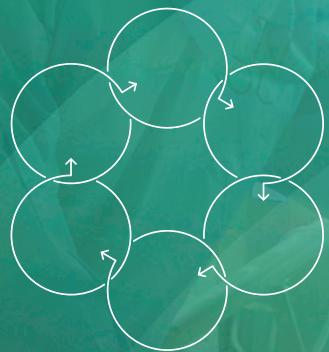




World Health Organization



Equitable access to COVID-19 tools

Aligning the private sector
with national response efforts



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Equitable access to COVID-19 tools: aligning the private sector with national response efforts

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Abbreviations and acronyms

HGF	health system's governance and financing department
ICMR	Indian Council of Medical Research
KCDC	Korean Center for Disease Control
KSLM	Korean Society for Laboratory Medicine
LMIC	low- and middle-income country
MERS	Middle East respiratory syndrome
MeSH	Medical Subject Headings
PHC	primary health care
PPE	personal protective equipment
WHO	World Health Organization

Introduction

With successive waves of COVID-19 battering low- and middle-income countries (LMICs), increasing attention has been directed to market and governance failures during the emergency response (1). These are most visible in LMICs, where shortages of COVID-19 tools are acutely felt. These include vaccines, diagnostics, and therapeutics including oxygen and personal protective equipment (PPE). In most LMIC contexts, demand for COVID-19 tools has far outstripped available supply, reflective of a highly inequitable global therapeutic context and a failure to meet the promise to “leave no one behind” (2–4). In some countries, during COVID-19 surges, “trauma was on vivid display”¹ with media attention directed to opportunistic behaviors and adverse practices within private healthcare service delivery compromising efforts to reach the right to health for all.

In many LMICs, the private sector in health is large, fragmented, and growing (5). The way the private sector is organised and operates is significantly influenced by the organisation and behaviour of the public sector, with well governed and competent public health systems generating complementary, reasonable-quality private healthcare service delivery (5). In contrast, countries with weak governance and an unregulated private health sector may also have an inefficient and inequitable public health system (6).

How accountable a country’s health system is to consumers of healthcare depends to a large extent on the degree of accountability between the public and private sectors (7). Where there is inadequate accountability, a culture of mistrust and ‘blame shifting’ may exist. This has formed part of the COVID-19 response narrative in many contexts. Response has varied, *“from swift and proactive at best to haphazard and negligent at worst”* (2). This rapid review seeks to understand why and where there has been swift and proactive action, to build better governance of national COVID-19 response.

For the purpose of this rapid review, governance is understood as the political processes by which

BOX 1 Terms

The **private sector** includes all individuals and organisations that are neither owned nor directly controlled by governments and are involved in the provision of health-related goods and services. These consist of formal and informal healthcare providers ranging from drug shops to specialised hospitals, comprising for-profit and not-for-profit entities, both domestic and foreign. For the purposes of this rapid review, we focus on domestic private sector entities.

COVID-19 tools include vaccines, diagnostics, and therapeutics including oxygen and personal protective equipment (PPE).

Governance refers to all processes of social organization and social coordination, encompassing non-state actors and institutions as well as government. Core elements of the right to health include the need for governments to have policies and governance arrangements in place to protect the right to health including appropriate oversight of the private sector to ensure the availability, accessibility, acceptability and quality of health facilities, goods and services.

Stewardship how government actors take responsibility for the health system and the well-being of the population, fulfil health system functions, assure equity, and coordinate interaction with government and society, including the private sector.

decisions are reached and upheld, while health system stewardship refers to the technical processes that inform those decisions (8). Critical decisions relate to managing and distributing scarce health resources based on the principles of health equity without distinction of race, religion, political belief, economic or social condition. Health governance is intended to promote joint action of the health and non-health sectors, of public and private actors and of healthcare consumers for a common interest. The WHO strategy, *Engaging the private*

¹ <https://www.bbc.com/news/world-asia-india-57911638>.

health service delivery sector through governance in mixed health systems (8), further conceptualises governance as behavioural in relation to how government conducts itself and orchestrates public and private actors and healthcare consumers to a situation or stimulus, in this instance, the COVID-19 response (9). Terms used in the review are further elaborated in Box 1.

Methodology and framework

We conducted a rapid review of the literature, searching the WHO COVID-19 Database and Google Scholar for articles published between January 2020 and June 2021. The search strategy was developed with Medical Subject Headings (MeSH) and text words, using Boolean operators to combine the search strings (see Annex 1). We included articles that discussed a combination of key concepts, including COVID-19 response/preparedness, private sector, governance, regulation, and public health policy within specific countries or groups of countries. Since our focus was on national response, we excluded articles that focused on the global COVID-19 response including global governance, global private/commercial sector, and global supply chains. We also excluded global and country level business philanthropy. We expanded the governance terms based on an (emergent) operational understanding of the governance behaviours (drawing from previous work on the AU paper). Annex 2 provides our inclusion and exclusion criteria. The case studies presented were selected to illustrate the six governance behaviours. They have been from the extracted literature review and selected based on the quality and scope of the available literature. Geographical representation has been taken into consideration to represent a mix of regional experiences.

