, are present in various systems. In some cases, these have been implemented with the explicit intention of reducing the loss of personnel even when not profit-generating. However, there is limited evidence regarding their effectiveness in retaining senior personnel, preserving training capacity, or ensuring long-term sustainability.

The disconnect between the training pipeline and healthcare provision presents further challenges when the training system remains predominantly public while healthcare provision skews towards the private sector. This creates a situation where there may be a misalignment between the trainee expectations, public financing of education, and private sector employment incentives, which has contributed to a workforce shortage, particularly of nurses. Nurses who, after receiving publicly subsidised training, are offered compensation that is considered insufficient, leading them to pursue options such as emigration, resulting in a net loss for the local health system.

Incentives for maintaining up-to-date knowledge and clinical practice are limited, contributing to stagnation or deterioration of care capabilities. This has been attributed to low levels of competition, minimal requirements for continued practice, and personnel paying for training out-of-pocket.

The transition towards increased utilisation and recognition of wider members of the cancer team, such as patient advocates, patient navigators, and psychosocial care providers, has not necessarily been reflected in the regulations defining and governing healthcare personnel. The result is that such personnel are restricted in their ability to support patients or to be compensated for their services, limiting the capacity of facilities to offer holistic care.

Approach:

- Strengthening training capacity within public systems while encouraging joint training partnerships with private institutions. Given the reliance of both the private and public sectors on public sector training, it is in the long-term interest of both sectors that the public training programmes remain strong and viable or that the private sector significantly expands its role in training. A robust health workforce pipeline would strengthen the sustainability and capacity for cancer management within the system.
- Collaborative workforce forecasting mechanisms between the private healthcare institutions and the public sector could improve alignment on the demand for the number and specifications of future personnel. This will enable adjustment of intake of trainees and the training process at earlier stages, thus reducing wasted costs and loss of investment due to emigration.
- Encouraging continuous professional development is important for cancer given the breadth of the field and the rate at which updates and improvements to best practices and guidelines are made. This could be achieved by introducing requirements that would necessitate that continuing education and training are a criterion for continued recognition of personnel's capacity to practice and of the institutions that host them. This, accompanied by incentives such as financing options or protected paid time will reduce barriers to seeking and pursuing continued training opportunities. Financing of these initiatives may be through public private partnerships.
- Dynamic frameworks would be able to incorporate developing roles and responsibilities for newer personnel into the regulatory and care ecosystems. Through consultations with patient advocacy groups, private providers, and other relevant parties, the government regulator can identify opportunities where the definition, recognition, and regulation of new roles could improve patient outcomes.

HEALTH SYSTEM REGULATIONS

These include laws, rules and standards that are established and implemented by legal or professional regulatory authorities, to govern what and how cancer services are financed, delivered, and monitored. This includes insurance, personnel, liability, and financial coverage.

Strategic objective:

Establish strong laws and regulations that protect, promote and facilitate access to appropriate cancer care providers including the private sector.

Challenges:

Private health insurance is present in many of the systems as an alternative to government programmes intended to protect against financial toxicity and promote access to quality treatment. However, in most cases private insurance is consistently unable to cover the costs associated with cancer. Therefore, patients are frequently transferred to continue their care in the public sector. This transition results in care disruption, patient dissatisfaction, and public cross-subsidisation of private insurance schemes. This has been attributed to the design of private insurance, where the maximum reimbursement rates are insufficient for cancer care, and maximum lifetime claims designed for acute rather than chronic or lifelong care.

The legal frameworks are often slow to change and do not necessarily reflect the realities on the ground or place the interests of the patients at the center. Laws may also not reflect multidisciplinary care models. The application of laws may not reflect the spirit in which they were adopted, for example laws mandating charging higher rates for patients being transferred from the private sector assume greater capacity of these patients to pay. However, timely services are often unavailable in the public sector and so most patients do not have any reasonable alternative. The result is that patients that are unable to seek services in the private sector as due to the higher rates are forced to wait far longer to receive a service in the public sector while their condition progresses, creating a punitive system that harms those with the least financial capacity.

There is also a lack of clarity regarding whether a patient referred to the private sector from the public sector is considered a public or private patient with regards to medical and legal liability, and who is responsible for supporting the patient's navigation and care completion.

