



**ENABLING THE PRIVATE HEALTH SECTOR IN
THE NATIONAL RESPONSE TO COVID-19:
*SIX CURRENT POLICY CHALLENGES***

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CONTENTS

- ACKNOWLEDGEMENTS..... 3**

- PRIVATE SECTOR ENGAGEMENT
IN RESPONSE TO COVID-19..... 4**

- EXECUTIVE SUMMARY..... 5**

- CONTEXT..... 6**

- PURPOSE..... 7**

- CHALLENGES..... 8**
 - 1. Planning..... 8
 - 2. Information..... 8
 - 3. Resources and Capacity..... 9
 - 4. Legislation..... 9
 - 5. Financing..... 11
 - 6. Risk Exposure..... 12

- NEXT STEPS..... 14**

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Private Sector Engagement in Response to COVID-19

David Clarke, World Health Organization, Headquarters

WHO calls on national governments everywhere to adopt a whole-of-government and whole-of-society approach in responding to the COVID-19 pandemic. Reducing the further spread of COVID-19 and mitigating its impact should be a top priority for Heads of State and Governments.

The COVID-19 crisis is leading to a surge in demand for health products and services that places even the best-resourced health systems under acute stress. Recent experiences in the countries with the largest outbreaks demonstrate that private sector capacity can play a crucial role in the response effort. Partnering with the private health sector requires governments to be creative in the types of partnerships adopted, flexible in its application of regulations; and strategic in its attempts to cover the costs. Risks and challenges are inherent in acting swiftly in a context of uncertainty, but ultimately, populations will benefit if governments act to engage the private sector and collaboratively work together as partners in the fight against the COVID-19 pandemic.

The COVID-19 response should be coordinated with actors in the private sector and civil society. WHO has developed new guidance: “[Engaging the Private Health Delivery Sector in the Response to the COVID-19: A Plan of Action](https://hsgovcollab.org/en/news/new-publication-engaging-private-health-delivery-sector-response-covid-19-plan-action)” (<https://hsgovcollab.org/en/news/new-publication-engaging-private-health-delivery-sector-response-covid-19-plan-action>) to help governments with their efforts to engage the private sector as part of a whole of society response to the pandemic and also to support governments efforts to engage the private sector to help maintain essential health services.

WHO is committed to supporting member states on how to implement this action plan over the coming months through technical documents with analysis of the evidence, best practices and experiences. The present analysis of the policy challenges is a foundational for this work. As countries progress through different phases of the pandemic, we will produce rapid, real-time, evidence-based, tailored support to improve private sector engagement in response to the COVID-19 crisis. In the near term, this work will help establish a strong foundation for stronger health system governance in the post-COVID world. In the long term it will contribute to renewed efforts to achieve Universal Health Coverage as countries work to replenish, recover and reform their health systems.

EXECUTIVE SUMMARY

“We called the private sector together to develop a private sector agenda and way forward...no time to waste...it is an emergency. We [private sector] should be proactive.”
- Tanzania

This document identifies and frames the policy challenges that low- and middle-income countries (LMICs) are facing in enabling the domestic private health sector to support the national response to COVID-19. Most countries in LMICs are currently in the containment phase of their response to the pandemic, and are thus focused on the early detection, isolation, and treatment for those infected with the disease, alongside contact tracing and screening. In this phase, six policy challenges have been identified as core priorities:

1. Countries are unsure of how best to include the private sector in planning for the national response effort;
2. Resource-based planning cannot take place as critical data on private sector resources and capacity are not held by the government;
3. The private health sector lacks certain inputs needed for it to play a role as an effective partner for the government in the response;
4. Emergency legislation, compounded by weak systems and regulation, can limit the private sector’s role;
5. Countries are unsure of whether, or how best to, reimburse the private sector for health services provided during the outbreak; and
6. Private healthcare businesses are exposed to significant financial losses at this time, but governments lack clear criteria for providing support.

In response to these challenges, the WHO’s *Private Health Sector for COVID-19 Initiative* (WHO-PCI) will, in its future research, identify and synthesize emerging examples of good engagement practices, and draw on these to provide real-time, evidence-based and tailored guidance for governments in LMICs.¹

¹As one of its first actions, WHO drafted interim guidance on how to engage private health sector capacity (staff, staff, supplies and systems) needed for the healthcare system response to the COVID-19 emergency (<https://hsgovcollab.org/en/news/new-publication-engaging-private-health-delivery-sector-response-covid-19-plan-action>).

CONTEXT

The COVID-19 pandemic threatens to overwhelm health systems in many countries. Ministries of Health are looking to mobilize their domestic private health sectors² as part of national efforts to contain and mitigate the pandemic. In addition, private health actors are looking for ways to contribute to the emergency response. However, they are often not well-positioned to work effectively with the government.

