

HEALTH SYSTEMS AND POLICY ANALYSIS

POLICY BRIEF 56

Engaging the private sector in delivering health care and goods

Governance lessons from the COVID-19 pandemic

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List of abbreviations

APA	Advance Purchase Agreement
CPO	Central Purchasing Organization (Lithuania)
FDA	Food and Drug Authority (USA)
HSRM	Health Systems Response Monitor
ICU	Intensive Care Unit
IRCCS	<i>Istituto di Ricovero e Cura a Carattere Scientifico (Italy)</i>
NGO	Non-government Organization
PPE	Personal Protective Equipment
PPO	Public Procurement Office (Lithuania)
PPP	Public-Private Partnership
TAPIC	Transparency, Accountability, Participation, Integrity, Capacity

Key messages

- **Private sector resources and expertise can enhance the delivery of health goods and services.** The private sector played a key part in the COVID-19 pandemic. It also has a wider role in the maintenance of essential health services and in ensuring health system resilience.
- **Learning from the experience of private sector engagement during COVID-19 can help countries avoid potential pitfalls** and ensure that policy objectives and health system goals and priorities are met. The experience has also generated useful evidence on how to support operational success and maintain financial probity in resource allocation and spending.
- **Effective private sector engagements require good governance practices.** Policy successes and failures during the pandemic highlighted key governance challenges and provide lessons for countries on how to engage the private sector in their health systems effectively.
- **Making the nature of private sector collaboration explicit is an important element of planning and managing effective relationships.** This entails:
 - setting out the objectives of both public and private sector actors clearly;
 - identifying how both parties can achieve their objectives within a collaboration; and
 - weighing up shared goals and the reasons for the private sector engagement as well as exploring other means of achieving the stated objectives.
- **Goal alignment and compatibility are central considerations** in working with the private sector and should be linked to appropriately targeted incentives.
- **Transparency and accountability are crucial** in ensuring private sector contracts are governed robustly.
 - Open and transparent information is closely linked to public trust and is needed to safeguard the integrity of government bodies dispensing large amounts of public funds.
 - Clear, transparent processes must be followed to identify and consider potential private sector partners and in justifying the choices made in awarding contracts in order to alleviate concerns about the risk of potential corruption. This is particularly critical in the area of public procurement.
- **Establishing emergency procurement guidelines for 'crisis contracting' now will protect countries in future emergencies.**
 - Countries can usefully establish clear guidelines for the application of emergency procurement and set out its legal basis.
 - Pre-vetting companies and potential suppliers using robust selection criteria defined by experts (and including a track record for reliability and quality) can underwrite confidence.
 - Making publicly available a range of information, such as registers of calls for tender and of contracts awarded reinforces the probity of procurement arrangements.
- **Building trustworthy partnerships between the public and private sectors is invaluable** and can help ensure alignment with the health system's strategic objectives.
 - Well structured agreements that clearly define roles, responsibilities and expectations help strengthen relationships with private sector partners.
 - Establishing avenues for effective dispute resolution in advance fosters trust.
- **Equitable risk-sharing is important for accountability and protection, and needs to be explicitly addressed in private sector engagements.**
 - Equitable risk-sharing protects public payers and strengthens private sector accountability.
 - Covering the full range of risks, including health risks, financial risks (to secure expected returns on financial commitments against potential liabilities or losses) and fulfilment risks (to guarantee supply obligations and quality standards) makes agreements more effective.

Executive summary

The private sector made major contributions to delivering and maintaining essential health care goods and services during the COVID-19 pandemic

Private sector facilities and resources played a key part in countries' responses to the COVID-19 pandemic, including supplying needed equipment and Personal Protective Equipment (PPE), providing hospital facilities and personnel to treat COVID-19 and non-COVID patients, developing digital health and other surveillance tools to support contact tracing, delivering diagnostic and laboratory services to upscale COVID-19 testing, and furnishing quarantine facilities and vaccination sites. They were also crucial to the development and supply of COVID-19 vaccines.

Pandemic experiences provide valuable lessons for future private sector engagements

In addition to demonstrating valuable contributions made by the private sector, real-life case studies showcase several governance challenges faced by health systems in their engagement with private partners. These are very instructive in providing guidance on how the private sector may be engaged more effectively in the future to ensure health system resilience, both in assisting with pandemic responses and more widely in the maintenance of essential health services should policy-makers choose to pursue mixed-provision models to meet health system needs. Since health systems are likely to continue to draw on private sector capacity, it is important to learn from the COVID-19 experience, to ensure that these relationships work as intended.

