

THE IMPACT OF COVID-19 ON THE PRIVATE HEALTH SECTOR: SYMPTOMS, CAUSES, CONSEQUENCES AND SOLUTIONS

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EXECUTIVE SUMMARY

In most low- and middle-income countries (LMICs), the private sector is an important provider of health products and services to the population. During the current pandemic, public health systems have re-focused their resources on testing, isolating and treating COVID-19 patients, reducing the supply of other health products and services to the population. At the same time, the private health sector has been subject to financial and operational disruption due to the pandemic, reducing its ability to address gaps in healthcare provision. **The net result is that healthcare systems are failing to ensure sufficient access to, and utilization of, essential health products and services during the COVID-19 pandemic.**

In this context, the World Health Organization is conducting empirical research to assess the scale of this problem, its causes and consequences, and the solutions available to address it. This briefing document provides a summary of the results of this research so far, focusing on the findings of: (a) a rapid survey of private health sector actors in eight African countries; and (b) a document and media analysis focused on LMICs in Africa and other parts of the world. Our sample covers countries that employ different 'governance regimes' with regard to the private health sector – including 'exclusive' regimes (in which health agencies focus their attention and activities mostly on the public delivery system) and 'inclusive' regimes (in which agencies also engage private sector actors (on a routine or selective basis), to address their policy priorities. We do so to capture any differences in terms of the problems, causes, consequences, and/or available solutions with regard to the private health sector during COVID-19.

The results emerging from the research to date shows that:

1. Service availability, staffing and the financial sustainability of private healthcare providers have all been seriously compromised by the pandemic. For example, almost all the healthcare businesses we surveyed report that COVID-19 has increased their monthly expenses and reduced their revenues, indicating a major reduction in net incomes during the crisis. A high proportion of facilities have closed, and approximately half of businesses have been forced to

¹ The authors would like to acknowledge Joel Klinton and Carlos Zamalloa for research assistance; and Bruno Meessen for a technical review.

furlough or lay off staff – though these **impacts are less severe in countries in which health policy and systems governance is more ‘inclusive’ of private sector actors.**

2. Reductions to service availability, staffing and financial strength in the private health sector have been driven by (i) government restrictions on healthcare delivery during the crisis, and (ii) reduced demand for services from the population. Financial impacts have also been aggravated by decreases in the availability of essential COVID-19 supplies, and disruptions to both general and health sector-specific supply chains.

3. In countries experiencing a surge in demand for diagnostic and therapeutic health services during the acute phase of the outbreak, **reductions in the capacity of private health sector providers have reduced the population’s access to and utilisation of COVID-related services.** This raises the possibility – which the WHO will examine in future work – of an even more widespread and severe impact of the crisis in the form of **reductions in the populations’ access to and the affordability of other (i.e. non COVID-related) services.**

4. Policymakers are currently seeking to address this problem using a variety of interventions. However, **governments that operate more ‘inclusive’ governance regimes** with respect to the private health sector were:

(a) more likely than others to **provide support to the private health sector** during the COVID-19 emergency, and

(b) more likely to **structure that support in ways that address the underlying ‘causes’** of the financial challenge and not only the ‘symptoms’ of this problem.

This might suggest that countries with more ‘inclusive’ regimes have greater ability to provide more systemic and therefore sustainable solutions to the financial sustainability challenge facing the private health sector.

1. INTRODUCTION

In most low- and middle-income countries (LMICs), the private sector – defined in this report as *all individuals and organisations that are neither owned nor directly controlled by governments and are involved in the provision of health goods and services* - is a major provider of health products and services to the population. This includes both for- and not-for-profit entities representing a wide range of activities in the health sector (e.g. service delivery, manufacturing, retail pharmacy, etc.). During the current pandemic, public health systems have re-focused their resources on diagnosing, isolating and treating COVID-19 patients, reducing the resources available for provision of other health products and services.² At this time, however, the private health sector has been subject to financial and operational disruption due to the pandemic, reducing its ability to address the resulting gaps in healthcare provision.

The net result is that healthcare systems are failing to ensure adequate access to, and utilization of, essential health products and services during the COVID-19 pandemic. We found in previous research³ that governments and their development partners are aware of the financial challenges facing the private sector and the potential consequences for the availability of essential health services during the crisis. However, additional interviews with policymakers/stakeholders at the national and global levels, alongside a virtual workshop comprising key stakeholders and technical experts involved in health system responses to COVID-19, pointed to three key knowledge gaps impeding the formulation of effective responses, i.e.:

- (i) The **scale** of the financial challenge facing private healthcare businesses and its impact on the operational capacity of these providers have not been delineated.
- (ii) The **causes** of the observed financial challenges have not been identified, such that it is difficult to know which policy responses are likely to be most effective in addressing them.
- (iii) The absence of any agreed **criteria** to determine which private healthcare providers should be prioritised for supportive actions by governments and/or their development partners.

