As COVID-19 leads to a “cash crunch” for the private health sector in developing countries, Mark Hellowell, Andrew Myburgh, Mirja Sjoblom, Srinivas Gurazada, and Dave Clarke consider the opportunities and risks of providing state support to health care businesses.

The World Health Organization is calling on countries to adopt a whole-of-government and whole-of-society approach in responding to the COVID-19 pandemic. Among other things, this requires policymakers to include the private health sector in efforts to contain, control and mitigate the health impacts of the outbreak. However, data gathered from a series of interviews with key informants in 12 low- and middle-income countries (LMICs) (Ethiopia, Kenya, Nigeria, Uganda, South Africa, Thailand, India, Sri Lanka, Pakistan, the Philippines, South Korea and Iran) has highlighted a surprising finding. Just as pressure is increasing on countries to ramp up health system capacity, measures designed to “flatten the curve” are reducing the demand for care and creating a “cash crunch” for the private health sector – one that is forcing providers to scale back their businesses and even lay off health workers.

There is a risk of this situation leading to large-scale insolvency among private health care providers. The stress is particularly acute for Small and Medium Size Enterprises (SMEs), (e.g. primary care practitioners, small community hospitals, individual laboratories and pharmaceutical retailers), many of which seem unlikely to survive the pandemic without additional financial assistance. This is likely to have major implications for health systems – especially in the majority of LMICs in which private providers play a major role in delivering essential health products and services to the population, including many poor people.

For many countries, the threat to health care supply could not be happening at a worse time. Current attempts to relax lockdown restrictions may generate a surge in health care demand for two reasons:

1. increasing COVID-19 cases (the WHO has estimated that COVID-19 will lead to an additional 3.6 to 5.5 million hospitalizations in the AFRO region), and
2. an increase in general health care needs. With respect to the latter, it is known that many patients – including those with urgent health concerns - have been unable or unwilling to visit health care facilities for several weeks. They are likely to visit health

3Nearly quarter of a billion people in Africa will catch coronavirus and up to 190,000 could die https://gh.bmj.com/content/5/5/e002647
facilities in large numbers once it is perceived to be safe and legal to do so; but will in many cases find those facilities operating at limited capacity.

In addition, there are likely to be long-term consequences from health facility closures. The impacts on access to essential basic medicines, as well as to both primary and secondary health care services, may be severe, potentially impeding future efforts to reach universal health coverage in LMICs.

Scoping out the Problem

As the owner of one hospital SME in Kenya told us, “This is a terrible time to be in the health care business…foot traffic has dropped, and we can’t get supplies due to border closures. I have laid off my staff…I am not sure I can stay in business.” We heard similar accounts from business owners and managers in other countries - in low and middle-income countries in Africa, and in South- and South-East Asia. The Africa Healthcare Federation, an association for private health care business in Africa, confirms this general picture, reporting that private hospitals’ revenues have dropped by an average of 40% since March.

In addition, the International Finance Corporation (IFC), which announced a US$2 billion Real Sector Crisis Response Facility for its clients in a number of industries, including the health sector, has received reports that providers in Asia and South America have experienced year-on-year reductions in their incomes of between 50-75%. There appears to be a wide range of reasons underpinning this problem.

The following were identified by our key informants:

1. Government regulations that require healthcare facilities to defer elective surgeries and regular outpatient health care services – often for an undefined period;
2. Due to lockdown conditions, many patients are unable to attend clinics and hospitals – and in some cases they do not wish to, for fear of contracting COVID-19;
3. Private hospitals are having to spend more on personal protective equipment (PPE), isolation capacity, and supplies for treating respiratory illness, increasing their costs;
4. Economic disruption due to the pandemic has reduced insurance coverage and in general the willingness and ability of individuals to pay for health care; and
5. Private insurance companies are delaying the settling of claims to protect the viability of their businesses.

There is an argument that private health businesses should ‘step up to the plate’ - managing the risks to their cash-flows by changing their operations, for example, scaling up their treatment of COVID-19 patients, or providing more services online. However, these measures are likely to be insufficient to overcome such a complex problem – one that has multiple causes, on the demand and the supply side, and is unprecedented in terms of its magnitude and severity. Few businesses can cope with such risks. Widespread insolvency of the private health sector is now a distinct possibility in several LMICs. A problem like this is unlikely to be resolved without some form of non-market intervention.