The search strategy identified 2,201 citations, 2006 through the WHO COVID-19 database and 195 identified through Google Scholar search. We used Rayyan as support software to screen the articles, which included a combination of original research, reviews, and commentaries. Through Rayyan the titles and abstracts of the articles were firstly screened with the aim to exclude articles with titles and/or abstracts unrelated to the private health sector response during COVID-19.

Through screening, 60 full text articles were selected and screened in a second phase. After the first full-text screen, 37 articles were extracted in total. The studies employed a range of methodologies including literature review, content analysis (of media reports and policies for example), qualitative and mixed methods research. These were comprised of seven literature reviews, seven commentaries, and one case study, with the remaining articles based on primary research. Extraction was done in an Excel matrix. A range of high income and LMIC contexts were included; often a comparative lens was used, looking at multiple countries or regional groupings (e.g., Arab states, East Asian states) while an almost equal number were country specific.

The analysis considered:

- What market failures occurred during COVID-19, particularly during emergency peaks in demand?
- What were the impacts on equity, access and catastrophic expenditure?
- How was 'market' intelligence gathered and how did governments respond to this?
- How were tools of government deployed to preempt or mitigate market failures?
- What governance behaviours/systems/regimes facilitated or hindered deployment?
- What lessons and recommendations can be distilled from the literature?

The rapid review is structured using the WHO governance framework (Figure 1). We provide a normative statement for each behaviour followed by findings of importance to the COVID-19 response. Country snapshots are used to illustrate each governance behaviour, followed by recommended actions. The rapid review outlines key governance behaviours that can be addressed in the immediate term. It will be supplemented by forthcoming guidance that addresses medium- and longer-term governance behaviours, which will draw from the methodology more extensively.

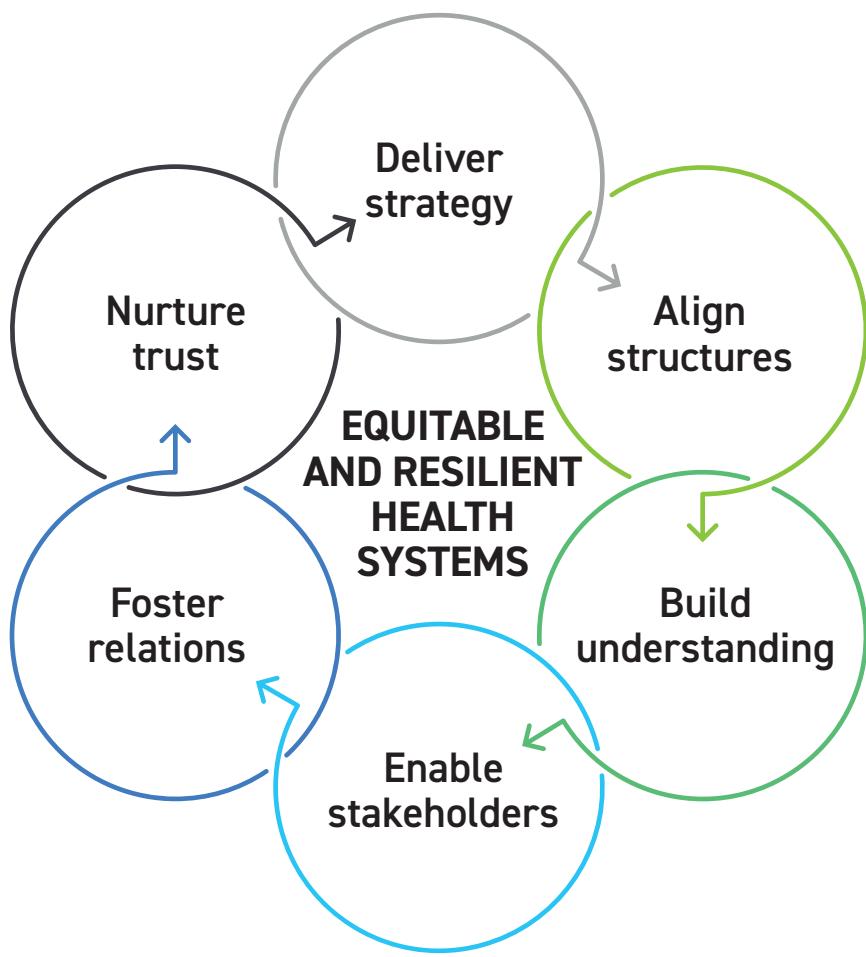
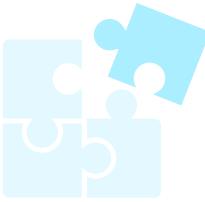


Fig. 1. Analytical framework

Align structures



Enlist all available infrastructure to respond to surges in demand by leveraging public and private sector capacity as part of the COVID-19 response

THIS BEHAVIOUR CONSIDERED THE ALIGNMENT OF PUBLIC AND PRIVATE STRUCTURES AND INSTITUTIONAL ARCHITECTURE FOR THE PANDEMIC RESPONSE.