² See: <https://www.who.int/news/item/31-08-2020-in-who-global-pulse-survey-90-of-countries-report-disruptions-to-essential-health-services-since-covid-19-pandemic>

³ Barbara O'Hanlon and Mark Hellowell (2020). [Enabling the private health sector in the national response to COVID-19: Six Current Policy Challenges](#). Geneva: World Health Organization. This paper reported the results of a series of interviews with technical experts at the country, regional and global levels (representing stakeholders from across each World Health Organization region) to identify the range of policy challenges faced by LMIC policymakers in enabling private health sector actors to support national responses to Covid-19. This brought to light perceptions that (a) the private health sector had been exposed to significant financial losses due to the pandemic, and (b) that these losses had reduced its capacity to contribute to national responses to COVID-19 and threatened to result in widespread insolvency of among private health businesses in the longer term.

In this context, the World Health Organization is working towards a publication that will provide clear guidance on the scale and impact of “the problem”, its pathways of impact, and the best policy mechanisms for addressing it. This publication will include guidance on the criteria that should be applied to the provision of supportive actions to the private sector, to ensure that such actions have the effect of maximizing the capacity of health systems to address population health need, and to minimize avoidable morbidity and mortality both during and after the crisis.

In this briefing, we present the results of a rapid survey addressing the first two knowledge gaps listed above.

Specifically, the objectives of the research reported in this briefing are:

- To investigate **the nature and scale of the impacts of COVID-19** on the operational and financial capacity of private providers in LMICs.
- To examine the **causes** of these impacts in terms of changing conditions in the health market, the socioeconomic context and/or government regulation.
- To study the **consequences** of these impacts in terms of the private health sector’s capacity to contribute to health system objectives during the COVID-19 pandemic. Explore how policymakers are **currently seeking to address the problem** and assess the adequacy of these from a health system perspective.

2. METHODOLOGY

As noted, this exploratory research began with a series of interviews in April and May 2020 with technical experts at the national and global levels. These interviews brought to light the widely held view among health policymakers that the private health sector had been exposed to significant financial losses due to the COVID-19 pandemic, and that these losses had given rise to much reduced availability of services (indicated by facility closures and reduced staffing) among private providers. Following this, we ran a virtual workshop in June 2020 to elicit perceptions of the health system/global health significance of this problem, key data gaps in relation to it, and options for resolving it. The workshop involved 22 participants from:

- (i) UN agencies closely involved in providing support to countries (including multiple divisions and regional offices of the WHO);
- (ii) bilateral and multilateral donors involved in providing financial support to the private health sector; and
- (iii) individual technical experts and health system/global health academics.

The workshop was recorded and transcribed, and the results analysed to identify key themes in relation to our objectives. The resulting analysis pointed to three major knowledge gaps that, in the view of the participants, have been impeding the formulation of well-informed, effective policy responses (Note: these are identified on page 3 as (i) the scale of the financial challenge facing private healthcare businesses and its impact on the operational capacity of these providers have not been delineated; (ii) the causes of the observed financial challenges have not been identified, such that it is difficult to know which policy responses are likely to be most effective in addressing them; and (iii) the absence of any agreed criteria to determine which private healthcare providers should be prioritised for supportive actions by governments and/or their development partners.) We sought to address these three knowledge gaps by conducting, in July and August 2020, a rapid online **survey** of individual healthcare businesses and their local representative bodies located in eight African countries (Nigeria, Cote D'Ivoire, Morocco, Ethiopia, Congo Brazzaville, Kenya, Uganda and Sudan).

The eight countries were selected to:

- ensure a representative geographic sample of countries on the continent (the sample includes Anglophone and Francophone countries located in the continent's Northern, Eastern and Western regions, and covers two WHO regions (EMRO and AFRO)), and
- reflect different health system types, defined with regard to the nature of the interaction between the public and private health sectors, ranging from the relatively 'exclusive' governance regimes (of Ethiopia, Uganda, Sudan, Congo-Brazzaville) to the more 'inclusive' regimes (of Kenya, Nigeria, Cote D'Ivoire, Morocco), in order to capture any differences in the nature and scale of "the problem", its consequences, and current responses (See Box 1 below for an explanation of these 'governance regime' concepts.)

The survey instrument included 28 questions related to objectives (i) to (iii) above, i.e.

- **the nature and scale of the impacts of COVID-19** on the operational capacity and financial sustainability of private healthcare providers in L/LMICs;
- the **causes** of these impacts (e.g. changes in demand, government regulations, socioeconomic disruption etc),
- the **consequences** of these impacts in terms of changes to the scope of private providers' operations, and their access to essential equipment, supplies and staff, and
- perceptions of **current policymakers' efforts** to address the problem.

Box 1: The ‘exclusive’ versus ‘inclusive’ governance regimes

Countries vary in the extent to which the public and private sectors work together to achieve health policy objectives. In more ‘exclusive’ governance regimes, health agencies tend to focus exclusively on the public healthcare delivery system. Common policy functions such as problem definition, policy design, implementation and communication, are carried out internally - with little engagement or understanding of the private sector component of healthcare delivery (e.g. data on the private sector’s role in healthcare delivery may be absent - or seriously inadequate). In contrast, in more ‘inclusive’ governance regimes, health agencies engage private sector actors (on a routine or selective basis), for example to fill gaps in public sector provision or address urgent policy priorities. In this case, health agencies collect and analyse data from private, as well as public, providers; and may even include private sector businesses and/or their associations in efforts to define particular policy challenges and/or to develop collaborative strategies to respond to them.