The laws and regulations may not sufficiently support all stakeholders in the fulfilment of their roles. Patient advocate groups and NGOs are considered as private sector entities and have an essential role in the various systems in promoting and driving reform while also holding public and private-for-profit sectors to account on quality and access. However, these organisations frequently did not have formal recognition or a role within the system, therefore affecting their ability to contribute to the healthcare sector and their financial sustainability.

Approach:

- Through discussions with stakeholders across the ecosystem, there is a need to identify where existing laws and regulations may be causing or exacerbating challenges. Once identified, they should be reviewed and evaluated as to whether they facilitate or hinder improved patient care and outcomes when implemented. If they are found to be a hindrance, they should be shortlisted for reform with inputs from all the relevant stakeholders.
- Support the role of patient groups and civil society by introducing laws that would reduce the burden on their participation and facilitate their ability to raise capital.
- Increased transparency regarding private insurance schemes to ensure that the patients are aware of the services and extent of care they are expected to receive when they receive a cancer diagnosis.
- The public sector may explore opportunities to enter into treatment agreements with the private insurers to provide care for privately insured patients who have exhausted their maximum claims limits. A similar negotiated approach between the public sector and private insurance may be used to determine how to process patients who are enrolled in both public and private insurance schemes, and where the private sector currently requires enrollment and exhaustion of the public option first.

CLINICAL CARE

This refers to all aspects related to the direct and active provision of health services provided within an inpatient or outpatient clinical setting, delivered by qualified personnel in accordance with local laws and regulations. The focus is on system-level aspects that impact clinical care and enhance quality.

Strategic objective:

Ensure patients receive appropriate, evidence-based, high-quality cancer care and have access to sufficient information to support informed choice of provider.

Challenges:

There is a widespread and persistent perception that the provision of services and quality of care in the private sector is of superior quality than in the public sector due to the availability of more resources and equipment and the presence of higher-qualified personnel. However, the varying quality of personnel and outcomes could not be assessed, in part as private providers tended not to be included in care monitoring programmes. With the exception in systems with very high degrees of public care provision, there remained a strong perception of the high quality of the public sector personnel.

In very limited cases, data on the quality of services being provided in the various private facilities was collected, though they did not seem to be used to support value-based purchasing, quality improvement, or to support decision-making. Concerns about the quality of personnel training and how well they remain up to date with new recommendations were shared by multiple public and private providers.

Care continuity is a persistent challenge, driven by a lack of resources in the public sector and exhaustion of insurance in the private sector. As the process of transition from one system to the next takes time, it disrupts care and may be repeated multiple times if a patient is referred to multiple institutions for different services, resulting in fragmented care.

There tended to be no unified national clinical guidelines or recommendations in many of the cities assessed. When a patient transitioned from one facility to another, they were not always sure they were continuing with the same protocol or guidelines. Though attempts have been made in many jurisdictions to introduce national guidelines that would govern public sector providers, stakeholders were unsure about if and how this would impact private providers, as they were not required to adhere to public guidelines.

There is limited to no support for decision makers about when they should initiate transfers of patients from the public institutions to private providers and when they should wait. Avoiding transferring patients and care discontinuity were cited as reasons why patients are not referred to the private sector, rather waiting for resumption of service in the public provider. Though the main reason was that patients could often not afford to be transferred to the private facility, the providers did not have enough information to be able to share with patients the impact of the delay on their condition for them to make an informed decision.

Approach:

- Clinical care should be supported by a system that promotes and facilitates constant improvement and refinement of care quality.
- Personnel are to be encouraged to improve their knowledge and skill capacity and apply them appropriately through continuous training and development. This is discussed under the section “Human Resources”.
- Introduction of criteria or indicators for quality of services and outcomes by the public sector to monitor the quality of care being purchased from the various private institutions would allow for better allocation when referring patients and ensure that public money is properly invested. Promoting improvement within the private sector by sharing such indicators with the hospitals, along with a comparative benchmark, allows them to identify and focus on improving the quality of care provided. In an attempt to improve comparative standing, private institutions may facilitate better personnel training, use updated guidelines, and focus on improving patient outcomes.
- The government may promote transparency and competition by simplifying these indicators into a publicly available scorecard to help patients make an informed decision on quality when seeking care. These initiatives would require strong buy-in from the various stakeholders to help determine the criteria and evaluation process, as well as a strong data monitoring and analytics system within the public sector.