The COVID-19 pandemic necessitated that governments formulate effective responses, covering all population groups, in the shortest time possible, based on available structures and resources. Some governments engaged the private sector in health with the aim of increasing surge capacity and reaching as many people as possible with services, including remote and marginalized

communities towards the fulfilment of their right to health. Pre-existing governance regimes dictated the ease in which this was done. In governance regimes with 'loose' integration of the private sector in health, surge response was constrained, or not implemented altogether (1, 10). In governance regimes with poor vertical alignment of public sector structures (e.g., nodal or devolved),

BOX 2

Aligning the private sector with the COVID-19 response in India

India, like other countries in Asia, had previous experience with previous influenza pandemics. During the influenza pandemic of 2009, the response was restricted to the public sector however public infrastructure was disproportionate to needs. Consequently, the National Health Policy (2017) recognised the role of public-private-partnership as an efficient model for disaster risk reduction (18). Despite this, during the initial phase of the COVID-19 pandemic, the Indian government did not pursue public-private-partnership models. The government maintained an exclusive public sector response but became quickly 'consumed', due to inadequate infrastructure, manpower, and resources (18).

A cross-sectional survey conducted early in the pandemic (April 2020) with private sector providers indicated the majority of respondents felt that the Government had not involved the private sector in health adequately, with almost half of respondents wanting to be part of policymaking. Priority areas suggested for private sector engagement included patient care, provision of equipment as well as continuity of care for non-COVID patients using tele-medicine (18). The study recommended developing a streamlined pathway for engagement, "*An open, healthy and swift discussion between the public and private sector should be the first step toward sorting grey areas*" (18). In the India context, there has been rapid growth of the private sector in health since the early 1990s with the majority of speciality beds, doctors, and ancillary services found in the sector (18, 19). This has made engagement paramount to health system resilience and pandemic response.

As part of the COVID-19 response, the Indian federal government constituted 12 task forces for handling pandemic related decisions with one group exclusively for private sector engagement. Many provincial governments constituted their own task forces and liaison mechanism with the private sector in health, given that health service delivery is primarily a provincial responsibility. The federal government, through Indian Council of Medical Research (ICMR), developed clinical guidelines and protocols (for all), accredited private laboratories for testing, prescribed tariffs, and facilitated access to private healthcare facilities for patients covered under government supported insurance schemes. The federal government also focused on mobilising the private sector for improving the 'supply of COVID-19 tools' as well as co-investment in R&D for vaccine development.

issues of 'territorial management' emerged, creating uneven response implementation, including competing or incompatible policies (11, 12). Loose integration may have further fragmented structures and heightened tensions, limiting government ability to mount effective COVID-19 responses (1).

Many governments chose not to leverage the private sector, or only did so selectively. Some governments explicitly imposed rules to prohibit private hospitals from offering treatment to COVID-19 patients, due to concerns with standards of infection prevention (1). In some instances, government authorities intervened and nationalised their private healthcare providers (1, 13). In Hungary for example, this was reportedly done to improve population access and address informal payments (13). "Spontaneous" response of the private sector in health has also featured, highlighting the importance of deliberate alignment of structures and the role of government in doing so to ensure quality, and coordinated action (10).

Countries with inclusive private sector governance regimes tended to mount more effective pandemic responses. In several countries in East Asia, institutional infrastructure and policy instruments were well established, based on learning from prior pandemics (14). For example, the Republic of Korea, strengthened the autonomy and authority of health professionals based on key lessons and policy recommendations from Middle East Respiratory Syndrome (MERS) in 2015. This was acknowledged as "*one of the most important factors that helped it to handle the COVID-19 disaster efficiently and effectively*" (15). Given that public hospitals comprise only 5.6 per cent of the Republic of Korea's health infrastructure (16), the alignment and active participation of the private sector in the COVID-19 response was essential. In the Republic of Korea and other East Asian contexts, alignment also included a high degree of civic participation (14) which has contributed to improvement and innovation of COVID-19 tools, ranging from digital Apps to drive-through testing (11, 17).

LESSONS LEARNT

- ✓ **Employ a resource-based approach to the COVID-19 response by enlisting all available private and public sector structures.**
- ✓ **Jointly define and align roles and responsibilities of private and public sector entities to deliver a gender, equity, and human rights-based response to COVID-19.**
- ✓ **Review and adapt roles and responsibilities to improve the COVID-19 response to surges in demand (over time) and better leverage public and private sector resources and capacity.**
- ✓ **Use review processes to inform national legislation and other relevant policy frameworks to improve the COVID-19 response (and health resilience more broadly).**

Foster relations



Ensure meaningful participation of the private sector in health in the COVID-19 national response through intersectoral and inclusive coordination mechanisms

THIS BEHAVIOUR CONSIDERED COORDINATION ARRANGEMENTS AND THEIR REPRESENTATIVENESS OF SECTORAL INTERESTS FOR THE COVID-19 RESPONSE.