In this analysis, we have assigned countries to these categories according to whether there is the presence/absence of engagement mechanisms - e.g. strategic purchasing arrangements and associated public-private dialogue structures. In inclusive governance regimes, such arrangements exist and are utilized either as a matter of routine, or regularly on an ‘as need’ basis. In contrast, in exclusive governance regimes, governments have very limited engagement of any kind with the private health sector. Government administration focuses exclusively on managing the public health care system.

Source: Hellowell, M, O’Hanlon, B, Elliott, D (forthcoming), Managing Markets for Health. See: <https://managingmarketsforhealth.org>

Participating Countries in our Survey	
‘Inclusive’ governance regimes	‘Exclusive’ governance regimes
Kenya	Ethiopia
Nigeria	Uganda
Cote D’Ivoire	Sudan
Morocco	Congo-Brazzaville

The survey was distributed to individual healthcare businesses and healthcare industry representative associations, in collaboration with the Africa Healthcare Federation – a pan-Africa umbrella organisation that includes 27 country-specific federations and two regional federations (the West African Healthcare Federation (FAOSPS) and the East African Healthcare Federation (EAHF)). We received 110 completed survey responses in total.

In addition, as we wanted to ensure the survey added to knowledge, and that we could relate our survey results to information already in the public domain, we undertook a **comprehensive document analysis**, underpinned by a systematic search methodology (see appendix 1), of all information in the public domain that we could find on this topic, and relating to a much wider group of low- and middle-income countries, including in Africa but also south- and south-east Asia, and the America. Through this method, conducted in August and September 2020, we

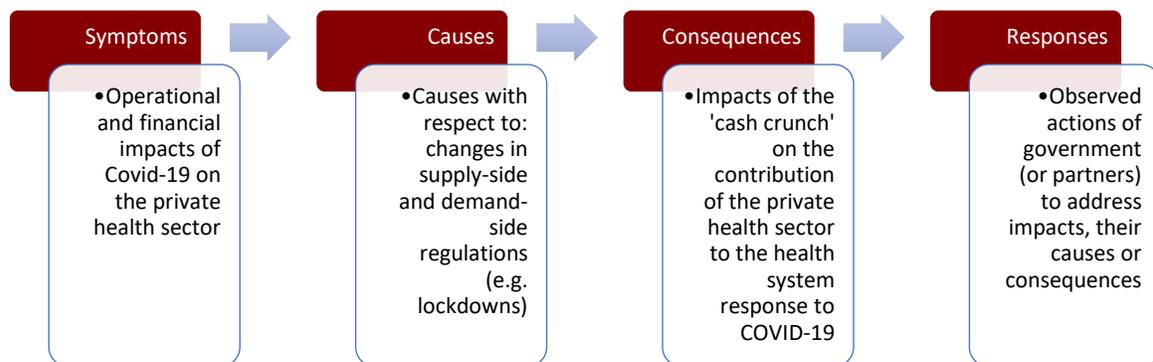
reviewed a total of 122 outputs – including news articles, blog posts, government policy statements and academic journal articles – drawing on these to triangulate the results of our survey data and place them in a more qualitative context.

Some limitations should be noted, in regard to: (i) the sample of the survey: only 8 countries participated to the survey and all were situated on the African continent; (ii) the nature of the survey: participants self-reported answers to questions designed to inform on the status quo, but not particularly designed to analyze the connections between symptoms, causes and consequences; (iii) a general lack of data on this topic (hence the methodology chosen for this research).

Consistent with our research objectives (outlined in section (I)), our survey and document analysis were focused on the following ‘lines of inquiry’:

- (i) the nature and scale of the impacts of COVID-19 on private healthcare providers’ operations and finances (*Symptoms*),
- (ii) the causes of these impacts on the demand and supply sides of the healthcare ‘market’ (*Causes*),
- (iii) the consequences of these in terms of the private sector’s contribution to the health system response to COVID-19 (*Consequences*), and
- (iv) the nature of recent and/or current actions (if any) of government policymakers to address these impacts, their causes or consequences (*Responses*) (see Figure 1).

Figure 1: Our ‘lines of inquiry’ in the survey and document analysis



3. RESULTS

3.1 Profile of survey respondents

We received 110 responses in total. Table 1 provides an overview of the respondents' characteristics. Approximately three-quarters of the responses (84) were completed by individual healthcare businesses (representing the perspectives of managers/owners at the business and/or facility level); while the remainder (26) was completed by senior staff of business representative groups (BRGs) (providing data on organisations representing a more sector-wide assessment). The individual businesses included cover a broad range of health system domains as follows: primary care (13%), hospital services (31%), laboratories (20%), and the manufacturer, distribution and retail of essential medicines and health products (37%).

