Conflicts of interest: an invisible force shaping health systems and policies

Despite years of discussion and frustration about why public health evidence does not influence policy decisions as much as it should, there has been little attention to a fundamental force in decision making: conflicts of interest. Conflicts of interest arise when the potential for individual or group gain compromises the professional judgment of policy makers or health-care providers. Conflicts of interest underpin rent-seeking and informal practice across the world, but their nuanced nature makes them challenging to identify, research, and address. Conflicts of interest are often very subtle; no action needs to be taken for them to exist. In many countries, the heterogeneous nature of mixed health systems and complex care pathways are compounded by weak governance mechanisms,[1] which increase the potential for conflicts of interest to occur and make them difficult to address with existing regulatory and policy frameworks, including self-disclosure mandates or malpractice procedures. To begin to illuminate these issues and to develop a research agenda, we have characterised three different types of conflicts of interest that are particularly pervasive in mixed or pluralistic health systems (table). We emphasise how these conflicts impede the development of health policies to better structure and govern state and non-state health-care providers.

The first type of conflict of interest occurs when policy makers or regulators have multiple or dual roles. In this scenario, their (primary) professional decisions are open to influence from other relationships that create financial, social, or familial ties with the institutions or industries that they are responsible for regulating. For example, owners of pharmaceutical companies or their family members often hold decision-making power in drug regulatory agencies responsible for making and implementing policies on drug quality and ethical marketing practices.[2] Thus, key decision makers are incentivised to influence the design of new policies or the resources allocated to implement policies, such that sales of medicines are not affected. Ultimately, this process protects their financial interests or those of their friends and families.

The second type of conflict of interest occurs because of hidden financial relationships between formal (licenced) and informal (unlicenced) health-care providers.[3,4] Owing to financial flows from informal to formal providers, the latter might publicly support stronger regulation of the informal health-care sector while covertly using their power to obstruct policies that curtail informal practice.[5] For example, in many countries, doctors and pharmacists illegally rent their professional licences to set up drug shops and clinics where lower paid attendants, typically without the desired or prescribed qualifications, can provide services.[2,6] Policies to address inappropriate delivery of health care by unqualified providers in such drug shops and clinics would, therefore, reduce a source of income for doctors and pharmacists, resulting in their often tacit opposition.

The third type of conflict of interest occurs when policy makers are influenced into taking a course of

	Competing interest	Example of effect on policies
Policy makers or regulators are expected to formulate and implement policies that ensure appropriate care delivery by private health-care providers	A secondary relationship that results in financial, social, or familial connection with the institutions they are responsible for regulating, such that the policy actor or regulator may prefer weaker controls.	Weakening of policies: policy formulation influenced such that weaker rules are introduced. Alternatively, policy implementing bodies (eg, drug inspection agencies) are under-resourced to enforce rules.
Formal health-care providers have a responsibility to provide and support the provision of health care in accordance with local regulations and professional ethics standards	Financial flows from informal (illegal) providers or practice create additional sources of income for formal providers.	Covert opposition to change: formal providers publicly support stronger regulation of informal practice, but covertly influence the policy-making process to enable it to continue and thrive.
Policy decisions should reflect public health evidence and best practice	Policy makers do not want to introduce or enforce rules to curtail the private sector as they know these will be unpopular with large segments of the population and could potentially expose gaps in roles of the public sector.	Regulatory impasse: stronger regulations to curtail inappropriate private sector activities, which are sound from a public health perspective, are avoided as they might cost policy makers popularity and personal career growth.

