

PRIVATE SECTOR DISCUSSION NOTE: COVID-19 TREATMENT

Introduction

Health systems around the world are deeply immersed in the battle against COVID-19. The pandemic has claimed just over half a million lives globally to June 2020. While treating COVID-19 patients has taken priority, several other health services have been neglected, threatening health globally. A major strategy proposed by the World Health Organization (WHO) has been a whole-of-government and whole-of-society approach.¹ This includes treatment for COVID-19 patients and access to other essential health services.

The disease itself presents unprecedented challenges to case management. While large proportions of positive cases are asymptomatic, for others, the disease necessitates hospitalization and access to intensive care. As the epidemiology of the disease progresses, from cluster to community transmission for example, treatment facilities must also respond, including in locations with limited health infrastructure.

In low and middle-income countries (LMIC) private health service providers can play an important role in a whole-of-society approach to COVID-19. In LMICs, the private health sector often provides a significant proportion of health services and products. Furthermore, private health sector engagement offers strained government health systems opportunities to increase access to services. Realizing that opportunity requires recognizing and building on the private sector's corporate arrangements, objectives, services, market-segmentation, pricing, and quality. The potential and challenge lie in bridging these differences to weave together a single, national COVID-19 response.

Anecdotally, many private health providers in LMICs are looking for ways to contribute to a national COVID-19 response. However, governments may not have in place the mechanisms for engagement nor is there a blueprint for a coordinated, whole-of-society response. Approaches and strategies adopted by wealthier countries may not be relevant or practical in LMICs. New, fit-for-context approaches, are [needed](#). The more that governments can identify key areas of complementarity, the greater likelihood that private and public health services will deliver an effective response. Role clarity and operational plans are critical.

Purpose and scope

The purpose of this discussion note is to support Member States with practical advice and illustrative examples of private sector engagement as part of a whole of society approach to COVID-19 treatment. Private sector health services for this briefing note encompass for-profit and not-for-profit clinics, hospitals, and pharmacies as well as community-based and home-

¹Barbara O'Hanlon and Mark Hellowell. Enabling the private health sector in the national response to COVID-19: Six Current Policy Challenges. Geneva. (2020)

based care. The discussion note is outlined using the WHO action plan framework – [plan, space, staff, stuff, systems, and supply-side financing](#). It should be read in conjunction with other WHO COVID-19 technical guidance.²



PLAN

What needs to be done?

Successful treatment requires capacity to safely meet demand of severe COVID-19 cases with minimal disruption to other essential health services; moderate and mild cases should be home-managed where feasible. Curative services must work in concert with public health initiatives to limit or control transmission. Plans should consider four related spheres: treatment, decongestion, transmission, and home-based care.

- **Treatment** specifically relates to severe cases of COVID-19 requiring hospitalization and/or intensive-care.
- **Decongestion** is the allocation of health resources to ensure that COVID-19 caseloads can be managed without compromising the safe provision of other critical essential health services.
- **Transmission** aims to limit the number of new cases, but also to identify or contain hotspots allowing curative resources to be deployed accordingly. This also relates to safety risks and the importance of infection prevention and control measures, such as health worker personal protective equipment (PPE), when treating patients and working in health facilities.
- **Home-based care** recognizes that most COVID-19 cases are asymptomatic or mild and can be treated at home. This may also be required for patients needing care after discharge from hospital.

The role of the private sector can be integrated within these four spheres. Plans that recognize and incorporate both sectors can bolster the resilience of the wider health system and increase capacity to meet surges in caseload. These roles must also be flexible, responding to changing conditions over time and space.

Planning within these four spheres should address “space”, “staff”, “stuff”, “system”, and “supply-side financing”. Plans should be revisited regularly and updated for any change in the COVID-19 transmission context and caseload.

In **Mexico**, private hospitals will treat patients who cannot fit into public hospitals to deal with the coronavirus in Mexico. “Todos juntos contra el COVID-19” (“All together against COVID-19”) is the name of the public-private agreement signed by President Andrés Manuel López Obrador on Monday, April 13.

Source: AMLO Signs Public-Private Partnership to Defeat Coronavirus. Panam Post. April 2020. <https://panampost.com/mamela-fiallo/2020/04/15/amlo-signs-public-private-partnership-to-defeat-coronavirus/>

²<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/maintaining-essential-health-services-and-systems>.