Among the respondents, about half (45%) employ less than 26 staff and can be characterized as small or medium enterprises (SMEs) – being single provider practices, neighbourhood pharmacies, or small multi-practitioner clinics. Another third employ less than 100 staff; and the remainder more than 100 staff. Therefore, the majority of our individual healthcare business respondents are of the category known to be particularly vulnerable to socioeconomic shocks such as that created by COVID-19.⁴ In addition, the BRGs included in the survey are representative of a range of business types (including SMEs and large corporates) and a broad range of sectoral areas - including health services providers, health product sellers, and supply chain players.

Table 1. Details of the 110 respondents included in the survey

Profile	Individual	Representative Organizations
Type of Respondents	76% (n=84)	24% (n=26)
Organization Structure	81% domestic businesses; 19% international businesses	72% domestic associations; 28% international associations
Legal status	90% for-profit 5% non-profit 5% 'other' (not specified)	55% for-profit 27% non-profit 18% 'other' (not specified)
Type of Business	Hospitals (31%) Labs and testing facilities (20%) Pharmacies (18%) Primary care centers (13%) Distributors (12%)	100% are representatives of a range of businesses (including SMEs and large corporates) across a range of sectoral areas.

⁴ Kruse FM and Jeurissen PPT. For-Profit Hospitals Out of Business? Financial Sustainability During the COVID-19 Epidemic Emergency Response. *International Journal of Health Policy and Management*, 2020, 9(10), 423–428.

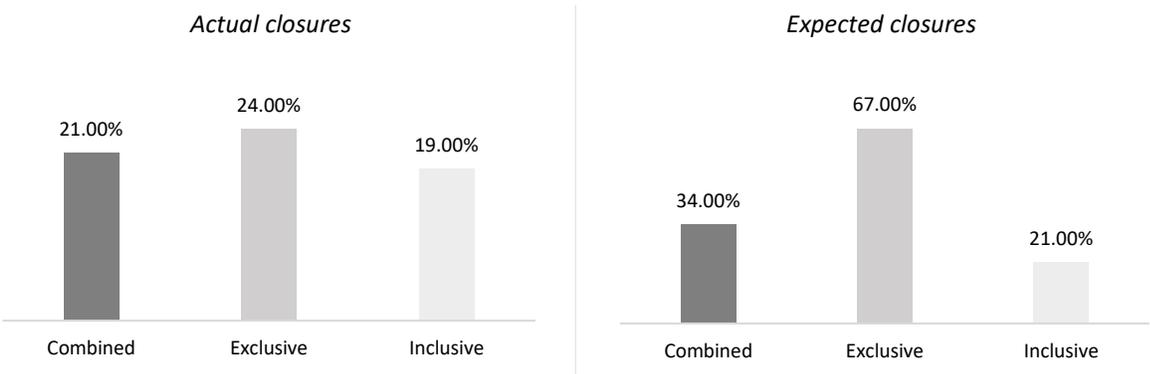
	Manufacturers (7%)	
Size of Business	45% of respondents have less than 26 employees 18% have 25 – 50 employees 16% have 50 – 100 employees 15% have 100 – 500 employees 6% have employed more than 500 + staff.	
Geographic focus	65% of respondents operate exclusively in urban areas 6% operate exclusively in rural areas 29% operate in both urban and rural areas	

3.2 ‘Symptoms’: operational and financial impacts of COVID-19 on the private health sector

3.2.1 Operational impacts

Service availability: More than one in five individual businesses (21%) reported that they had been forced to close their health facilities for at least three months during the COVID-19 outbreak. Closures were, in the sample, more common in countries running ‘exclusive’ health system regimes (24%) compared to countries running ‘inclusive’ regimes (19%). In addition, more than one third of individual businesses (35%) reported that they expected that facility closures would be necessary in the near future. In this case, there were large differences between governance regimes. While 67% of respondents in ‘exclusive’ regimes reported an expectation of future closures, only 21% of respondents in ‘inclusive’ regimes did so (see Figure 2).

Figure 2. Individual businesses’ reporting ‘yes’ to closing facilities, or expecting to do so