At the time of writing, most LMICs are in the *containment* phase of their response to the epidemic, focusing on early detection, isolation, and treatment of people infected, with tracing and screening of their contacts. They are also preparing for the *mitigation* phase. Several LMICs are using this period to:

- a. engage the private sector in *containment* activities (and in particular, testing); and
- b. prepare for *mitigation* by enabling the private sector to support national efforts to tackle the forthcoming surge in demand for healthcare, as community transmission of COVID-19 increases.

The nature and severity of the challenges experienced during this period vary

across countries. This is because pre-existing regimes for governance of the private sector differ. Some countries – especially those with comprehensive social insurance systems - have fairly inclusive governance regimes in place, in which the private health sector is already embedded in delivering healthcare to a majority of the population. The small number of countries in this category (e.g. South Korea, Thailand and the Philippines) have faced fewer/less severe challenges to date with engaging the private sector for the COVID-19 response. However, for many other countries, working relationships with the private sector are at a far less advanced stage. In this document, we focus on the challenges faced by the majority of countries that are in this latter category. In future outputs, we will provide further analysis of what *all* LMICs, regardless of pre-existing governance regimes, can learn from international best practice in this area.

“Most LMICs are in the containment phase of their response to the epidemic, focusing on early detection, isolation, and treatment of people infected, with tracing and screening of their contacts. They are also preparing for the mitigation phase.”

²We define the domestic private health sector as all non-state actors involved in the delivery of health-related products and services in a country, including all for-profit and not-for profit entities, whether they are in the formal or informal sectors.

PURPOSE



This document aims to identify and frame the challenges that LMICs are facing *right now* in mobilizing the domestic private health sector to support national COVID-19 responses.

The WHO-PCI team has conducted a comprehensive document analysis to identify and describe such challenges. This has been supplemented with data obtained in interviews with a range of key stakeholders based in 12 countries (Ethiopia, Kenya, Nigeria, Uganda, South Africa, Thailand, India, Sri Lanka,

Pakistan, the Philippines, South Korea and Iran). Our key informants include staff in Ministries of Health and National Public Health Institutes, private healthcare businesses and their representative bodies, WHO and World Bank offices, and think tanks and academic research groups (see Appendix 1 for our sampling framework).

CHALLENGES

CHALLENGE 1

Countries are unsure of how best to include the private sector in planning for the national response effort

Before the pandemic, countries varied in the extent and quality of public-private dialogue (PPD). The COVID-19 pandemic has exacerbated these variations. Frequently, such dialogue has been both *ad hoc* and opportunistic, and based largely on personal connections between public officials and private sector businesses, rather than systemic approaches. For example, in Ethiopia, in the lead up to COVID-19, and in the early stages of anticipation and containment, the government did not reach out to private health sector businesses; nor, according to local private healthcare respondents, did it return calls when it was approached by private actors.³ Similar problems were reported by respondents in Nigeria and Uganda.

In countries in which the private health sector is better organized (e.g. organized into professional associations with experience of dealing directly with Ministries of Health and other arms of the government), they didn't always wait for the government to engage. As private sector leaders watched the pandemic unfold in south-east Asia and Europe,

they convened multiple meetings among themselves to identify how their members could assist the government during the crisis. Many countries, including Kenya, Liberia, Tanzania and Uganda, followed a similar process to organize themselves and start a dialogue with the government by convening internal meetings, collecting data on members' resources and capacity, and meeting with government officials to map out potential roles for the private sector.

CHALLENGE 2

Resource-based planning cannot take place as critical data on private health sector resources and capacity is not held by the government

Before the pandemic, many LMICs lacked basic data about the private health sector. This is still largely the case. Private health sector assessments over the past decade have consistently highlighted the lack of information on the private health sector held by governments in LMICs. Basic information is not routinely collected, and is often not available in any form, in relation to basic facts, such as the number and types of facilities in a country, or the range of

³At the time of publication, this has been resolved and the government is now in support of working with the private health sector in Ethiopia.

health professionals, infrastructure and equipment deployed within these.

With the onset of the COVID-19 outbreak, many LMICs were unable to take a “resource-based approach” to planning for the mitigation phase of the response. In some contexts, private sector groups have mobilized to address data gaps by conducting rapid assessments of their capacity and resources (Kenya, Liberia, Uganda, Tanzania). For example, the private sector has used simple approaches to collect data, ranging from calling every private hospital (Kenya), emailing excel spreadsheets to member organizations (Uganda), and forming WhatsApp groups, comprising regional private healthcare federations to share information (continent-wide).