- The establishment of clinical guidelines could improve uniformity and create a quality benchmark that is specific to the country, in addition to clarifying how the adoption of such guidelines would impact the private sector particularly as it pertains to treating patients, access to funding, and reimbursement. It could be beneficial to bring in the private providers into the process to help shape the contents and application of these guidelines through broad stakeholder engagement platforms, given the recognised technical clinical capacities in the private sector. Private providers would also be able to provide a perspective on how these clinical guidelines may be interpreted and their impact on the private market when implemented.

DIGITALISATION

This refers to the process of increasing the utilisation of digital technologies of all forms in the management, communication, processing and delivery of health information and service delivery. In this context, it includes the interaction and integration of digital data, platforms, and processes across the public and private sectors as relevant to present cancer care delivery or for research to inform future cancer care practices.

Strategic objectives:

Utilise digital technologies to streamline and facilitate care delivery between the public and private sectors through frameworks that support the development of robust datasets and allow for the utilisation of advancing technologies to improve surveillance, quality monitoring, and advanced analytics.

Challenges:

All health systems expressed a strong interest in the prioritisation of an accelerated transition towards digitalisation across the system, driven by the inefficiencies of paper-based systems and the potential of digital technologies.

Paper-based referral processes place substantial administrative burdens on patients as they are required to obtain and transport physical documents, including clinical information, coverage, and treatment authorisations. Patients may be required to visit multiple offices to acquire the papers, resulting in delays in accessing care, stress associated with administrative navigation and increased indirect costs. There is also a greater potential for errors that would require repeat visits due to missing or incorrect information or documents, as patients may not be familiar with the process and the requirements. In cases where patients are referred for multiple services or continued care, the burden compounds and may interrupt care continuity.

Private care institutions are often reluctant to accept publicly covered or referred patients as the paper-based process consumes significant administrative time and cost, resulting in further narrowing the profit margins. The system to verify rendering of services and to process payment from the public sector payer is often paper-based, characterised by a high administrative burden, slow communication, and delayed and inconsistent processing and payment.

Paper-based record keeping constrains the establishment and maintenance of effective surveillance and monitoring systems. Overstretched public sector staff may not have the capacity to transfer information about patients into their public files for care they received in private institutions or to upload this information into a surveillance or monitoring system.

The public sector intends to lead the development of digital infrastructure and requires the participation of private care providers through their platforms. Though the public sector has indicated that there is a strong interest in expanding and developing the digital capacity, it is uniformly acknowledged that the private sector providers have greater knowledge and experience in digitised care, record keeping, and billing. Given that private sector providers are more likely to have digital systems that are already in use, the heterogeneity of platforms presents logistical and financial challenges to data collection and integration.

The public health sector has limited experience managing and collaborating with large technological firms. The majority of health systems have indicated an interest in expanding their capacity to utilise newer technological innovations, such as artificial intelligence to improve access and quality of care. While some have experience with health technology companies, few have extensive experience with larger technology companies. Regulation and governance are a particular concern in situations where these technology companies may act as both partners and investors.

Approach:

- The digitisation process requires an effective and complementary engagement between the private and public sectors and the digital technology strategic plans and teams, supported by internal alignment within the public sector to provide clear and consistent guidance to private actors on their role in the digital transition.
- Include private institutions and providers in the design and implementation process of the digital health strategy. The inclusion of the private sector will allow for the leveraging of their technical expertise and increase their buy-in when implementing decisions. Buy-in from the private providers is critical if they are to contribute to the surveillance and monitoring systems, as it may be costly for them to adjust their processes or technologies to ensure compatibility without which the data and understanding of the broader cancer care space would be incomplete. Incentives to promote participation, especially if profits associated with publicly referred patients are low or the transition may be too costly, such as government support in the form of grants or concessional financing to either begin digitisation or transition their system for data sharing compatibility are vital.
- Adopt a prioritised approach to digital transformation based on which technologies would result in the greatest return on investment. Many of the stakeholders had a vision for digitisation that spanned multiple components of the healthcare system, often requiring substantial and complex technological and physical infrastructure. Maintaining a focus on the problem areas and prioritising high-impact solutions that leverage existing infrastructure with limited additional resources should be the focus.