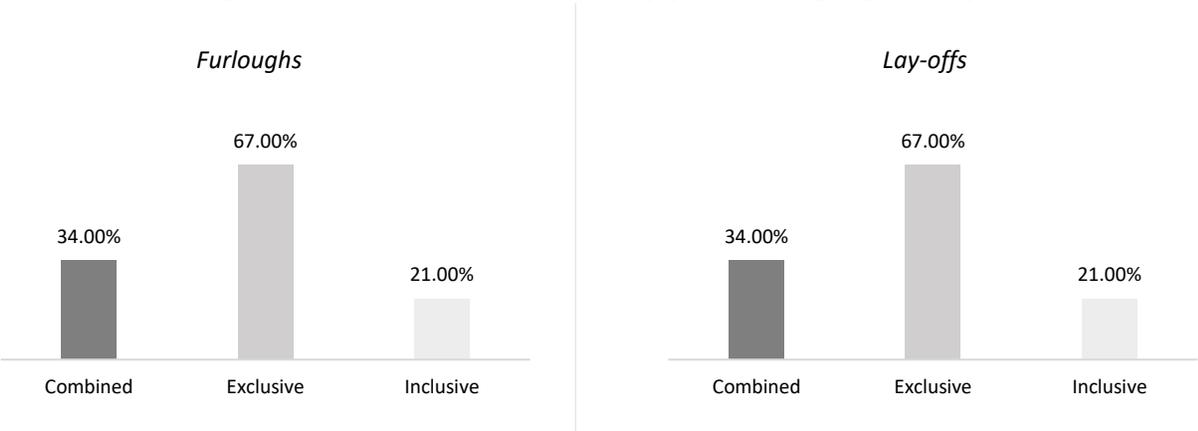


The data from the BRG respondents supports the impression that *governance regimes matter* in this context. While *all* (100%) of the BRGs operating in ‘exclusive’ health system regimes reported that their members had been forced to close facilities *and* that further closures would

be necessary in the near future, only a minority of BRGs operating in more inclusive regime countries did so (*less than half*, and *less than a quarter* of such respondents, respectively). However, it should be noted that, given the small numbers involved (with only three responses on these questions from the BRGs in ‘exclusive regime’ health systems), we are unable to undertake analysis that would allow us to show that recorded differences in governance regimes *cause* differences in the incidence of facility closures. Such differences may be specific to the countries considered or driven by a variable other than governance regime.

Workforce retention: More than half of the individual businesses surveyed (57%) reported that they had been forced to furlough (i.e. grant unpaid leave of absence to) their staff due to the COVID-19 outbreak; while 17% reported they had been forced to make staff redundant. Among the group that had furloughed staff, the plurality (44%) estimated the proportion of staff affected at 1% to 25%; while 42% estimated this at 25% to 50%. It is notable that a far higher percentage of businesses in the more ‘exclusive regime’ health systems (81%) reported that they had furloughed staff compared to businesses in more ‘inclusive regime’ systems (48%). In addition, among the group reporting that they had laid off staff, 80% estimated the proportion of staff affected at 1% to 25%. And again the data shows variation between countries with different governance regimes: i.e. the incidence of lay-offs is far greater in countries with more ‘exclusive regime’ health systems (30%) than in countries that run more ‘inclusive’ regimes (10%).

Figure 3. Individual businesses’ reporting ‘yes’ to furloughing or laying off staff



The responses from the BRGs depict a similar overall picture, though these bodies were more likely than individual businesses to have observed staff lay-offs than individual businesses (with 42% of BRGs reporting that they had witnessed such lay-offs among their members, compared to (as noted) 20% of individual businesses).

In summary, the results in this subsection show that service availability and staffing in the private health sector have materially diminished due to the COVID-19 outbreak in the countries studied. This is also supported by the document analysis. For example, in media coverage of the impacts of COVID-19 on the private health sector, facility closures are a major theme - in Africa, as well as in other LMICs. For example, the media in Kenya has reported on the severe impact of COVID-19 on healthcare businesses in Nairobi, with many facilities closed, others scaled down, and thousands of staff laid off.⁵ The document analysis suggests these impacts are widespread across Africa – and, indeed, also outside of the continent. For example, it has been reported that several hospitals in Manila, in the Philippines, have been forced to lay off staff - mostly due to financial losses from cancelled services and delays in insurance reimbursement.⁶

3.2.2. Financial impacts

Expenses: Almost all of individual businesses surveyed (94%) reported that COVID-19 had affected their monthly expenses. Among the group experiencing such effects, the majority (69%) reported that expenses had increased. Of these respondents, the plurality (45%) estimated increases of 1-25%, a slightly smaller group (44%) estimated them at 25-50%; and the remaining respondents (9%) estimated them at 50-100%. In addition, 73% of respondents were expecting to see increases in their expenses due to COVID-19 in the near future. There were differences between businesses in ‘exclusive regimes’ compared to those in ‘inclusive regimes’ with respect to their estimates of the impacts of COVID-19 on *current* and *future* expenses. For example, while 100% of businesses in the former category reported that they anticipated increases in the near future, ‘only’ 81% of businesses in the latter category did so.

The responses from the BRGs depict a similar overall picture, although these groups were more likely than individual businesses to have observed increases in the expenses of their members (with fully 79% of BRGs reporting that they their members had experienced increases, compared to 69% of individual businesses; and 94% anticipating increases in the near future, compared to 73% of individual businesses).

