

# AN ACTION PLAN TO ENGAGE THE PRIVATE HEALTH SERVICE DELIVERY SECTOR IN THE RESPONSE TO COVID-19



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 response should be coordinated with actors in the private sector and civil society. WHO has developed this interim guidance 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 <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/maintaining-essential-health-services-and-systems>.

This interim guidance is based on a draft private sector engagement roadmap currently being developed by the WHO Advisory Group on the Governance of the Private Sector. <https://www.who.int/news-room/articles-detail/public-consultation-on-the-draft-who-roadmap-engaging-the-private-health-sector-through-integrated-service-delivery-governance-in-mixed-health-systems>

## Background

One of the critical lessons of the 2014-16 West African Ebola epidemic was the need to quickly mobilise the entire health system, both public and private in response to the epidemic <sup>1</sup>

In response to COVID-19, WHO's advice is that governments should take a whole-of-government and whole-of-society approach to their response efforts. This approach should include drawing on the capacities and resources of the private health sector (including commercial and not-for-profit providers of health products and services). Drawing on private sector resources and capacity is critical because in many low- and middle- income countries (LMICs), the private health sector provides a significant proportion of health services and products. For example, research shows that the private sector is the dominant source of treatment for children with fever or cough in a sample of 70 LMICs.<sup>2</sup> New research commissioned by WHO in 2019 showed that the private sector provides nearly 40 per cent of health care across the majority of WHO regions and provides 62 per cent of health care in the EMRO region<sup>3</sup>.

As Figure 1 shows, with the private sector represented in green and the public sector in blue, the private health sector can be present in

<sup>1</sup> Elston, J. W. T., Cartwright, C., Ndumbi, P., & Wright, J. (2017). The health impact of the 2014–15 Ebola outbreak. *Public Health*, 143, 60–70.

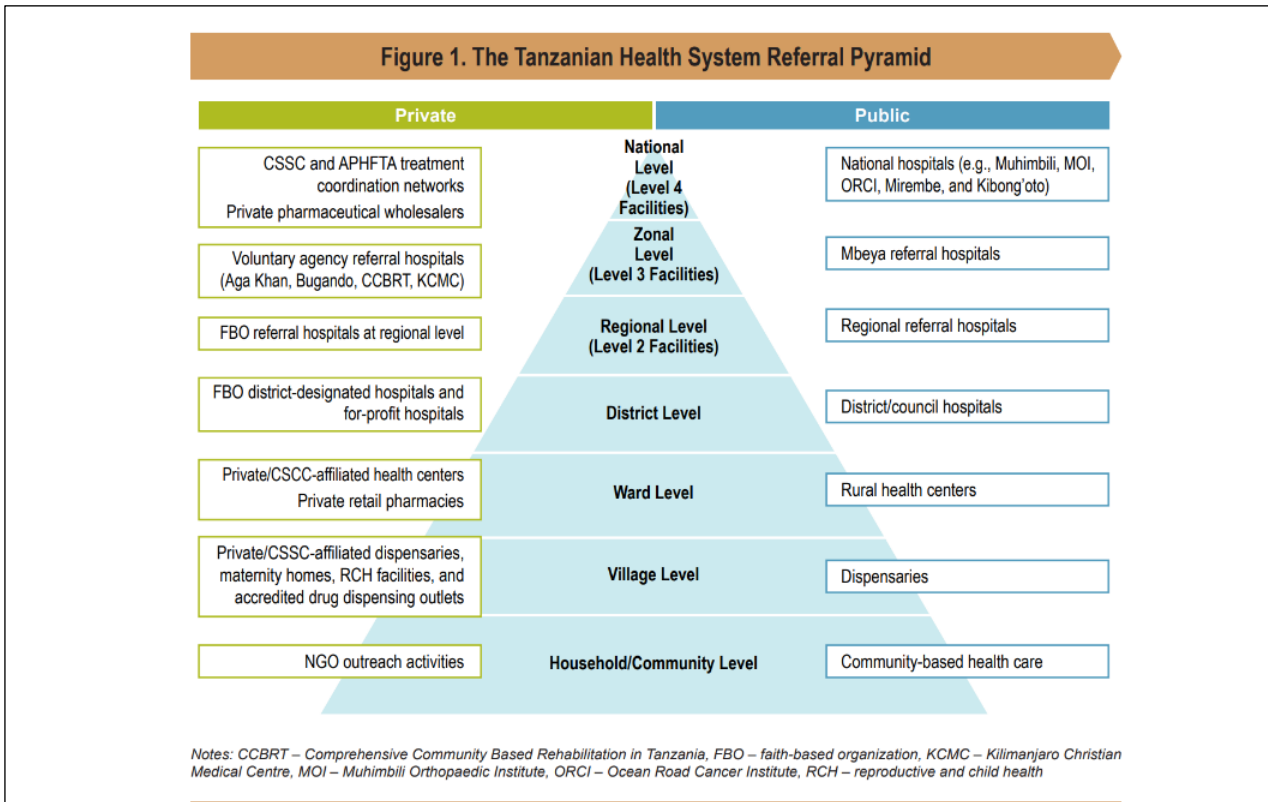
<sup>2</sup> Grepin, K. 2016. Private Sector an Important But Not Dominant Provider Of Key Health Services in Low- And Middle-Income Countries. *Health Affairs* 35, no.7. 1214-1221.