- Develop clear, stakeholder-informed criteria for the consideration of digital technologies and how they add value. These could be developed by a broad coalition of stakeholders across the cancer ecosystem with a focus on reducing the current and future burden on patients. Clear criteria would ensure that any investments in technology are unlikely to be performative by requiring that any process must demonstrably reduce burden on patients, improve care outcomes, or improve access. The broad coalition of stakeholders not only allows for better identification of problem areas but may also allow for the development of solutions that result in shifting roles or bundling solutions.
- Establish clear governance structures that promote and regulate the role of technological partners, as well as data collection and use by private care providers. These structures should be created through transparent and representative mechanisms that include stakeholders from the health, legal, and technological sectors, as well as private, public, civil, and patient representation. Their role should be to review how data can and cannot be collected from across the public and private sectors for cross-cutting databases, how these would be maintained, and who has access and ownership of the data.

CONTRACTING

The process by which the public sector initiates, selects, and implements legally binding agreements with private sector cancer care providers for provision of services. This encompasses the selection process and the contents of the contract, including the services to be delivered, standards requirements, payments, risk and accountability mechanisms.

Strategic objective:

Ensure contracts maximize value to patients through a process that promotes fair competition that builds trust within the community of the health system, while maintaining adequate legal protections to prevent undue risk.

Challenges:

Engagements between the public and private sector tended to utilise personal and informal networks when selecting partners, and there is also a greater reliance on trust rather than enforceable legal commitments.

Agreements between the public sector and private sector providers frequently occur at the level of the hospital, led by clinicians or administrators. The contracts are often derived from templates that may be ill-suited to the context. As agreements are made at the hospital level, staff reviewing and attempting to maintain these contracts often do not have the necessary training and capabilities for contract management. The perception that contracts are a formality rather than a strong and enforceable legal agreement contributes to the reliance on personal networks where trust and familiarity act as guarantees. As a result, private providers prefer to limit the scope of agreements to reduce their risk exposure.

The contracts frequently do not specify quality or performance standards associated with the services being procured. This reinforces the perception of private providers as solely being profit-driven when services were thought to be inadequately rendered. The contracts often do not usually include the necessary language to protect either party from perceived or actual breach of contract, and even when included the legal system in the country may not operate sufficiently well as to provide a remedy to the parties.

Potential and actual conflicts of interest are a concern in the process of awarding, negotiating, and enforcing agreements. The notion that public decision makers may be influenced or seeking their own benefit rather than patient benefit is particularly a concern when clinicians or administrative personnel operate or are affiliated with both private and public sector institutions.

Approach:

- Transitioning the process of awarding contracts, their review and negotiation to a centralised specialised technical team. The hospital-level staff would indicate when they are interested in pursuing an agreement with a private sector provider and engage the technical team. The technical team would have the necessary legal and economic expertise to negotiate and draft context-specific contracts. This would reduce concerns regarding conflict of interest as the technical team would be able to evaluate that the services being purchased are costed appropriately and suggest or identify alternative providers if necessary.
- The contracts should be adapted to the context of the agreement and include specifications and standards for the services to be delivered thus increasing the relevance and utility of the contracts compared to standard templates. This reduces the likelihood of disagreements due to miscommunication or perceived bad-faith negotiations.
- Transitioning the role to an independent technical team would increase confidence in the system as there is less potential for personal incentives or conflict of interest. As such, this would ensure that contracts are outcome-oriented, relevant, patient-centred and include protections.
- Centralising the process would provide the public sector with a large amount of system-wide market intelligence regarding the state of the market for services, and of the health care system. The aggregated information can be used to determine where shortages and constraints exist in the public sector in addition to providing price and quality data on services and providers.
- There may be limited scope for stakeholders in the healthcare sector and at the city level to introduce or support legal reforms to ensure that all parties are held to account. Therefore, it would be worth exploring the inclusion and utilisation of binding dispute resolution frameworks or bodies that may be better suited to address concerns rapidly.

PAYMENT AND REIMBURSEMENT

The mechanisms through which private cancer care providers are compensated for their services and the rates at which they are compensated. It encompasses what is to be paid for and how the rate is determined, if there are any associated incentives related to cost, quality, performance or other indicators, how and when payment would occur, and any forms of remediation or dispute resolution.