Revenues: The vast majority of individual businesses surveyed (89%) reported that COVID-19 had led to reductions in revenues. Among the group reporting such reductions, the plurality (43%) estimated the decreases at 25-50% of revenues, a smaller group (37%) estimated them at 1-25%; with the remaining respondents (19%) estimating them at 50-100%. In addition, 83% of respondents reported that they anticipated further COVID-19-related reductions in income in

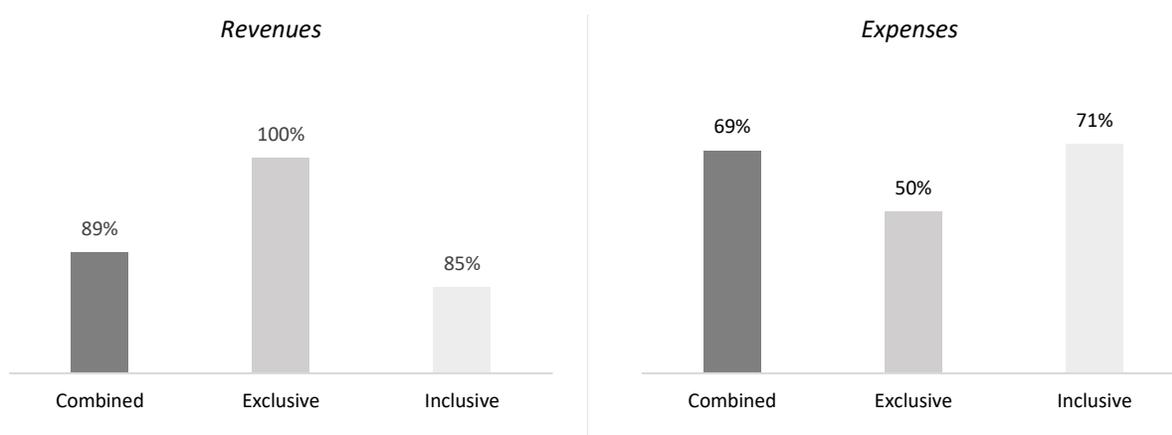
⁵ <https://nairobineews.nation.co.ke/news/concern-rises-as-patients-keep-off-public-and-private-hospitals>. See also: <https://blogs.lse.ac.uk/africaatlse/2020/06/25/declining-health-service-use-in-nairobi-has-health-implications-beyond-covid-19/>

⁶ <https://www.philstar.com/nation/2020/05/03/2011578/ust-hospital-lays-staff-over-financial-losses-pandemic>

the near future. There are modest differences between businesses operating in different ‘governance regimes’. For example, while 89% of businesses in ‘exclusive regime’ systems reported anticipating decreases in the near future, ‘only’ 81% of businesses in the ‘inclusive regime’ category did so. Once again, the responses from the BRGs depict a consistent overall picture, with a very similar proportion of BRGs reporting observed decreases in the revenues of their membership, and to be anticipating further decreases, as that of individual businesses.

The key message emerging from this subsection of the data is that the financial position of most private healthcare businesses in the study countries has been compromised by COVID-19. This is consistent with the picture emerging from the document analysis – in which representative organisations have called attention to the financial distress mostly due to COVID-19.⁷ As one health policy expert argued with respect to Kenya, “There are real concerns that should COVID-19 persist without state intervention or business and operational innovations on the part of private hospitals, many will close down due to the inability to fund operational costs.”⁸ Such concerns have been echoed in media coverage focused on countries in Africa, and elsewhere.

Figure 4. Individual businesses’ estimates of changing expenses and revenues



For example, the President of the Philippine Hospital Association has been quoted as follows: “An immediate crisis response and recovery objective is to ensure that both public and private hospitals are also able to recover from the challenges brought about by COVID-19, which not only include higher risks faced by health frontliners, but also the two-pronged pressure of higher costs combined with dramatically lower revenues.”⁹

⁷ <https://news.abs-cbn.com/video/news/06/01/20/some-small-private-hospitals-losing-money-due-to-covid-19-pandemic-says-group>

⁸ <https://blogs.lse.ac.uk/africaatlse/2020/06/25/declining-health-service-use-in-nairobi-has-health-implications-beyond-covid-19/>

⁹ <https://thediplomat.com/2020/05/fighting-covid-19-in-the-philippines-the-scalpel-vs-the-axe>

3.3 Causes

Service availability and staffing: According to the survey data (based on multiple choice options), the most commonly selected causes of facility closures were as follows:

- (a) Government policies that required closures, aimed at preventing transmission of COVID-19 within healthcare settings (25% of individual business respondents reported this as a major driver of health facility closures; and 32% of BRG respondents did so);
- (b) Reduced demand for services from the population (25% of individual business respondents and 18% of BRG respondents);
- (c) Inability to access essential supplies to test and/or treat COVID-19 (18% and 18%, respectively);
- (d) Disruptions in both health product-specific and general supply chains (14% and 14%, respectively); and
- (e) Restricted movement of health workers (11% and 18% respectively).¹⁰

The survey results were similar across governance regimes categories, except that government regulations were more commonly reported to be a major driver of facility closures in ‘inclusive’ regime health systems compared to ‘exclusive’ regimes. This may indicate that governments with a stronger regulatory ‘presence’ and ‘reach’ in the private health sector were more able to re-shape and re-deploy technical resources towards case management of COVID-19 patients.