Focusing on robust governance can help harness the benefits of private sector engagement and protect public payers from potential harm

Good governance practices help to ensure that policy objectives and health system goals and priorities are met when partnering with private sector actors. They also promote operational success and financial probity in resource allocation and spending. This Policy Brief uses the dimensions in the TAPIC governance framework – transparency, accountability, participation, integrity and capacity – as a lens through which to analyse real-life country case studies and identify where potential governance problems within private sector engagements are likely to be sited. Also informing the analysis is the list of six governance behaviours identified by the WHO Advisory Group on the Governance of the Private Sector for Universal Health Coverage that are critical to successful governance of private health service delivery and robust collaborations. The governance behaviours can be described as a way to govern in practice and move from frameworks to actionable governance. They encompass strategies for achieving delivery frameworks, aligning structures, building understanding through information gathering and exchange, enabling stakeholders and partners through systems of incentives and sanctions, fostering relations to encourage private sector participation and nurturing trust through transparent, accountable and inclusive institutions.

By using a sample of illustrative case studies we present archetypal experiences of how countries in the WHO European Region engaged with the private sector during 2020–2021. The chosen case studies come from several countries and cover three broad areas of activities: the delivery of health services, namely of hospital and ICU beds for COVID-patients and the provision of vaccination sites for the administration of COVID-19 inoculations; procurement of PPE and upscaling of COVID-19 laboratory testing; and Advance Purchase Agreements (APAs) for COVID-19 vaccines. Each case study is designed to outline the objective of the private sector engagement and how it was carried out. Where particular governance challenges arose, the aim of the case studies is to show how countries responded with solutions and the resulting impacts, with implications for policy.

Goal alignment and compatibility, as well as appropriately targeted incentives, should be the key drivers in establishing potential private sector engagements

The key aim of harnessing private sector capabilities is to enhance the delivery of health goods and services, and to do so in a way that effectively engages the private sector in alignment with health system goals and priorities. Thus, from a public policy perspective, goal alignment and compatibility should be key drivers in establishing potential private sector engagements. This is a minimum requirement and can act as the bedrock for any further developments that may be pursued by policy-makers and implementers in aligning institutional and regulatory structures that either promote or more actively integrate private sector engagements in mixed-provision health systems. Case study evidence also underlines that consistency and predictability of commitments are key elements for maintaining trust and building successful public-private relationships.

Some foundational governance-enhancing lessons for entering into private sector engagements and effectively delivering health services are:

- Whether private sector engagements are part of mature mixed-delivery systems or are being contemplated as part of a policy solution to fill a health services gap, being able to draw on policy capacity to enter into such engagements is an important asset.
- Setting clear objectives for both public and private actors helps to identify shared goals as well as appropriate incentives. It also makes clear the rationales for entering into collaborations and supports the monitoring and achievement of outcomes.
- Well structured agreements that reflect the health system's strategic objectives, and define respective roles, responsibilities and expectations, provide the necessary solid basis for engagements with private sector partners. They are also the basis for nurturing trust between partners and setting out avenues for resolving disputes.

Open and transparent procurement practices are vital to securing accountability and maintaining integrity

Procurement was one of the major areas of private sector engagement during the pandemic and was critical to bolstering supplies of PPE at a time when demand in both national and international markets was exceptionally high and disruptions to global supply chains led to widespread shortages. Similarly, the centrality of COVID-19 testing as part of “test, trace and isolate” strategies to stem transmission of the virus required a massive ramping-up of laboratory processing of COVID-19 tests. In this context, there was also a need to act swiftly in order to secure purchases to protect public health: “crisis contracting” often involved reverting to European Union (EU)-mandated options such as using truncated timeframes for tendering or direct contracting which allowed greater agility and speed to secure required products. Nevertheless, from a governance perspective, pivoting to more flexible but non-standard procurement practices poses potential problems for transparency and accountability that need careful management.