Coordination mechanisms have featured in all national response contexts, often taking the form of COVID-19 command centres and bespoke taskforces. Given the complexity of the COVID-19 response, inter-sectoral and multidisciplinary collaboration is needed, ideally drawing on a wide range of stakeholders (20–22). However, membership on COVID-19 task forces may not be well known, may not include the full range of recommended actors, and be skewed politically and towards certain disciplines, with experts on the health,

and the societal aspects of the COVID-19 response not well represented (22). For example, COVID-19 taskforces have been heavily composed of men and have involved little engagement in COVID-19 planning of entities that represent the interest of the vulnerable groups such as people with disabilities, refugees and ethnic minorities among others (22). Collaborative efforts with the private sector in health based on existing coordination mechanisms therefore may not adequately consider issues of gender, equity and human rights.

BOX 3

Governance relationships with the pharmaceutical sector in LMICs

In many LMIC contexts, governance of the pharmaceutical sector is weak, its expansion has been market-led, uncontrolled by government (26). Growth has been accompanied by significant public health concerns in relation to the quality and safety of medical products and dispensing practices. These have been acute during the COVID-19 response in relation to fake or sub-standard products, scams through online medicine sales, and price gouging in response to high demand (26). In some contexts, there have been efforts to improve interorganizational coordination of the pharmaceutical sector for the response, working through professional associations and other representative bodies. This has focused on ensuring uninterrupted access to medications and supplies and reinforcing professional ethics and integrity of the sector; in others it has been in anticipation of a role in vaccine deployment (19). However, a lacuna in pharmacy education and lack of clarity around pharmacist roles in the pandemic response remains in many contexts (19, 23). This encompasses the role of e-pharmacy which has grown significantly in LMICs during the pandemic. Its very growth and heightened awareness of pharmaceutical practice, both good and bad, offers opportunity for better consolidation of the sector, the development of best practice guidelines and regulatory structures (26).

Coordination mechanisms may not reflect the diversity of the private sector in health despite having private sector representation (23). In high income and LMIC contexts alike, they may exclude some cadres, such as representatives of small-to-medium primary care enterprises (19, 24). For example, a study conducted in England found that primary care was inadequately represented at a strategic level, as it did not include practicing general practitioners (25). In some LMIC contexts, the pharmaceutical sector has not been well engaged or coordinated as part of the response, despite governmental concerns with product quality and dispensing practices (19, 26), as well as the potential role the sector can play in vaccine deployment (19). Where representatives have been engaged through professional associations, they were found to have enabled frequent and regular updates on standard operational procedures, adapted in response to the evolving nature of COVID-19 (20).

Issues with coordination are indicative of the degree of interorganizational networking that existed prior to the pandemic, and the heterogeneity, position, and power of private sector entities in healthcare within such networks. In LMIC contexts, interorganizational structures include professional associations, healthcare federations and other alliances, not all of which are formally recognised by government. A recent private sector study in Africa found that despite the mushrooming of healthcare federations, the private sector is still poorly organized in many contexts; these entities may not reflect sectoral concerns, particularly those of small-to-medium primary care enterprises which often know first-hand “where the shoe pinches” (23).

LESSONS LEARNT

- ✓ **Include diverse interest groups in COVID-19 response structures, accounting for differences in gender, disability, ethnicity, geographic location, and age among others.**
- ✓ **Facilitate the engagement of sub-sector constituencies and sub-group interests (such as gender and diversity specific interests) through private sector interorganisational networks (e.g., federations, associations, councils, etc).**
- ✓ **Include private sector representatives in ministerial planning / monitoring meetings to report on their contribution to the response.**
- ✓ **Optimise intersectoral and interorganisational relationships through the use of virtual communication platforms and protocols.**

Build understanding

Optimise private sector data capture and information exchange for the COVID-19 response



THIS BEHAVIOUR CONSIDERED PRIVATE SECTOR DATA CAPTURE AND INFORMATION EXCHANGE TO DRIVE ACTION AS PART OF THE COVID-19 RESPONSE.

Effective governance of the pandemic response is predicated on access to and use of data and information. This requires that health information systems are calibrated to capture existing private sector health service provision, as well as information on the structure of the market and utilisation patterns. However, integration of private sector data and information is a challenge for many national health information systems and has posed a barrier to the COVID-19 response (27). Challenges include even the most basic of information on private sector health resources and their distribution, such as infrastructure and human resource capacity (1), including disaggregation of the health workforce by gender. More successful response has been predicated on well-connected information systems and use of data for information exchange (28, 29).

Digital innovation has also aided COVID-19 information exchange during the pandemic. Digital tools have 'mushroomed' for a range of purposes and contexts in LMICs (30). For example, an assessment of COVID-19 tools indicated that Kenya had 51 digital health tools deployed on a national scale while 62 operated at a subnational scale (31). It was not clear based on the assessment which were the most critical or valued digital tools nor how they were being deployed as part of the response. While this situation is not unique to Kenya, it serves to illustrate challenges with oversupply of innovation pilots and operationalisation of e-health policies. There is potential for fragmentation of innovation without strong governance of the use of digital technology.