At the time of the survey, most individual and BRG respondents anticipated that governments would ease regulations governing facility closure (and, indeed, we know from our documentary data this has occurred in several countries). However, most respondents across the two groups reported concerns that non-regulatory constraints - including reduced demand for services, limited access to essential COVID-19 supplies and disruption to supply chain - would continue to threaten service availability in the private health sector. Continued closures, in addition to ongoing reductions in the demand for services from the population, were perceived by the majority of respondents as likely to produce further reductions in the health workforce through furloughing and/or lay-offs.

Changes in net revenues (revenues minus expenses): According to individual and BRG respondents, the main drivers of decreased revenues occurred on both the demand and the supply side. Reductions in the demand for services were cited by 34% of respondents, changes in the availability and prices of essential COVID-19 supplies (leading to higher costs of production) were mentioned by 19% and disruptions to supply chains by 18%. The most

¹⁰ Survey participants were invited to select from this menu of options to record their perception of the main driver of closures. Participants were also able to record and specify a different reason for such closures; however, none did so.

commonly cited source of expenditure pressure related to supply shortages (cited by 24% of respondents).¹¹ The document analysis provides insights into how parts of the private sector have been responding to supply shortages. In some cases, there has been a sharp increase in the price of key inputs (especially the price of PPE, which one of our key informants in a west African country suggested had increased by 5000% since the start of the pandemic). This has led to some suppliers to engage in actions such as hoarding and profiteering, all of which have cost implications for healthcare businesses – and, ultimately, for the prices that patients have to pay. For example, in Pakistan, local media sources reported that the price of oxygen cylinders had increased by some 500% over the course of a single week during the pandemic.¹²

3.4 Consequences

The document analysis demonstrates that reductions in the service availability, staffing, and financial resources of the private health sector (recorded in section 3.2 above) have had significant adverse consequences for the health system response to the crisis, in two important respects. *First*, in countries experiencing a surge in demand for COVID-19-related diagnostic and therapeutic health services, reductions in the operational and financial capacities of the private health sector have reduced the population’s utilisation of such services.^{13, 14, 15} *Second*, a more widespread, and more severe, impact has been reported in the form of reductions in access to and affordability of other (non-COVID-19-related) health services for the population.^{16 17, 18, 19}

As one Kenyan health policy expert wrote, “there are real concerns that should COVID-19 persist without state intervention [...] many private hospitals will close down due to the inability to fund operational costs [...]. The net effect will be a serious lack of sufficient health service providers to serve Kenyans”.²⁰

¹¹ The results were not significantly different between individual businesses and BRGs on this particular question.

¹² <https://gandhara.rferl.org/a/pakistan-faces-unprecedented-healthcare-crisis-amid-mounting-coronavirus-infections/30679490.html>

¹³ Kruse FM and Jeurissen PPT. For-Profit Hospitals Out of Business? Financial Sustainability During the COVID-19 Epidemic Emergency Response. *International Journal of Health Policy and Management*, 2020, 9(10), 423–428.

¹⁴ “As Private Hospitals Rake It in, Should the Government Use Its Pandemic Powers, or Simply Let the Free-Market Be?” *Profit by Pakistan Today*, 28 June 2020. Available at: profit.pakistantoday.com.pk, <https://profit.pakistantoday.com.pk/2020/06/28/as-private-hospitals-are-to-start-treating-covid-19-patients-families-complain-of-billing-surprises/>.

¹⁵ How Do Countries Adjust Hospital Payment Systems for COVID-19? – Cross-Country Analysis. analysis.covid19healthsystem.org, <https://analysis.covid19healthsystem.org/index.php/2020/06/15/how-do-countries-adjust-hospital-payment-systems-for-covid-19/>. Accessed 3 Aug. 2020.

¹⁶ Significant drop in OPD cases at private hospitals with Covid wards. *Times of India*. Available at: http://timesofindia.indiatimes.com/articleshow/78192720.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

¹⁷ Maharashtra's private hospitals, district Covid centres battle heavy staff attrition. *The Economic Times*. Available at: https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/maharashtras-private-hospital-hit-by-heavy-staff-attrition-amid-coronavirus/articleshow/78140839.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

¹⁸ Telangana warns private hospitals against 'fleecing' Covid patients. *The Hindu Business Line*. Available at: <https://www.thehindubusinessline.com/news/national/exorbitant-covid-treatment-charges-telangana-threatens-to-take-over-50-beds-in-private-hospitals/article32323118.ece>. Accessed on 21 September 2020

¹⁹ How hospitals rip off Covid-19 patients. *Star*. August 2020. Available at: <https://www.the-star.co.ke/news/2020-08-14-how-hospitals-rip-off-covid-19-patients/>. Accessed on 21 Sep 2020

²⁰ <https://blogs.lse.ac.uk/africaatlse/2020/06/25/declining-health-service-use-in-nairobi-has-health-implications-beyond-covid-19/>

3.5 Policy responses

Almost half (45%) of individual business respondents stated that the government had offered some form of economic support for small- and medium-enterprises (SMEs) in their countries. However, the data indicates that few governments in Africa have extended such support to the health sector. Only about one third (34%) of individual business respondents reported that economic support is available to them – though, once again, category of governance regime seems to matter a great deal (governments in the ‘inclusive’ category were almost five times more likely than those in the ‘exclusive’ category to extend economic aid to healthcare businesses according to our business respondents (with 50% of respondents in the former category reporting the existence of such support compared to just 11% in the latter category doing so). The most common forms of economic support provided to healthcare businesses are reported to be tax waivers (30%) and access to capital through low-interest loans (30%).