Lessons for robust governance of procurement with the private sector illustrate that open and transparent procurement practices – particularly in time-sensitive scenarios – strengthen accountability and safeguard against potential risks of corruption in contracting or mismanagement of public funds. Some key areas for the development of good practices in public procurement include:

- as part of future emergency preparedness plans, establishing guidelines for emergency procurement and the legal basis upon which it is based. Governments could take the opportunity to review and revise public procurement procedures generally, with a view to strengthening due diligence and reforming procurement processes if necessary;
- as part of longer-term arrangements, building up stocks and reserves of PPE and other medical consumables to be deployed quickly in the event of emergencies and relieve pressure on “crisis contracting”;
- pre-vetting companies and private health services providers in order to establish lists of preferred suppliers for medical goods and equipment and of private providers (accompanied by pre-planned agreements to be activated when necessary);
- instigating vetting processes that ideally would involve consultations with qualified professional bodies which can aid government authorities and advise on selection criteria that would ensure the inclusion of qualified candidates with established track records in the respective market or field, thus building up a reserve of trusted sources. Such processes provide a concrete opportunity to involve stakeholders with the necessary expertise and know-how to participate in the effective implementation of private sector engagements in procurement; and
- publishing public procurement guidelines, lists of pre-vetted companies and registers of procurement contracts so that they are in the public domain and widely available.

Explicitly addressing equitable risk-sharing protects public payers and strengthens accountability of private sector suppliers

The pandemic demonstrated that during emergencies, governments were prepared to take more risks than usual when entering into supply agreements with contractors, not only because of time pressures but also because the uncertainties and the risks associated with not acting could also extract high costs. APAs for COVID-19 vaccinations provide some of the most salient examples and highlight all the key reasons why equitable risk-sharing should be addressed clearly and in detail when entering into private sector engagements.

Key governance lessons highlight that comprehensively and explicitly addressing risks within agreements provides appropriate protection to public payers and strengthens accountability of private sector suppliers. Ideally, APAs should set out respective risk-bearing responsibilities for:

- health risks: safeguarding the safety of the population or targeted sub-groups receiving the medical goods or services in question;
- financial risks: adequately securing the expected returns on financial commitments against potential liabilities or losses; and
- fulfilment risks: ensuring recourse measures in the event of delays or failures to supply the goods or services stipulated in agreements and to the required quality standards.

Covering all of these points not only ensures that the interests of the public sector partner are adequately protected but also contributes to the robustness and comprehensiveness of agreements, minimising loopholes and ambiguities, even if all the details of these safeguards may not be able to be disclosed publicly owing to commercial confidentiality clauses.

POLICY BRIEF

1. Introduction: Why this Policy Brief?

Private actors made major contributions to delivering and maintaining essential health care goods and services during the COVID-19 pandemic, even in strong publicly-based health care systems, but these contributions were sometimes fraught with challenges

Health systems all over the world rely on a mix of public and private inputs in the financing and provision of health services and products, with varying degrees of involvement of the private sector. A primary form of this public-private mix consists of public funds paying for health services and products supplied through private providers. There are different types of private sector partners – for-profit and not-for-profit entities¹ – and the engagement of private sector actors can take a variety of forms (Box 1).

Box 1. Defining private sector engagement and what it requires

Private sector engagement is the meaningful inclusion of private providers for service delivery in mixed health systems. Private sector engagement requires that governments focus on governance of the whole health system – both private and public – to ensure access to and quality of care and financial protection for patients, irrespective of where they seek care. It requires that the private sector aligns with public sector health goals and commits to working to support the government agenda.

Source: WHO, 2020a

Nowhere was this more in evidence than during the initial two years of the COVID-19 pandemic in 2020 and 2021, where governments engaged with the private sector in numerous ways. During the pandemic, it became evident that public providers, government departments and public sector bodies were not sufficiently equipped to respond effectively to the emergency. Throughout the crisis there were examples of how private sector capacity made major contributions: private actors engaged or worked in partnership with the national health system to supply rapid and often innovative solutions to strengthen some existing services and develop new ones. At the same time, there is also evidence of significant challenges, such as lack of transparency, unbalanced risk-sharing, inefficiencies and potential corruption, profiteering or waste of public funds, all of which undermined effective health system performance and eroded public trust. This pandemic-specific experience can be usefully harnessed to obtain insights into how the governance of public-private relationships in the health care sector can be strengthened to achieve health policy outcomes and maintain the core values of health system functions and objectives.