BOX 4

Using national information systems and mandates to strengthen emergency response in Ethiopia, Nigeria, and Pakistan

Government ability to access, analyse and initiate action based on data was assessed using a rapid situational analysis methodology, triangulated through a Delphi-structured indicator prioritisation workshop, key informant interviews and a simulation exercise to improve preparedness in Ethiopia, Nigeria, and Pakistan (32). In these contexts, challenges exist within national health information systems with receiving data from private healthcare entities, which may outnumber public healthcare entities (32). The study found that national health information systems lacked the authority and resources for rapid sharing of data from public and private sector entities. A lack of clarity about how data was to be used was a deterrent to data sharing. There was also a cost associated with data sharing, which needed justification in terms of use and benefits. Finally, there were perceived risks associated with exposing weaknesses in data quality or sharing commercially or financially sensitive data. The study concluded that national health information units need to routinely monitor a broad set of priority indicators that reflect the country context.

Primary health care (PHC), while an important source of localised information, has been unevenly deployed and utilised in many contexts as part of the COVID-19 response, given emphasis on tertiary and intensive care facilities. Even in more successful responses such as the Republic of Korea, PHC facilities had limited roles

during surges in COVID-19 (25). A study from the Republic of Korea reinforced the importance of PHC and need for regular monitoring of the response at this level so that governance structures remain abreast of evolving contexts (25).

LESSONS LEARNT

- ✓ **Review the degree to which private sector data is disaggregated and captured in national health information systems as part of the COVID-19 response.**
- ✓ **Review how data and information are used/optimised at the national, sub-national and primary care levels for the COVID-19 response.**
- ✓ **Strengthen the mandate and cross-sectoral reach of national health information directorates to improve private sector data capture.**
- ✓ **Strengthen governance of and use of digital technology for the COVID-19 response (inclusive of legal and regulatory provisions) to reduce digital fragmentation.**
- ✓ **Conduct rapid research to understand barriers and enablers to data sharing and information exchange between sectors and levels of healthcare as part of the COVID-19 response.**
- ✓ **Collaborate with the professional and sectoral associations to collect up-to-date data on infrastructure, staff expertise and medical equipment.**

Enable stakeholders



Demonstrate regulatory agility to pre-empt and mitigate market failures as part of the COVID-19 response

THIS BEHAVIOUR CONSIDERED THE DEVELOPMENT AND IMPLEMENTATION OF REGULATIONS FOR THE COVID-19 RESPONSE.

Regulation was widely used as a tool of government as part of the COVID-19 response, enlisted to either promote or restrict the private sector in health. Many regulatory measures were introduced temporarily as a response to the COVID-19 pandemic. These included price caps for COVID-19 treatment. Despite their introduction, these were sometimes not implemented due to a lack of skill – a ‘conflict of competence’⁽³³⁾ – or as a result of bureaucratic and fragmented approaches to regulation. There were also instances of lack of will to enforce sanctions, until pressured to do so⁽¹⁾. This left many patients unable to access care during peaks in demand due to high-cost barriers and catastrophic expenditure, and points to the need for a strong role of the state in financing COVID-19

care^(34, 35). While effective public sector health services can act as a regulatory tool⁽⁶⁾, this lever may not always be optimised due to limited enforcement of standards within public sector facilities.

Determining a fair cost for COVID-19 treatment was often not addressed in a proactive, rigorous, or transparent way as part of the response. In the absence of government intervention, private health markets set prices while private and public insurers in several high income and LMIC contexts opted not to cover the costs of COVID-19 treatment⁽¹⁾. In some contexts, government price caps on hospitalised services were considered very low by the private sector leading to forced co-payment or

BOX 5

Steering the private sector in COVID-19 diagnostic development in the Republic of Korea

Based on learning from MERS, the Republic of Korea recognised the need to test early for COVID-19⁽³⁸⁾. The government updated its infectious disease governance regulations and committed to “intensive investment” in the biotech industry and public–private-partnership⁽³⁸⁾. To ensure rapid testing capacity, the government of the Republic of Korea introduced a fast-track approval process for the development of test kits and opened this up to competition from pre-vetted domestic biotech companies. To assure quality, the Korea Center for Disease Control (KCDC) validated test results through the Korean Society for Laboratory Medicine (KSLM) and its accredited network of over 100 laboratories. For its part, the Ministry of Health and Welfare provided clear communication to the general public on the private sector partnership to develop test kits.