However, the data has not been independently verified. Its scope is also limited, focusing mainly on space (e.g. ICU capacity), staff (e.g. ICU staff but also specialists like pulmonologists) and equipment (e.g. sources for PPEs, test kits and oxygen in addition to number and location of ventilators and GeneExpert machines) and less on systems (e.g. triage and referral protocols) or on costs and patient fees and co-payments. That said, these data have helped to shape the discussion on how to best harness private sector capacity (Nigeria, Kenya), and have begun to demonstrate to the government, often for the first time, the extent to which private sector resources might become a valuable part of the mitigation strategy.

CHALLENGE 3

The private health sector lacks certain resources and capacity needed for it to be an effective partner

For the private health sector to be effectively engaged, the government needs to ensure that private facilities have the supplies needed to (a) provide high quality care for patients and (b) protect employees from becoming infected. Currently, private sector respondents report a lack of access to a number of required inputs, including (i) critical data on the progression of the local epidemic; (ii) government clinical protocols, (iii) training and updates of key medical professional (e.g. respiratory physicians, nurses, anesthetics and ancillary staff); (iv) critical commodities such as drugs, testing kits and related lab materials and medical equipment; and (v) Personal Protective Equipment (PPE).

Without such inputs, the private sector’s role in the national response effort may be undermined, e.g. as doctors and nurses refuse to attend work for fear of contracting COVID-19 in the absence of PPE, overall health system capacity is thereby diminished.

CHALLENGE 4

Emergency legislation, compounded by weak systems and regulation, can limit the private sector’s role

In several countries with extreme lock-down orders, (e.g. Uganda, Nigeria

and India), some frontline healthcare providers like retail pharmacies have been forced to close, due to lack of supplies, human resources (e.g. in Uganda, policies only allow for employees to go to work if they can reside onsite) and falling demand. Elsewhere, regulations have required some private health facilities to cancel defined clinical activities. For example, in India, several hundred private hospitals have been designated as COVID-19 hospitals. Under emergency legislation, they have been forced to cancel non-urgent operations in order to conserve resources and capacity for the expected surge in COVID-19 demand.

However, as the surge in COVID-19 demand has not yet occurred in many countries (many are in the containment stage and have relatively low case numbers, and few people requiring hospitalization), the anticipated income stream has not been forthcoming. While regulation to focus healthcare resources on COVID-19 cases may be justified, there may be unanticipated consequences for private sector businesses, many of which are already facing dire financial circumstances (see challenge 6 below); and governments need to think carefully about taking actions that may further impede the role of private sector capacity during the mitigation phase.

Price regulation, while a good thing for patient access to testing and treatment, may reduce the willingness of healthcare businesses to provide essential health services – especially in countries where

there is no offsetting public funding (the usual case, at this time). For example, in India, regulated patient charges for COVID-19 treatment in an ICU are approximately one seventh of the average market price. This may imply that marginal revenues from providing such treatment fall short of marginal costs – which could create perverse incentives not to diagnose and manage cases appropriately.

In many cases, pre-COVID-19 regulations and systems are hindering the private sectors' contribution to the COVID-19 response. Patient confidentiality requirements do not allow for the use of telehealth. Scopes of practice and HR certification do not allow for staff movement (e.g. outside the country, within the country), or the reactivation of retired staff, or reassignment of staff from public to private. Regulations governing competition do not allow suppliers to coordinate to secure economies of scale in procurement. Import taxes and custom fees undermine procurement efforts. Customs processing on drugs and medical equipment delay procurement. Addressing these regulation barriers will be critical.

There are also, of course, cases where the extent of government regulation is too limited. For example, in some countries, private facilities are testing and treating COVID-19 patients, but policymakers express concern about inadequate reporting of these cases to the government (e.g. in Uganda, Pakistan, South Africa). In India, the

private health sector seems to have failed to notify cases during the early stages of the outbreak. There are concerns that health facilities may be subject to incentives not to notify. For instance, there have been reports of patients bribing hospital staff to avoid enforced isolation or hospitalization. However, in India, under emergency legislation passed in mid-March 2020, the Ministry of Health was given the power to seize private sector assets in cases of failure to notify authorities of cases. The private sector is now reliably notifying cases, according to local stakeholders.

CHALLENGE 5

Countries are unsure of whether, or how best to, finance private sector health businesses during the outbreak

In some countries, as noted, private health businesses charge market or regulated prices for COVID-19-related testing, isolation and treatment. In India, where private healthcare facilities have substantial diagnostic capacity and a strong system for empanelling accredited laboratories, patients can be charged a tariff of 13,500 rupees (approximately \$180) for a course of three tests. In addition, patients can be charged 4,500 rupees for COVID-19-related treatment (about \$60 per day for an ICU). In contrast, in Pakistan, patients are being charged normal market prices for these services. In both contexts, inequity in service use and financial protection are the result – a challenge that can only be addressed via increased public financing through subsidies or contracts. Indeed,

in Pakistan, provincial governments are discussing purchasing strategies and reimbursement arrangements through the relevant healthcare commissions with the private health sector. However, formal arrangements have not been agreed.