SPACE

Private sector spaces contribute to the public health response, identified through planning

Space needs to consider COVID-19 surge capacity, segregated spaces and/or designated facilities for essential services, spaces to cater for staff and staff, and ancillary spaces such as isolation and quarantine sites (i.e. repurposed facilities or homes).

Surge capacity. Space needs to be able to expand to meet COVID-19 treatment demands. This has tended to focus on hospitalization requirements for severe cases, accounted for in terms of ICU bed capacity. In many contexts, space has included private and public referral hospitals, leaving lower level facilities as triage and referral points. As demand for ICU beds, ventilators and care fluctuates, some governments have repurposed other private spaces, such as stadiums or erected tents to accommodate demand. In some contexts, such as France and India, trains have been repurposed as mobile ICUs to address spatial constraints.

Segregation. Space also needs to allow for segregation of COVID-19 treatment wards from other hospital spaces and functions. This may require modifications to physical layouts to reduce risks of exposure. Where they exist, hospital guidelines should be adhered to by all participating facilities, both public and private treatment and triage sites.

Essential services. COVID-19 caseload may compromise the provision of essential health services. This may necessitate reprioritization of essential services, or their relocation. Private health facilities (those not designated as COVID-19 treatment sites) and community-based or mobile outreach may be used to decongest treatment facilities and reduce risk of exposure for non-COVID-19 patients/clients. This form of spatial arrangement requires mapping of public-private spaces, including mobile outreach and telemedicine, as well as the establishment of referral mechanisms with communities and facilities.

Ancillary spaces. Other space considerations include rest facilities for staff and secure storage space for equipment and PPE. Where demand for these services is likely to be transient, they can be outsourced to the private sector. Treatment spaces also need to work in close coordination with isolation and quarantine facilities, which may be set up for those infected or exposed to the disease, who may require treatment (for COVID-19 or other conditions).

In **South Africa**, scientists at the University of KwaZulu-Natal conducted a detailed reconstruction of how the COVID-19 virus spread in a private hospital in Durban based on floor maps of a hospital, analyses of staff and patient movements, and viral genomes. The study recommended splitting the hospital into green, yellow, and red zones based on their COVID-19 exposure risk, limiting staff movements between those zones, and weekly testing of frontline staff. This single incident is attributed with the infection of 39 patients and 80 staff and 15 patient deaths. All recommendations were implemented by the private hospital.

Source: Study tells 'remarkable story' about COVID-19's deadly rampage through a South African hospital. Science Mag. May 2020. <https://www.sciencemag.org/news/2020/05/study-tells-remarkable-story-about-covid-19-s-deadly-rampage-through-south-african-hospital>



STAFF

Mobilize and direct private health staff for the public health response, augmenting public sector capacity

Similar to considerations on “space”, private sector staff also need to be identified and allocated to support surge requirements, the provision of essential services, and other auxiliary requirements. In hospitals and other settings, a critical consideration is a sustainable workforce with a focus on infection control to minimise intra-hospital exposure.³ In terms of home-based care, individuals, their family members, and community-based entities such as dispensing chemists and community health workers (CHWs) may also be considered “staff”.

Considerations include the following:

Staff allocation. Private (and public) health workers may be allocated to COVID-19 treatment through staff deployment using a rota system. They may be seconded from one entity to another (private to public for example) to address acute capacity requirements in response to surges in demand for hospitalization in the public sector. Staff in private practice (e.g. physicians, clinical officers, nurses/midwives) should be engaged as these individuals are likely to encounter suspected COVID-19 cases and should form part of the referral pathway for testing and treatment.

Task shifting and licensing. Ministries of health may also task shift responsibilities to other health cadres to decongest public spaces, address excess demand and/or ensure access to essential services. This is likely to include private facility and community-based staff (i.e. CHWs, retired midwives and nurses) as part of ambulatory and primary health care. This may necessitate flexibility in professional licensing, relaxing and/or fast-tracking certification requirements.

Staff capacity. In both the public and private sector, both facility- and community-based, staff should be capacitated to deliver continuity - and *quality* - of care. This would entail continuous medical education on treatment standards, discharge/home-based care guidelines, and safety and referral protocols, to name but a few topics. Staff should also be kept abreast of changes in transmission and response strategy as well as evolved understanding of suspect case definitions, risk stratification and clinical and home-based care protocols and patient outcomes. This can be facilitated through a central “command” structure working with professional associations or healthcare federations which, in turn, can cascade information to their members. Concurrently, devolved health departments should also take a whole sector approach to staff communications and orientation (public, private, both facility- and community-based).