4IFC report to the board of directors on a proposed investment in IFC fast track covid-19 facility world region
5For example, in India, several hundred private hospitals have been designated as COVID-19 facilities. They have been forced under emergency legislation to cancel non-urgent operations to conserve resources and capacity for the expected surge in COVID-19 demand. Yet this surge has not yet occurred (the country currently has low numbers of hospitalizations), and so the expected revenue stream has not been realized.
6For example, in countries with social health insurance institutions in place, such as Ghana, Kenya and the Philippines, large sections of the private sector are accredited to provide free or subsidized services to the insured population. However, policy responses in the form of ‘lockdown restrictions’ have led to a lack of demand, and delayed payments from insurers – undermining providers’ income streams.
Identifying Opportunities

New forms of aid, such as the IFC’s Real Sector Crisis Response Facility, as well as state aid, including loans, guarantees, and grants are urgently needed to support companies’ working capital and allow them to make scheduled debt repayments and thereby avoid falling into default. Yet governments need to protect their interests too. Currently, they lack a clear analysis of what conditions might be applied to such state aid. In this context, the chance might be missed to enhance the national response effort and build a new social contract between the public and private sectors in health care – a crucial matter for the achievement of the Sustainable Development Goals, such as universal health coverage.7

In some cases, states may opt to ensure that taxpayers are positioned to benefit once businesses return to positive profits, through (for example) taking equity stakes in the businesses. In some countries, this may help to win over an otherwise skeptical public. However, a similar increase in public support might be achieved if states make their support conditional on changes in commercial operations that support public health objectives – most obviously, ensuring that certain segments of the population that have in the past been unable to access paid-for care can do so in future, or at least during the period of the COVID-19 outbreak.

Where states, or state-backed social insurance agencies, are already financing private health businesses via supply- or demand-side financing, policymakers will find it easier than those in other settings to ensure a reasonable “bang for their buck”. For one thing, authorities in such contexts should already have a clear sense of which providers are ‘systemically important’ for addressing population health needs; and have the quality systems in place to provide safe and effective care.8 Finding appropriate strategic approaches – e.g. moving from volume-based to front-loaded availability-based payments - should also be relatively straightforward.

This would have the advantage of supporting providers at a time when large amounts of assets, staff and supplies are standing idle, while ensuring they are able to deploy these resources quickly if and when the likely surge in health care demand occurs. Purchasers may also need to make necessary adjustments in provider-purchasing arrangements, to the new realities – by, for instance, extending reimbursements to cover more benefits, including services provided online.

In other countries, effective resolutions to this problem may require new forms of engagement between the sectors to emerge. And, whatever form of support is favored, it is essential that clear criteria are developed to determine ‘who gets what’. A core principle is that decision makers at the country and the global levels should prioritize investments in health care facilities that can deliver the most value at the lowest cost. Without such criteria, it is possible that public funds will be misallocated, with well-connected and politically influential health care companies being prioritized for funding. Others – including those facilities that might play a larger role in providing health care to the majority of the population and achieving public health objectives – are likely to lose out.

This may undermine containment and mitigation efforts during the COVID-19 outbreak, which is now entering a critical phase in many developing countries, and have deleterious effects on equitable access to health care in the longer term.

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8Policymakers in some high-income countries are acting on this opportunities. In the US, Congress recently passed legislation that provides $175 billion in emergency funding for health care organizations. On 10th April, the Department of Health and Human Services began disbursing funds any healthcare organizations that received Medicare payments in 2019.
Mitigating Risks
The need to act quickly means that agencies may not have the time to implement standard processes, and will rely on emergency approaches to provide subsidies. This, however, may open the door to corruption, price gouging and the provision of poor quality care, leading to avoidable morbidity and mortality. Governments need to be transparent about the details of state aid and monitor who has benefited, and to what extent (e.g. in terms of revenues/profits). Where possible, all such information should be in the public domain, and subjected to sources of independent scrutiny and challenge, including analysis by official (i.e. government/parliamentary) audit institutions. The government should also carefully monitor performance under these arrangements, and publicize the results.

In the context of emergency procurements, there is a strong rationale for governments to restrict access to contracts to those providers with an established track record of delivering consistently high quality care. Where strategic purchasing arrangements already exist, this is likely to be easier since existing empanelment/accreditation processes should confirm which providers have the systems in place to do so.

But in other contexts, too, the process of engaging healthcare businesses to provide needed support should be used as a means of establishing greater accountability and information-sharing between public authorities and private providers. Policymakers are now dealing with a huge and time-sensitive problem. It requires governments to engage with and seek to mitigate risks in defining an urgent solution. Yet the opportunity exists to establish a new whole-of-society approach to addressing population health needs – one that will strengthen countries’ capacities to address the COVID-19 pandemic, but also, perhaps, in the longer term, strengthen public-private dialogue and information exchange to build stronger health systems, so that countries can quickly regain lost momentum on the path to Universal Health Coverage.

Postscript
This blog raises a number of important policy issues and questions, including –

- Whether state and donor aid should be made available for the private health care sector.
- What conditions, criteria and priorities should apply to the award of aid.
- What risks arises from the provision of state and donor aid and how do we manage them.
- What would a new social contract between the public and private health sector consist of, how would it contribute to countries long term efforts to achieve UHC and how could it be implemented.

To come up with advice for our member states and potential donors, WHO plans to convene a meeting of experts and key stakeholders, and will use a Delphi process to help provide rapid answers to these important questions.

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This blog is a product of the World Health Organization’s Private Health Sector Engagement for COVID-19 Initiative (WHO-PCI).