<sup>3</sup> Dominic Montagu, and Nirali Chakraborty, Standard survey data: insights into private sector utilization, a technical report for WHO.

multiple service areas, including community health and prevention, tertiary and specialised health services, pharmaceutical manufacturing and retail pharmacies.<sup>4</sup> During health emergencies, the activities of the private health sector actors must be aligned with national response efforts. For example, all providers public and private should be notifying cases, abiding with clinical protocols for testing, isolation and treatment, and ensuring financial and other barriers to care utilisation are eliminated). Moreover, the private health sector owns and manages resources that can contribute to surge capacity for responding to the pandemic: facilities, health professionals, medical equipment and essential supplies (such as isolation equipment, ventilators, oxygen, and personal protection equipment (PPE)). Where public sector resources are insufficient to cope with the increase in emergency-related demand

while maintaining routine essential health care requirements, governments should also act to mobilise all resources available – including the resources and capacities of the private sector. Here the private sector can contribute to the response and also help to maintain other essential health services.

The challenge in many LMICs is that the public and private health sectors operate in two parallel and separate spheres. Moreover, the private health sector is often fragmented and disorganised (see Figure 2). **This Action Plan for Private Sector Engagement (PSE) outlines concrete steps governments and Ministries of Health (MoHs) can take to harness private health sector resources so that both sectors are aligned and can act in concert to respond to the COVID-19 pandemic, while managing risks and mitigating conflicts of interest.**



<sup>4</sup> SHOPS Project. 2013. Tanzania Private Health Sector Assessment. Brief. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

Figure 2. Current interactions between public and private sectors

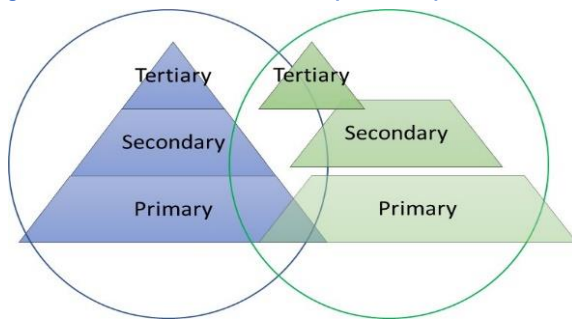
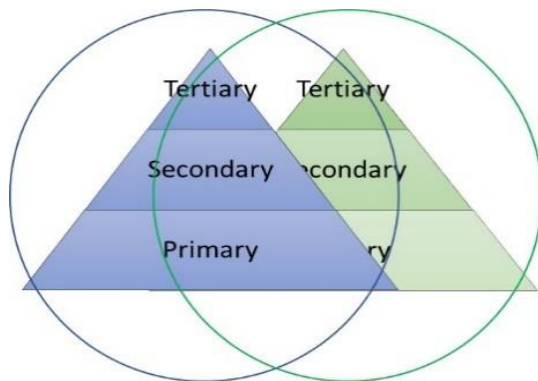


Figure 3. Potential interaction between public and private sectors



The Action Plan aims to create a single, unified, coherent response to the COVID-19 pandemic that integrates the public and private health sectors (see Figure 3). The intention is to ensure that care-seekers experience no material difference in terms of access or quality of services in public and private sector settings while being tested and treated for essential services during the COVID-19 outbreak. The Plan is organised around a simple framework to help governments plan to engage their local private health sector's *space, staff, stuff, and systems* to address the surge in demand through *supply-side* financing (see Box 1).

#### Box 1. Private Sector Resources

- Space – infrastructure, facilities
- Staff – # and cadres
- Stuff – equipment, test, PPE supplies
- Systems – data, communication, referrals, transport, etc.
- Supply-side financing

Adapted from Paul Farmer, Partners in Health

Before outlining the Plan, it is essential to note that all LMIC governments will have to rapidly access additional funding for the COVID-19 response (see section 6 on supply-side financing, below). The first funding source is the government. The World Health Organization (WHO) has outlined recommendations on how government can leverage the range of budgetary mechanisms available (see <https://p4h.world/en/node/8821>). The second funding source is the development sector. Development partners, such as the World Bank, United States Agency for International Development and a range of philanthropic foundations like the Bill and Melinda Gates Foundation, are reallocating their funds to address the pandemic in crucial 'hot spots' around the world.