³Goh, K J, Wong, J, Tien, J-C, Ng, S Y, Wen, S D, Phua, G C and C K-L Leong, 2020. Preparing your intensive care unit for the COVID-19 pandemic: practical considerations and strategies. *Critical Care* (2020) 24:215 <https://doi.org/10.1186/s13054-020-02916-4>.

In **Singapore**, staff considerations and strategies to maintain ICU capacity and services were developed for the containment and crisis phases of the response. These considerations are applicable to public and private COVID-19 ICU settings and may be supported through the private sector (i.e. helplines, training, etc.)

Containment or alert phase

- Staff segregation into ‘frontline’ teams
- Implement strict infection prevention and control measures
- Education of healthcare workers (HCW) on infection control measures with “just-in-time” N95 fit testing
- In situ, just-in-time simulation training with before-and-after multidisciplinary peer-review processes
- Periodic re-training of HCW on infection control measures
- Staff surveillance (e.g. temperature monitoring) and access to designated staff clinics
- Ensure dissemination of timely and factual information and establish two-way communication
- Provide helplines and psychological support, temporary staff quarters, gratitude messages from hospitals and public
- Initiate ICU hands-on training for non-critical care nurses and ICU refresher courses for HCW using online materials and instructional videos

Pandemic or crisis phase

- Minimise unnecessary procedures and transport
- Increase manpower capacity by changing work structure (e.g. extra shifts or work hours) and restricting leave
- Suspend elective procedures and non-essential services
- Redeployment of HCW with critical care experience from other departments into ICUs
- Consider reducing nurse- and doctor-to-patient ratios
- Mass critical care: reassign non-intensive care HCW from other departments to support essential services, with ICU nurses providing a supervisory role

Source: Goh, K J, Wong, J, Tien, J-C, Ng, S Y, Wen, S D, Phua, G C and C K-L Leong, 2020. Preparing your intensive care unit for the COVID-19 pandemic: practical considerations and strategies. *Critical Care* (2020) 24:215 <https://doi.org/10.1186/s13054-020-02916-4>



SPACE

Whole-of-society approach for treatment commodities

Using COVID-19 treatment protocols, ministries of health should establish an “essential list” of equipment and supplies for both facility and home-based treatment. It should also consider other equipment and supplies for non-COVID-19 essential services. These should receive adequate priority and not be displaced due to COVID-19. Consistent with a whole-of-society approach, “stuff” needs to be considered for public, private and community-based treatment as well as maintenance of other essential health services. What is needed and where it will be needed will change over time with the evolution of the pandemic.

The guidance outlines the breadth of “stuff” required to mount a whole of society response to COVID-19. This is expanded upon in the supplies guidance.

- **Treatment.** Medicines and consumables, medical equipment, PPE, infection prevention and hygiene materials.
- **Ancillary services.** patient care items such as beds and linen; facility management such as waste disposal, utilities; and ancillary services such as security, catering, laundry, and ambulatory services.
- **Home-based care.** Medicines for symptomatic treatment or post-recovery; infection prevention and hygiene materials.



SYSTEM

Integrate elements of private and government systems to provide flexibility, coverage, equity and reach to COVID-19 treatment

The more that systems are seamless across private and public interests, the greater the opportunity to extend service coverage, equity, and reach.

Case management system. Opportunities for seamless integration include the use of telemedicine. This can be used between sectors and providers, for example by enabling more physician and qualified health personal to provide advice and support other frontline service providers.

Referral system. Referral systems need to be established for COVID-19 patients as well as non-COVID-19 patients. These need to factor in supply-side financing, as these may influence who is treated, where, as treatment in private facilities may attract out-of-pocket expenditure. It is important to create a whole system continuum of care, from communities to facilities and back to communities for recovery care.