The document analysis, which incorporated sources of information relating to a greater range of low- and middle-income countries, supports the finding that governments in more ‘inclusive’ health system governance regimes were more likely than others to provide support to the private health sector during the COVID-19 emergency. However, there is also consistent evidence that (a) the range of economic support options considered and/or implemented was greater in ‘inclusive regime’ countries; and (b) these tended to focus more on the underlying ‘causes’ of the financial impact challenge and not only the ‘symptoms’ than in other countries.

The range of such responses captured in the document/media analysis include the following:

- Emergency purchasing arrangements for diagnosis and treatment of COVID-19;²¹
- Temporary authorisation and funding to expand services and population coverage;
- Rapid deployment of existing reimbursement systems;
- Increased compensation and reimbursement rates;²²
- Top-ups for hospitals to cover additional costs – e.g. for PPE, ICU beds;
- Establishment of laws to reimburse private hospitals for COVID-19 services through National Health Insurance Schemes.²³

²¹ Espectador, El. “ELESPECTADOR.COM.” ELESPECTADOR.COM. www.elespectador.com, <https://www.elespectador.com/coronavirus/gobierno-entrega-de-forma-anticipada-mas-de-780-mil-millones-las-eps-articulo-912131/>. Accessed 21 July 2020.

²² How Do Countries Adjust Hospital Payment Systems for COVID-19? – Cross-Country Analysis. analysis.covid19healthsystem.org, <https://analysis.covid19healthsystem.org/index.php/2020/06/15/how-do-countries-adjust-hospital-payment-systems-for-covid-19/>. Accessed 3 Aug. 2020.

²³ The Bayanihan Act. Republic of the Philippines, 2020, <https://www.senate.gov.ph/Bayanihan-to-Heal-as-One-Act-RA-11469.pdf>.

4. CONCLUDING SUMMARY

In this document, we set out the results of our survey and document analysis focused on generating new knowledge in respect of the following:

- **The nature and scale of the impacts of COVID-19** on the operational capacity and financial sustainability of private healthcare providers in LMICs.
- The **causes** and **consequences** of these impacts in terms of the private health sector's capacity to contribute to COVID-19 national responses efforts.
- How policymakers are **currently seeking to address the private health sector's financial problems**; and how these vary between different countries and different regimes of health system governance.

Our main findings, based on our document analysis and survey data, in respect of these objectives are as follows:

The availability of services in the private health sector has materially diminished due to the COVID-19 pandemic. More than one in five of the healthcare businesses surveyed reported that they had been forced to close their facilities for at least three months during the COVID-19 outbreak, and a third are anticipating further facility closures in the near future.

The health workforce employed in the private sector has been compromised due to the COVID-19 pandemic. More than half of the healthcare businesses surveyed reported that they had been forced to furlough (i.e. grant unpaid leave of absence to) their staff due to the COVID-19 outbreak; while one in six reported they had been forced to make staff redundant.

The financial capacity of the private health sector has been adversely impacted by the pandemic. Almost all healthcare businesses surveyed reported that COVID-19 had increased their monthly expenses and reduced their revenues, indicating a significant reduction in net incomes during the crisis, and a deterioration of many service providers' financial position.

Governance regimes matter! A consistent pattern across the data sources is that, while service availability and staffing in the private health sector have diminished due to the COVID-19 outbreak, these affects have been less severe in countries operating more 'inclusive' governance regimes than in more 'exclusive' regimes.

On the **causes** of these impacts we found that government policies requiring closures, alongside reduced demand for health services from the population (indicating reduced access to and utilisation of services) were the most commonly cited drivers. Financial impacts were

aggravated by decreases in the availability of, and increases in, the prices of essential COVID-19 supplies, and disruptions to supply chains due to the socio-economic impacts of the pandemic. In terms of consequences, we have found that reductions in the service availability, staffing, and financial resources of the private health sector have had significant adverse consequences for the health system response to the crisis, in terms of addressing demand for COVID-19-related care in particular, and to ensure access to, and affordability and utilisation of other essential health services for the population.

Overall, it is apparent that the private health sector's financial problem is also a health system problem – especially during a period of which governments are attempting to optimise the health systems response to COVID-19.

On how policymakers are **currently seeking to address the financial problem and its consequences, we found significant differences between countries deploying different governance regimes.** The document analysis supports the finding that governments in more 'inclusive' health system regimes were more likely than those in 'exclusive' regimes to provide support to the private health sector during the COVID-19 emergency. However, there is also evidence that (a) the range of economic support options considered and/or implemented was larger in 'inclusive regime' countries; and (b) these tend to focus to a larger extent on the 'root causes' of the financial impact challenge, and not only the 'symptoms' than in other countries, which may be correlated with a higher chance of ultimate success.