Through swift action, the KCDC was able to approve the very first test kit in late January 2020, with others following rapidly behind. The Republic of Korea was able to export test kits to more than 60 countries by April 2020; this included donated kits for diplomatic and aid purposes⁽³⁸⁾. Nationally, the country reached a test capacity of more than 20 000 people per day. The Republic of Korea response is considered one of the most successful cases of proactively mitigating COVID-19 without substantive disruptions in daily economic, political, and social activities⁽¹⁵⁾. A key factor in the Republic of Korea’s success was attributed to the deliberate intent of government to nurture the capacity of the private sector and enable an effective public–private partnership⁽³⁸⁾.

hoarding of hospital services for patients 'willing' to pay higher prices. In other contexts, 'staggering deals' were made with the private sector, "particularly when compared to the limited financial resources at the disposal of LMICs" (1). Staggering deals also plagued some high income contexts which privileged private hospitals during the emergency response; this has prompted calls for transparency in the evaluation of temporary measures (36). It was further recognised that financial models for crisis healthcare need to be developed that address the "*realities of private sector healthcare economics (as) the notion that civilian hospitals would willingly operate below*

capacity in order to ensure surge capacity for a medical crisis is financially unrealistic" (34). This holds for both high income and LMIC contexts.

Some contexts demonstrated regulatory agility, by acting fast while maintaining high standards of "quality, tolerability, and effectiveness" (37). During the COVID-19 response, regulation predominantly focused on product management and supply chains, international cooperation and adoption of digital tools and present opportunity to 'leapfrog' into more contemporary regulatory approaches (36).

LESSONS LEARNT

- ✓ **Facilitate regulatory certainty by creating a 'rule book' (such as guidelines and standard operating procedures) that public and private sector entities play by for the COVID-19 response.**
- ✓ **Ensure that government authority is accompanied by accountability, through proactive supplier communication and dialogue on the 'rule book'.**
- ✓ **Reduce invitations for abuse by enforcing regulations and proactively monitoring private sector/market activity (focusing on the most potential areas for abuse) as part of the COVID-19 response.**
- ✓ **Review the fair cost of COVID-19 services (including a gendered analysis of cost) and create financial incentives for private sector participation using regulatory and payment levers.**
- ✓ **Commit to easing the regulatory burden through the adoption and use of digital technologies.**
- ✓ **Review temporary COVID-19 regulatory measures to determine if these can be adopted in the long-term to achieve more efficient regulatory systems.**

Nurture trust



Recognise and consistently manage competing and conflictive public and private sector interests as part of the COVID-19 response

THIS BEHAVIOUR CONSIDERED THE SOCIAL CONTRACT BETWEEN THE PUBLIC, PRIVATE AND CIVIC SECTORS FOR A WHOLE-OF-GOVERNMENT, WHOLE-OF-SOCIETY RESPONSE TO COVID-19.

As noted in the World Health Report of 2000, the harm caused by market abuses is difficult to remedy after the fact (6). The harm caused by a lack of effective governance of the whole health system is also difficult to remedy after the fact. As much as poor practice and adverse behaviors have existed in the private sector, rent seeking and other adverse behaviors by health technocrats and political actors have also featured as part of the COVID-19 response, adversely affecting health systems trust (39). Mistrust between public and private sectoral actors hinders the effective deployment of tools of government (e.g., regulation, financing, and information). It also serves to undermine the social contract between citizens and governments and the extent to which this is built upon inequities. This inhibits a whole-of-government, whole-of-society response to COVID-19.

Governance structures need to proactively recognise and consistently manage competing and conflicting interests as part of the COVID-19 response, effectively balancing the range of “private sector interests, public sector demands, and political tides” that exist, both at global and national levels (2). Given the centrality of the public to the COVID-19 response, the ‘more public’ governance of the response is, the greater likelihood of wider cooperation and compliance (2, 14, 28). In contrast, when engagement is focused on compliance with centrally defined and imposed measures, there is erosion of public participation and trust, including from the private sector (29). This has played out in a number of contexts, both LMIC and high income, and is an on-going concern in the context of pandemic fatigue.

BOX 6

Cooperative governance and civic participation in the COVID-19 response in the Republic of Korea

Key lessons from the Republic of Korea from a MERS outbreak was that a lack of risk communication contributed to the failure of the country’s response; to rectify this, a legal framework to ensure the public’s right to information was established (16). This provided the framework for transparent communication with the public and media during the COVID-19 response, which extended to the provision of detailed information on the government policies (including plans for rapid testing) and reduced opportunities for political interference (16). This has reinforced public trust in and cooperation with response policies.

While public-private and central-local cooperation frameworks played a decisive role in the Republic of Korea’s response, enabling “extensive testing, comprehensive tracing, and effective treatment” (16), clear roles for PHC were not envisaged as part of the response (25). A Delphi process with leading experts on the role of primary care facilities identified telehealth, surveillance, infection prevention of health workers and the maintenance of in-person essential medical services as feasible and urgent needs (25). The study recommended that relevant laws be developed or adapted including reimbursement models for private primary care providers to cater for telemedicine and infection prevention.

In more successful COVID-19 responses, governance has been the ‘hidden hero’ (15). Concepts such as ‘cooperative governance’ have been used to emphasise the role of government, the private and civic sectors in the formulation and evolution of response policies (1). In the cooperative governance arsenal, primary care systems have proven to be ‘powerful weapons’ (29). For example, in the Indian state of Kerala, over 30 000 health workers were enlisted in the COVID-19 response, complemented by broad investments in social protection (2). Governance

was extended to the community through women-led networks which monitored the wellbeing and medical needs of the elderly and vulnerable citizens (10). Cooperative governance has also capitalised upon digital technology to facilitate real-time information exchange. Taken together, three ‘core competencies’ have been proposed: digital technology, efficient health governance, and civic partnership as policy imperatives for pandemic response (17).