Strategic objective:

Ensure compensation processes are fair, predictable, and promote active engagement and limit any unintended consequences to the broader cancer care ecosystem.

Challenges:

Across the systems, private providers consistently identified reimbursement rates and payment delays as major barriers to engaging with the public sector. To receive payments owed from the public sector, private providers had to go through longer, slower, and more complex administrative processes. Even when approved, payments were consistently delayed with great variability. As delays were unpredictable, private providers found it difficult to depend on or plan around cash flow from working with the public sector.

Reimbursement rates were often determined unilaterally by the public purchaser, with limited private-sector input. This approach was seen to be riskier in systems with greater private sector engagement, as the responses in the form of service withdrawal or reduced availability would be more far-reaching. The isolationist approach makes it challenging to determine the market reaction's potential impact and introduce mitigation measures, as it is only apparent after implementation.

Reimbursement rates are not often dependent on value generation. Reimbursement rates are often fixed when the agreement is between the public system and a private care provider, however when the agreement is between private and public care providers, there tends to be greater variability and opportunities for negotiation. Performance-based incentives are not commonly included as part of the agreements.

Approach:

- Active exploration of reforms to streamline reimbursement processes and reduce friction to engaging with the government. This is the most frequently cited concern, notably referred to more often than the absolute reimbursement amount as a reason to not work with the government. There is a need to establish a team within the public sector to review what essential information is needed to interact effectively with the private providers, with the aim of minimising the paperwork burden to simplify and reduce the administrative costs for both parties.

- Including digital payments as part of a broader digitisation strategy would reduce administrative costs, and limit processing delays. Reducing administrative burden associated with reimbursement through a digitised process was positively received by those in both the private and public sector, including in areas with very high or very low rates of private-public sector engagement. Notably, this resulted in increased access for patients as more private providers tended to participate and bid on government contracts when the payment process was streamlined.
- Increased inclusion of the private sector through structured mechanisms in the process of developing the forms and setting the reimbursement rates, either directly through direct negotiations or indirectly through stakeholder inputs. Bodies within the public sector, determining the types of compensation and rates are often understandably concerned about excess influence or conflicts of interest, however given that private-public engagements are a partnership therefore effective avenues for dialogue must be established. Bodies driving reforms in the public sector or setting rates can invite stakeholders and private providers to discuss and provide feedback on changes or introduce mitigation strategies. With regards to setting rates, the bodies may decide to allow private care providers to provide bids while the rates are being independently determined internally to act as a market signal and an indicator of uptake.
- There should be transparency in how rates are determined and if there is a discrepancy between providers, explain the reasoning, to allow providers to understand the process and bid on contracts accordingly. Differences in reimbursement rates based on the service or outcome and not institution type would allow for increased competition and give greater opportunity for smaller and newer private providers to engage with public sector patients.

ADMINISTRATION

It includes the organisational and operational functions as well as the personnel that facilitate them in support of the functioning of the health system. It includes aspects such as planning, coordination, record keeping, logistics, and compliance.

Strategic objective:

Limit administrative burden through streamlining and consolidation of administrative tasks, ensuring that the administrative scope, roles and responsibilities are assigned to those qualified and trained.

Challenges:

Public health system fragmentation and decentralisation contribute to administrative redundancy. They may be multiple schemes and programmes, operated by the varying administrative levels of the state or programmes with a defined scope or population. The various schemes and programmes often do not coordinate with one another, even when they are facing similar challenges. This may be attributed to the absence of coordination mechanisms and limited political will. As such, private providers providing services for publicly referred patients through various schemes, have to enter into multiple smaller agreements, reducing the benefit of bulk purchasing. Executing each of these individual contracts results in inefficiencies. The administrative burden of having multiple schemes and programmes also affects private providers and patients who have to navigate through different requirements of these schemes.

Those responsible for the administrative work may not be best suited to do so and can be better utilised elsewhere. As the agreements often occur at the level of the hospitals, associated administrative tasks are often completed by clinicians or hospital administrators who may not be trained to complete them.