In other countries, COVID-19-related treatment is being delivered to patients for free – as a matter of formal or informal government regulation. As patient numbers are currently low, private health businesses have not experienced large-scale financial losses, although the situation will change when cases increase. In that eventuality, how private health businesses will be compensated is unclear. One key informant based in an African country stated that, *“the government seems to expect the private health sector to deliver COVID-related services for free as part of their patriotic duty”*.

In Pakistan and other countries, where there has been a discussion on provider reimbursement, it has mostly focused on in-kind donations (e.g. test kits, PPEs, etc.). In some countries (e.g. India, South Africa), the government has allowed the private sector to charge fees for services, albeit at regulated (capped) prices. But, as one respondent said, there may be limited willingness to provide care for such patients: *“treating COVID patients is risky because it is so hard to estimate costs because of variability of inputs...the price keeps changing because of the broken supply chain!”* (Kenya private sector leader).

In several countries, in which the compensation arrangements for treating COVID-19 patients are unclear, private facilities have declined to partner with the government in the COVID-19 response and/or are refusing COVID-19 patients (e.g. in Bangladesh, India and Uganda). In Uganda, key private partners – faith-based organization (FBOs) – have declined an invitation to act as COVID-19 isolation centers on the alleged grounds that the government is too unreliable a purchaser. In Bangladesh, private hospitals are turning away COVID-19 patients because there is no provider reimbursement.

CHALLENGE 6

Private sector businesses are exposed to significant financial losses, but governments lack clear criteria for providing support

Due to the COVID-19 pandemic, many private healthcare businesses in LMICs are facing a large reduction in the demand for their services, and a resulting decrease in their revenues. Some private health sector leaders interviewed expressed growing fear that many small- and medium-size healthcare business (solo practitioners, small hospitals, individual labs and retail pharmacies) may not survive the pandemic without some form of economic assistance. Where such providers are an important source of essential health-related products and services for the population, the lack of demand is a major concern, indicating that some patients are foregoing needed

or even urgent care. In addition, facility closures run the risk of long-term effects on public health.

The contraction of the private health sector results from a confluence of multiple factors. When government regulations require healthcare facilities to defer non-urgent/non-essential health services for an indeterminate period, revenues decrease. Under lockdown conditions, many patients with non-COVID-19-related health needs cannot, or are reluctant to, attend clinics and hospitals. Economic disruption reduces the ability and willingness of individuals and households to pay directly for healthcare of any form. Finally, the number of those with public or private insurance is diminishing in line with job losses in the formal sector, further reducing the demand for care.

In LMICs that are experiencing this challenge, governments are under strong pressure to provide subsidies or other forms of support to ensure the financial sustainability of healthcare businesses. Currently, however, there is no agreed criteria for making decisions on which businesses should qualify for government support. Without agreed criteria, public funds will likely be misspent. Well-connected healthcare businesses might be prioritized for funding. While systemically important businesses, those that deliver essential health products and services to the population might lose out. No clear analysis exist of what conditions governments might apply to support arrangements (e.g. patient volume

guarantees, tax breaks, subsidies) to enhance the national COVID-19 containment and mitigation strategies, and/or accelerate progress on longer-term health systems strengthening objectives, including Universal Health Coverage (UHC).

NEXT STEPS



The unprecedented challenges presented by the COVID-19 pandemic call for unprecedented action by governments in LMICs, and an appropriate level of support from the WHO.

Fortunately, the WHO is well positioned to help. The six policy challenges highlighted in this research are closely related to traditional challenges that governments face in private health sector engagement. Best practices, resources and tools already exist to support countries in exercising

appropriate governance of the private health sector. WHO can make these resources available. Secondly, WHO is well placed to help governments learn effectively from other countries that have progressed further through the phases of the COVID-19 pandemic.

The priority challenges evidenced in this report will guide the future technical focus of WHO-PCI activities to support WHO staff at all levels currently involved in advising countries' health ministries in their efforts to contain and mitigate COVID-19.

ABOUT THE PROJECT

For more information about the work, please contact Dave Clarke, clarked@who.int

ANNEX 1

Sampling Framework

LIST OF COUNTRIES	REPRESENTATION	
	Private Sector	Public Sector
Ethiopia	6 individuals	2 MoH officials
Kenya	4 country level federations	1 regional WHO staff member
Nigeria	1 regional federation	2 WHO country offices
Uganda		1 World Bank country office
South Africa		1 LMIC-based health policy think tank
Thailand		
India		
Sri Lanka		
Pakistan		
Philippines		
South Korea		