LESSONS LEARNT

- ✓ **Recognise, mitigate and manage competing and conflictive interests as part of the COVID-19 response.**
- ✓ **Recognise the critical role of PHC as the first line of essential services and pandemic defence by integrating response functions within frontline structures (public, private and civic).**
- ✓ **Apply governance behaviours consistently (across public and private sector entities) and constantly (over time).**

Deliver strategy



Identify governance interventions and behaviors that can be implemented in the immediate term, while building organisational learning and change management in the medium term

THIS BEHAVIOUR CONSIDERED ORGANISATIONAL LEARNING AND INNOVATION TO IMPROVE ENGAGEMENT OF THE PRIVATE SECTOR FOR THE COVID-19 RESPONSE.

As the governance behaviours illustrate 'how to deliver' is as important as 'what to deliver' for the COVID-19 response (10). Response should be jointly designed through goal-oriented engagement of the whole health sector. If all hands are indeed 'on deck' articulation of roles and responsibilities is needed, under direction of a strong response 'captain' (40). This is the role of government as steward of health systems.

Findings also illustrate the need for organisational learning and change management. Learning is integral to the COVID-19 response or should be. Health systems that do not learn from their own or others' experiences can

repeat mistakes. However, many health systems do not have sufficient capacity to use and retain and generate new knowledge as professional or bureaucratic norms may not encourage self-reflection and positive learning cycles (41). This suggests the need for the development of more robust monitoring and evaluation capacity, in collaboration with partners, such as academia and normative agencies, such as WHO. It further suggests commitment to change management. This should be systematic to institutionalise conventions, norms, behaviours, values and ethics within health systems. COVID-19 provides an unprecedented opportunity to rethink institutional inertia (42).

LESSONS LEARNT

- ✓ **Recognise the critical role of private-public-civic cooperation to improve health system resilience and equity as part of the COVID-19 response.**
- ✓ **Draw on collaborative skills sets to build core governance competencies for the COVID-19 response.**
- ✓ **Develop more 'deliberative, explicit, and transparent approaches' to resourcing the COVID-19 response (as part of transition from the emergency to management of COVID-19) (42).**
- ✓ **Optimise the use of digital technology as a tool for organisational and behavioral change, across the public, private and civic sectors.**
- ✓ **Use the COVID-19 'window of opportunity' for policy change, through diagnosis of health governance behavioural gaps, and the development of strategies and political appetite to redress these.**
- ✓ **Enlist support from international organizations such as WHO and other intermediaries in the development of policies and capacities.**

Conclusion

COVID-19 has reinforced the need for a whole-of-society approach to the pandemic response. This has tested the foundation of public and private sector relations in healthcare, and either nurtured or exacerbated trust. In many instances, the private sector has demonstrated solidarity and delivered critical essential and COVID-19-related health services and products. However adverse behaviours and opportunistic practices have also featured. These have exacerbated the State's duty to 'protect' the right to health, improve health security and system resilience for universal health care.

The pandemic has further exposed the need for robust governance of health systems. This is good for both the private and public sectors, but most importantly, consumers, including those most likely to be left behind. In times of emergency, real solutions do not benefit from divisive tactics, but arise through collective action and responsibility, that places the 'public' at the centre of health systems. These efforts should facilitate market reliability and build trust between consumers and the health system.

Delivery of COVID-19 tools through more effective engagement of the private sector

TOGETHER, WHO AND ITS PARTNERS ARE WORKING TO IMPROVE THE EQUITABLE PROVISION OF COVID-19 TOOLS AND ESSENTIAL HEALTH SERVICES THROUGH STRONGER (MORE INCLUSIVE, GENDER SENSITIVE) HEALTH SYSTEM GOVERNANCE AND ENGAGEMENT OF THE PRIVATE SECTOR IN HEALTH.