Agreements for services and recognition of institutions are often renewed annually, though all stakeholders tend to view these processes as formalities. Across most health systems, non-renewal of an agreement or contract was rare.

Approach:

- Administrative tasks and processes should be minimised, and cooperation sought to reduce inefficiency and redundancy.
- Within the public sector, initiatives should be introduced to establish cooperation and coordination mechanisms between the various schemes to determine the type and size of demand within the broader public system. Collective negotiations could then be pursued based on the aggregate demand.
- Review current forms and processes to remove any unnecessary or redundant components to streamline and simplify the process. There is a need to coordinate with other schemes and programmes within the public sector to develop a standardised or unified set of processes to reduce the navigational and administrative burden on patients and providers. Not only does the current approach disincentivise private providers, it also disadvantages smaller or specialised providers who may not have the same administrative capabilities.
- Centralised contracting would reduce the burden on clinicians, and would most likely result in better outcomes as it would be conducted by trained personnel thus freeing already strained physicians for other responsibilities they are better suited for.
- The impact of digitisation is discussed under the section digitisation. It would lead to reduced administrative processing time and burden.

EQUIPMENT

The machines, devices, and tools used in the delivery of cancer care. Aspects considered include the procurement, maintenance, safe use, and optimisation practices related to these machines, devices, and tools.

Strategic objective:

Ensure investments in equipment and infrastructure prioritise sustainability and service continuity.

Challenges:

The services most often disrupted in the public sector are those requiring the use of high-cost equipment, such as imaging or radiation therapy. This is often due to public institutions not having these equipment due to their high upfront costs or equipment downtimes due to inadequate or inconsistent maintenance.

Approach:

- The purchasing of equipment from private vendors for the delivery of care should include planning and budgeting for the regular maintenance. Bids by private companies should include all components and subscriptions to allow functional use of the equipment, not just the initial purchase.
- The priority should be for access to the equipment rather than ownership. It is therefore essential that public health providers explore opportunities that allow for access to the equipment and services, such as co-ownership with a private provider, hosting but not owning the equipment, or renting of the equipment.

CONCLUSION

Private sector engagement is an essential component of cancer care delivery in many cities, particularly as public systems face constraints in capacity, financing, or specialised services. Current engagement models, often informal or weakly governed, may limit opportunities to improve equity, continuity, and system efficiency. Effective engagement therefore depends not on whether collaboration occurs, but how it is structured and governed.

This guide emphasises that effective public–private engagement must be grounded in a clear and credible vision, supported by strong governance arrangements and coordinated action across key health system functions. A well-articulated vision provides direction to both public and private actors, enabling alignment of investments and capabilities with population needs. Governance mechanisms should establish transparent decision-making processes, clarify roles and responsibilities, and ensure accountability for quality, equity, and outcomes. With these foundations, reforms in contracting, payment, or service delivery can achieve sustainable impact.

Engagement is not solely a technical or contractual exercise but requires a broader paradigm shift and ecosystem development, with change management, human resources, and administrative capacity as critical enablers. Health systems undergoing transition must proactively manage uncertainty, communicate clearly with stakeholders, and build institutional capabilities to steward increasingly complex public–private relationships. Workforce challenges, in particular, underscore the shared dependence of both sectors on publicly financed training systems and the need for collaborative approaches to workforce planning, retention, and continuous professional development.

Regulatory frameworks, contracting arrangements, and payment mechanisms must evolve in parallel to support value-based, patient-centred care. Regulations should reflect modern care pathways and clarify responsibilities across public–private boundaries. Contracts should move beyond informal or relationship-based arrangements toward standardised, enforceable agreements that specify quality expectations and accountability. Predictable and timely payment systems are essential to sustaining provider participation and safeguarding patient access.

Digitisation and equipment investment should be approached as strategic levers rather than isolated interventions. When aligned with broader engagement strategies, digital tools can reduce administrative burden, improve care coordination, and strengthen monitoring. Similarly, prioritising access to critical equipment over ownership can enhance service continuity while reducing financial risk.

Collectively, the approaches outlined in this guide offer cities a flexible, system-oriented framework for strengthening public–private engagement in cancer care provision. While contexts will differ, a deliberate shift from reactive collaboration toward strategic partnership is essential to improving access, quality, and sustainability, with patient outcomes at the center of all engagement efforts.



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