Also, resources from the broader philanthropy sector may be available with a growing number of organisations, including those associated with banking, telecoms and other vital industries as well as individual philanthropists contributing to the response effort. Countries may wish to establish a task force, comprised of government officials and private sector leaders to mobilise funds from public and private sources for the response efforts. Such a task force could also be responsible for ensuring that funds are used effectively and efficiently, and for accounting for fund use.

## The PSE Action Plan



### Get organised to work together

#### Plan

1. Convene a high-level meeting with public and private sector representatives to determine if the private sector is willing to support the COVID-19 response and, if so, agree on how public and private actors will work together and in what areas during the response. Anchor public-

private dialogue within existing country policy dialogue mechanisms.

2. Conduct a rapid scoping exercise to identify private sector resources (e.g. space, staff, supplies and systems) and assess their relevance to the response effort.
3. Map out public and private resources, identify gaps, and define strategies to raise funds from public, private and international sources to address the funding shortfall.
4. Define roles, responsibilities and a definite 'division of labour' in the response effort (see 2.2 below) and the key terms for collaboration (e.g. via purchasing/contracting models).
5. Create mechanisms for fluid, transparent and continuous communication between the public and private sectors throughout the response.
6. Invite a select, but representative, group of private sector service delivery leaders from large and small- and medium-facilities to become part of the National Emergency Response Team and present at all government debriefings.



Space

### Secure private sector assets to increase surge capacity

1. Work with owners and managers of private health hospitals, labs, clinics and ambulance response services to conduct a rapid inventory of "space" resources (e.g. testing, lab diagnostics, ERs, ICUs, etc.).
2. As a cross-sector team, agree on how to organise levels of care needed to respond to COVID-19 (e.g. who will screen, and where? who will test, and where? who will analyse tests, and where? Who will treat patients with manageable symptoms, and where? Who will treat patients with

respiratory failure and other ICU conditions, and where?).

3. Reduce financial barriers to the population by identifying an appropriate and available partnership modes to engage private health facilities (see section 6, below).
4. Co-determine which public, private health facilities are best suited to respond to each level of care. In many LMICs, the private sector owns and operates well-equipped and well-staffed hospitals that comply with MoH quality standards. Establish volume/activity targets for each public and private facility based on forecasts of the disease's spread.
5. Similarly, the private laboratory sector – particularly, large chains such as Lancet in sub-Saharan Africa and ICMR in India – have strong capacity (e.g. state-of-the-art equipment, many points of service sites, a steady inventory of supplies, trained staff, etc.). Allow private labs to analyse tests as a matter of routine, referring complicated analysis to the MoH central lab.
6. Think beyond health care facilities and explore hotels, sports facilities, warehouses and schools to stage testing sites, erect quarantine services, isolation points and field hospitals and store emergency supplies.
7. Temporarily loosen laws and regulations to ensure private sector capacity can be used and to remove barriers to using private sector capacities, while maintaining quality and balance short term benefits & long term impact on the public health system.



Staff

### Mobilise and rationalise public and private health staff assignments according to need

1. MoHs should quickly draft COVID-19 clinical protocols and disseminate these to the **entire** private health sector so they can comply with them and become active participants in the response. Work with private sector leaders to disseminate the new protocols – as well as other critical information – using their own channels (e.g. through professional associations).
2. The MoH is responsible for the health and well-being of **all** healthcare providers.<sup>5</sup> Make sure all private healthcare providers have the necessary equipment and supplies – particularly PPE and cleaning supplies, so they are safe while performing their tasks according to the clinical protocol.
3. Work with owners and managers of private health hospitals, labs and clinics to conduct a rapid inventory of “staff” resources (e.g. number, health profession, level of certification, etc.). Staff assessment can be done during the inventory of “space” resources (see 2.1).
4. Map all health staff (both clinical and support) to areas of intense demand, and the public or private facilities within those areas. Reassign staff between public and private facilities as needed.
5. If possible, map private providers in solo practices (e.g. physicians, clinical officers, nurses/midwives). Empower these practitioners to become “front-line” providers to screen and refer possible COVID-19 patients for testing and treatment to the appropriate public or private facility as well as treating other patients to tackle non-emergency related demand.

6. Involve staff in selected private sector facilities in rapid training of COVID-19 protocols. Encourage these providers to cascade the training within their own facility and, if possible, with other private providers in/near their private facility.
7. Be flexible in professional licensing to mobilise as many health staff as possible by relaxing certification requirements and/or fast-tracking certification of health workers. Examples may include allowing retired nurses and doctors to practice without a current license or allowing fourth-year medical students to carry out certain functions, such as monitoring ventilators, etc.
8. Ensure an adequate supply of non-clinical staff also critical to COVID-19 - such as security, cleaning, laundry, food - in both public and private health facilities. Allow both public and private facilities to temporarily hire more staff to fill these positions.
9. Work with the private sector leaders to keep their workforce informed about the progress of the disease, changes in strategy, and additional opportunities for them to coordinate with the public health team.