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annex 1

search strategy

WHO COVID-19 Database

<https://search.bvsalud.org/global-literature-on-novel-coronavirus-2019-ncov/>

Concept	Search string	Results
#1 Private health sector terms	"private health" OR "Market failure" OR "public-private"	536
#2 Private organization terms	"for profit" OR "public-Private" OR enterprise* OR NGO* OR "non-government" OR "Non-governmental" OR self-financ* OR charit* OR "Faith-based" OR business* OR enterprise* OR compan* OR corporate OR "private organizations" OR "private organisations" OR "private organization" OR "private organisation" OR "profit-driven" OR privatization OR "Private Sector"	9193
#3 COVID health products/ services?	Medical OR Health OR Vaccine* OR Innoc* OR Medicine* OR Drug* OR Pharma* OR protecti* OR PPE OR Mask* OR Oxygen OR ventilator* OR diagnostic* OR "intensive care" OR ICU	139 371
#4 Selling	procur* OR distribut* OR Access* OR provision OR retail* OR suppl* OR price* OR cost* OR charg* OR Fee OR fees OR expenditure* OR selling* OR contract* OR governance* OR Allocat*	35 411
#5	#1 OR (#2 AND #3) AND #4	
Combined #1 OR (#2 AND #3 AND #4)	((("private health" OR "Market failure" OR "public-private") OR ("for profit" OR enterprise* OR NGO* OR "non-government" OR "Non governmental" OR self-financ* OR charit* OR "Faith-based" OR business* OR compan* OR corporate OR "private organizations" OR "private organisations" OR "private organization" OR "private organisation" OR "profit-driven" OR "Private Sector")) AND (Medical OR Health OR Vaccine* OR Innoc* OR Medicine* OR Drug* OR Pharma* OR protecti* OR PPE OR Mask* OR Oxygen OR ventilator* OR diagnostic* OR "intensive care" OR ICU)) AND (procur* OR distribut* OR Access* OR provision OR retail* OR suppl* OR price* OR cost* OR charg* OR Fee OR fees OR expenditure* OR selling* OR contract* OR governance OR Allocat*))	2006 (*)

Google Scholar

Concept	Search string	Results
#1 Private health sector terms	(COVID OR CORONA)	
#2 Private organization terms	("public-private" OR "Non governmental" OR business OR company OR organization)	
#3 COVID health products/services?	(Vaccine OR Drug OR PPE OR protective OR Mask OR Oxygen OR ventilator OR diagnostic)	
#4 Selling part 1	(procurement OR distribution OR Access OR provision OR retail)	
Selling part 2	(supply OR price OR cost OR selling OR governance)	
#5	#1 AND (#2 AND #3 AND #4 (1)) #1 AND (#2 AND #3 AND #4 (2))	
Combined	filetype:pdf (COVID OR CORONA) AND ((("public-private" OR "Non governmental" OR business OR company OR organization) AND (Vaccine OR Drug OR PPE OR protective OR Mask OR Oxygen OR ventilator OR diagnostic) AND (procurement OR distribution OR Access OR provision OR retail)) filetype:pdf (COVID OR CORONA) AND ((("public-private" OR "Non governmental" OR business OR company OR organization) AND (Vaccine OR Drug OR PPE OR protective OR Mask OR Oxygen OR ventilator OR diagnostic) AND (supply OR price OR cost OR selling OR governance))	195

annex 2

Inclusion and exclusion criteria

Search categories	Inclusion	Exclusion
Private health sector (screen here first, second screen governance)	<ul style="list-style-type: none"> ■ For profit health facilities ■ Not for profit health facilities ■ Public health facilities ■ Distributors/retailers (of products) ■ Pharmacies ■ Itinerant/informal providers 	<ul style="list-style-type: none"> ■ Non-health sector businesses (e.g. B2B, B2C) ■ Global private/commercial sector ■ Manufacturers (i.e. vaccine mfgs)
Selling	<ul style="list-style-type: none"> ■ Corruption ■ Price/cost/fee ■ Market ■ Procurement ■ Profit 	<ul style="list-style-type: none"> ■ Global/formal supply chains ■ Global market shaping
C-19 emergency	<ul style="list-style-type: none"> ■ Equity/fairness ■ Human rights/gender ■ Allocation ■ Resources ■ Access ■ Scarcity ■ Demand ■ Distribution ■ Quality ■ Compliance 	<ul style="list-style-type: none"> ■ Non-health services (e.g., screening for travel) ■ Non-COVID 19 services/products ■ Surveillance ■ Social measures (lockdowns, etc)
Governance – accountability	<ul style="list-style-type: none"> ■ Stewardship/leadership ■ Incentives ■ Consistent use of structures ■ Centrality of the consumer ■ Recourse and mitigation measures ■ Role of intermediaries 	<ul style="list-style-type: none"> ■ Non-COVID related
Governance – financing	<ul style="list-style-type: none"> ■ Contract/MoU ■ Subsidy/voucher ■ Grants ■ Loans ■ Insurance 	<ul style="list-style-type: none"> ■ Non-COVID related
Governance – regulation	<ul style="list-style-type: none"> ■ Rules ■ Certification ■ Accreditation ■ Legislation ■ Control/cap ■ Qualification ■ License 	<ul style="list-style-type: none"> ■ Non-COVID related

Search categories	Inclusion	Exclusion
Governance – information	<ul style="list-style-type: none"> ■ Coordination (of suppliers) ■ Communication/dialogue (with suppliers) ■ Communication (with consumers) ■ Social media/social accountability ■ Data systems (inclusivity and quality) ■ Information exchange (transparent use of data and information) 	<ul style="list-style-type: none"> ■ Non-COVID related
Governance – structure	<ul style="list-style-type: none"> ■ Organisation (of suppliers) ■ Organisation of the public sector (include PPP) ■ Evolution of structures ■ Participation in public policy ■ Goal oriented engagement ■ Articulation of roles and responsibilities ■ Metrics and monitoring mechanisms 	<ul style="list-style-type: none"> ■ Non-COVID related



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