Table: **Summary of the different types of conflict of interest pervasive in mixed or pluralistic health systems with weak governance mechanisms**

action that is more likely to win political support, rather than following public health evidence. Policy makers are cognisant that introducing or enforcing rules to regulate private health-care provision could be unpopular because of dependencies on the sector's contributions.[7] Ultimately, such policies could be detrimental to their careers. For example, the reliance on unlicenced medicine sellers to provide access to essential medicines for populations in under-resourced areas is hugely challenging for policy makers in numerous countries.[2,8] Policies to reduce service provision by private providers, including those that are untrained and providing substandard care, are often avoided due to concerns that they will expose gaps in health care that the public sector should be providing.[5]

We have discussed the role of conflicts of interest in mixed health systems with weak governance mechanisms, but the influence of conflicts of interest on health policies is widespread. The ongoing pandemic showcases the extent to which conflicts of interest have surfaced in COVID-19-related policy decisions in every country, including some high-income countries often associated with low corruption. Concerns have also been raised about the influence of conflicts of interest on funding decisions and global health partnerships.[8] In our research, we have found that analysis of, and action on, conflicts of interest will be essential for properly managing the use of antibiotics to stem antimicrobial resistance and for achieving universal health coverage by reducing out-of-pocket payments.[2,3,5]

Although conflicts of interest remain a global issue that is neglected, underestimated, and overlooked by health policy makers and researchers, conflicts of interest connect with many wider issues within health policy and systems research. At present, there is a growing body of evidence and concern surrounding corruption in health systems.[9,10] This attention to corruption is likely to result in interest in examining and making sense of conflicts of interest in the coming years. We hope that our characterisation of conflicts of interest is a useful tool in beginning this necessary work.

We declare no competing interests.

*Afifah Rahman-Shepherd, Priya Balasubramaniam, Meenakshi Gautham, Eleanor Hutchinson, Freddy E Kitutu, Robert Marten, *Mishal S Khan*
mishal.khan@lshtm.ac.uk

Department for Global Health and Development, London School of Hygiene & Tropical Medicine, London WC1E 7HT, UK (AR-S, MG, EH, MSK); Public Health Foundation of India, New Delhi, India (PB); Department of Pharmacy, Makerere University, Kampala, Uganda (FEK); Alliance for Health Policy and Systems Research, WHO, Geneva, Switzerland (RM); Department of Pathology and Laboratory Medicine and Department of Community Health Sciences, Aga Khan University, Karachi, Pakistan (MSK)

1 Lagomarsino G, Nachuk S, Singh Kundra S. Public stewardship of private providers in mixed health systems. New York, NY: The Rockefeller Foundation, 2009.
2 Khan MS, Durrance-Bagale A, Mateus A, et al. What are the barriers to implementing national antimicrobial resistance action plans? A novel mixed-methods policy analysis in Pakistan. *Health Policy Plan* 2020; **35:** 973–82.
3 Suy S, Rego S, Bory S, et al. Invisible medicine sellers and their use of antibiotics: a qualitative study in Cambodia. *BMJ Glob Health* 2019; **4:** e001787.
4 Gautham M, Shyamprasadn KM, Singh R, et al. Informal rural healthcare providers in North and South India. *Health Policy Plan* 2014; **29:** 20–29.
5 Gautham M, Spicer N, Chatterjee S, et al. What are the challenges for antibiotic stewardship at the community level? An analysis of the drivers of antibiotic provision by informal healthcare providers in rural India. *Soc Sci Med* 2021; **275:** 113813.
6 Sheikh K, Josyula LK, Zhang X, et al. Governing the mixed health workforce: learning from Asian experiences. *BMJ Glob Health* 2017; **2:** e000267.
7 Mayora C, Kitutu FE, Kandala NB, et al. Private retail drug shops: what they are, how they operate, and implications for health care delivery in rural Uganda. *BMC Health Serv Res* 2018; **18:** 532.
8 Marten R, Hawkins B. Stop the toasts: the Global Fund's disturbing new partnership. *Lancet* 2018; **391:** 735–36.
9 García PJ. Corruption in global health: the open secret. *Lancet* 2019; **394:** 2119–24.
10 Hutchinson E, Balabanova D, McKee M. We need to talk about corruption in health systems. *Int J Health Policy Manag* 2019; **8:** 191–94.