See Step on Supply Side Financing with respect to pay for staff.



### Staff

### Ensure all health facilities and staff have the supplies they need to respond to the crisis

1. Establish an “essential list” of equipment and supplies based on the new clinical protocols to be used by all providers.
2. Based on the essential list, assess the current supply of essential equipment and

<sup>5</sup> See WHO guidelines on occupational safety and health of all health care workers at <https://apps.who.int/iris/rest/bitstreams/1272583/retrieve>

supplies between the sectors, identify gaps from a whole health system perspective, and rationalise current supply according to need (can be done at the same time as 2.1 and 3.2).

3. Establish a pooled procurement mechanism to purchase supplies for all providers participating in COVID-19 response, minimising competition in demand and mitigate the risk of 'price gouging'. If not possible, explore the potential for the government to donate emergency supplies or extend subsidies (e.g. reduced prices) to private health providers.
4. Explore local capacity to manufacture essential medical equipment and supplies needed, given the unreliability of global supply during the pandemic. Possible examples include contracting: (i) businesses (e.g. sugar and distilleries) to develop hand sanitizer; (ii) clothing manufacturers to produce gowns and masks; and (iv) engineering firms to produce ventilators.
5. Rapidly put in place Guarantee Purchase Agreements to incentivise manufacturers to ramp up current production and/or re-purpose current manufacturing capacity.
6. Explore local private transport and warehouse companies' capacity to store and ship essential supplies to all facilities participating in COVID-19 response.
7. Be creative and explore non-health related logistics companies (e.g. soda and alcoholic beverage distributors, bus companies, pharmaceutical distributors) with expertise and capacity to rapidly move equipment, supplies and people.



### Establish systems to integrate the public and private sector response effort



### Supply-side

1. Create easy mechanisms (e.g. web-based and/or mobile technology) for the private sector to notify new cases to government authorities. Build on this system to share up-to-date and "real-time" data on the progress of the virus with the private health sector.
2. Establish a single communication channel with the private sector. In addition to the daily public debriefings that everyone can access, LMICs governments can set up an appropriate communication mechanism to interact with private providers working on the response to share critical information (e.g. clinical protocol, essential supply list, staffing, assignments, location of testing sites), updates on supplies, and changes in strategies for deploying space, staff and stuff.
3. Based on agreements regarding the organisation of care (see section 2), establish a transparent referral system and mechanism to transfer COVID-19 patients between public and private facilities as well as who (public or private) will tackle demand for other essential services during the outbreak.
4. The referral systems should, where possible, be complemented by telemedicine solutions (including teleradiology) to share expertise and minimise patient transfers.
5. Set up a logistics system that supports both public and private health facilities to ensure that all participating COVID-19 facilities have the supplies they need on a timely basis.

### Supply-side financing

1. Identify appropriate and/or existing partnership models to engage private health facilities to cover their costs so that



no one is denied access to care in a private health care facility.

2. Possible mechanisms include (i) relaxing legislation governing procurement (e.g. review the Public Disposition Act) to purchase medical services; (ii) easing accreditation requirements under national/social health insurance schemes to empanel new/additional health facilities quickly; and (iii) allowing local governments to directly contract with private facilities under “state of emergency” laws to purchase essential capacity.
3. Get budgetary processes in place to rapidly pay private providers for assets and/or services on a volume-based prospective basis, thereby incentivising rapid scale-up of supply.
4. If purchasing is not an option, in extreme cases, the government may be required to temporarily requisition what is needed for the response effort.
5. Require that ***all*** private health insurance schemes cover ***all*** COVID-19 related costs. A post-crisis assessment can determine if the government will need to “bailout” the industry.
6. Consider other possible mechanisms to help defray private provider costs while participating in the emergency response, including (i) tax relief, and (ii) subsidised and/or (iii) donated inputs.

## Conclusion

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. As this Action Plan shows, partnering with the private

health sector requires governments to be (i) creative in the types of partnerships adopted, (ii) flexible in its application of regulations; and (iii) strategic in its attempts to cover the costs. Risks and challenges are inherent in acting swiftly in a context of uncertainty, but ultimately, patients will benefit if governments act to engage the private sector and collaboratively work together as partners in the fight against the COVID-19 pandemic. 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. These resources will link to other support and resources being developed by the WHO.

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WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update. Otherwise, this interim guidance document will expire 2 years after the date of publication.