Reporting system. Data is critical to the treatment and management of COVID-19 patients as well as for the treatment and management of non-COVID-19 conditions. COVID-19 necessitates a single reporting system for patient outcomes. Ideally this would be web-based and/or through mobile technology and be updated in real-time. For non-COVID-19 conditions, private providers should report through the health management information system (HMIS) as it is important to monitor in real time the effects of COVID-19 on other health services and outcomes. This is a challenge as many LMICs have incomplete data from the private sector.

Communications systems. It is important to establish a streamlined communication channel with the private health sector. Communication mechanisms should facilitate sharing of critical information such as clinical protocols, essential supply lists, staffing assignments, location of testing sites and any changes in strategies for deploying “space”, “staff” and “stuff”. It is also important for the private sector to be kept abreast of changing epidemiology, treatment outcomes, and transmission patterns all of which may necessitate an adapted response.

In **Thailand**, the Department of Disease Control has produced guidelines and a protocol for case management which apply to both public and private hospitals. As part of this, private hospitals must report cases daily to the National COVID Management Center, chaired by the Prime Minister, for daily public reporting at noon. (Thailand declared a State of Emergency from 28 March until 30 April and extended this to end-May 2020).



SUPPLY-SIDE

Establish mechanisms to coordinate and rationalize payments for COVID-19 services to promote equitable treatment

Mechanisms for supply-side financing are dependent upon existing private sector contracting mechanisms and national policy imperatives, such as extending the coverage and quality of treatment services (both COVID-19 and non-COVID-19 related). Where both sectors are aligned and can act in concert, while managing risks and mitigating conflicts of interest, there is greater scope to achieve treatment objectives.

Considerations include the following:

Pricing. Pricing needs to consider level and location of care, as well as patient care requirements. For hospitalization, these may be set as day or bed rates, while other modalities such as capitation may be appropriate for out-patient or community care. In contexts where an existing contracting mechanism does not exist, ministries of health may also consider price caps, in order to bring down the cost of treatment in the private sector. These may be achieved through subsidy or through tax credits (see cost offsets). Complete removal of patient out-of-pocket costs may not be possible but catastrophic expenditure can be contained through these types of measures. It is important to establish national pricing guidelines and communicate these to the public.

Contracting. Where agreements are made for private facilities to provide COVID-19 treatment, these require the identification of a contracting authority, such as the ministry of health, national health insurance or other authority. Contracts need to consider the scope of engagement and modalities for reimbursement of services rendered. Services should be reimbursed at a fair rate, to reinforce quality standards and safety protocols (if not, quality and safety may be rationed).

Cost offsets. Other mechanisms may be used such as soft loans and sharing agreements; these may be useful for large treatment cost inputs, such as modifications to space, use of ancillary services, or secondment of staff. To make inputs more affordable, governments may also relax or reduce VAT, and/or waive import duties and other clearance costs. The private health sector may be included within bulk orders or guaranteed purchasing agreements to benefit from economies of scale. The private health sector may also access donated inputs. Any subsidy at input level should be reflected in pricing and reimbursement schedules.

In **India**, the ABPM-JAY is assisting state government to temporarily empanel private health facilities to provide emergency care and treatment for other serious illnesses for all, particularly the poor and vulnerable. Also, in India, the state government of Maharashtra has capped treatment costs in private hospitals for people without medical insurance. For others, the capped prices will come into effect once they exhaust their medical cover. The decision comes after several patients with COVID-19 and other ailments highlighted the exorbitant cost of treatment at private hospitals.

Source: NHA launches empanelment for private hospitals to provide treatment under AB-PMJAY. The Economic Times. April 2020. <https://health.economictimes.indiatimes.com/news/policy/nha-launches-empanelment-for-private-hospitals-to-provide-treatment-under-ab-pmjay/75094234>

Source: COVID-19 | Maharashtra invokes five laws to cap high private hospital costs. The Hindu. May 2020. <https://www.thehindu.com/news/cities/mumbai/covid-19-maharashtra-invokes-five-laws-to-cap-high-private-hospital-costs/article31485224.ece>

About this discussion series

The WHO's Private Sector Engagement COVID-19 Initiative (WHO-PCI) discussion series is for Member States seeking to engage the private health sector in their COVID-19 response. The series seeks to promote a culture of "learning by doing", recognizing that necessity and urgency are producing examples of private sector engagement. As the COVID-19 context is dynamic, this series will be periodically updated with emergent practice. A [draft private sector engagement strategy](#) has been developed and provides further guidance on governance of mixed health systems.