Since health systems are likely to continue to draw on private sector capacity, it is important to learn from the COVID-19 experience to ensure that this relationship works as intended

Learning from the COVID-19 emergency period experience is particularly important as it is likely that governments will continue to collaborate with private sector providers for several reasons. Firstly, they may have had positive experiences during the pandemic, where different ways of working with external partners presented viable alternatives to achieve specific goals or to generate novel solutions to problems (Waitzberg et al., 2022). Moreover, in the post-pandemic landscape, engaging with the private sector may be one possible means to meet pressing capacity constraints, particularly in the context of keeping up with the demand for health services and dealing with the legacy of addressing backlogs and longer waiting times to access health care services and procedures (van Ginneken et al., 2022). Finally, while strengthening publicly funded health systems has emerged as a crucial factor in meeting future challenges, bringing in additional private sector resources and knowhow may be a viable means of addressing infrastructural and other health system weaknesses that were exposed during the pandemic.

Appropriate governance can help harness the benefits of private sector engagement and protect from potential harm

As stressed in the definition in Box 1, private sector engagement involves more than just implementing a legal or contractual relationship between a public payer and a private supplier; the crux of successful engagement is that while producing mutually beneficial results, the activity aligns with and supports government goals in the health sector. One of the main concerns over engaging with the private sector is that badly designed relationships with private sector partners can potentially weaken existing public structures (Gottlieb, Filc & Davidovitch, 2020; Vecchi, Casalini & Cusumano, 2020) and engender an uneven distribution of risks and returns. From this perspective, a precondition for achieving health systems' goals is to foster strong and well performing publicly funded health systems. On top of that, being able to delineate appropriate areas of private sector engagement and associated governance-strengthening strategies ensures that all health system actors, including private sector collaborators, operate in ways that are consistent with the explicit goals of countries' health systems, such as equity, efficiency, financial protection, responsiveness and improved population health (Clarke et al., 2019).

Robust governance can also serve to safeguard publicly financed health systems from potential misuse. With this objective in mind, good governance is the means to reach the triple goals of:

- meeting policy objectives and health system needs in order to serve populations;
- achieving operational success in the delivery of services or outcomes; and
- securing financial probity and value for money in the allocation and spending of health system resources.

¹ Non-government Organizations (NGOs) and faith-based organizations are another category of actors that make up substantial parts of health care delivery in some countries but these are not the focus of the Policy Brief.

This policy brief offers insight into actual private-public engagements implemented during the pandemic to draw lessons on how the governance of this relationship could be improved

This Policy Brief does not seek to provide recommendations or conclusions on whether or not it is desirable for publicly funded health systems to engage with the private sector. Rather, the aim is to analyse some of the available evidence from the pandemic experience, identify the relevant issues shaping this engagement (both positive and negative) and set out the policy implications on governance for policy-makers who may choose to engage with the private sector in the future. The objective is to draw out lessons for strengthening different aspects of governance and avoiding potential pitfalls in future collaborations with private sector actors.

In Section 2 we briefly lay out the methodology used in this Policy Brief. Section 3 provides a summary of the types of private sector engagements that were conducted during the pandemic, while Section 4 delves into more detail on some key findings and governance lessons that can be derived from the pandemic experience, using illustrative case studies. Section 5 offers some concluding remarks.

2. Methodology

This Policy Brief uses a purposive sample of case studies that have been selected to illustrate archetypal experiences of how countries in the WHO European Region engaged with the private sector during 2020–2021. Several frameworks have attempted to identify key components of good governance (see Annex) but for the purposes of guiding this analysis we use the TAPIC governance framework, developed by Greer and colleagues (Greer, Wismar & Figueras, 2016), since it is the result of an extensive mapping and synthesis of the key principles of governance that have been identified and validated in the literature (Greer, Wismar & Figueras, 2016; Greer et al., 2019).

The TAPIC governance framework identifies five dimensions where governance problems are likely to be sited. These are **transparency, accountability, participation, integrity** and **capacity**, abbreviated to the “TAPIC framework” (Box 2). The approach focuses on identifying problems, and troubleshooting existing policies.

Also informing the analysis is the list of six *governance behaviours* identified by the WHO Advisory Group on the Governance of the Private Sector for Universal Health Coverage that are critical to successful governance of private health service delivery and robust collaborations (WHO, 2020b). The strategy focuses on providing useful *policy actions* whose elements cohere with the key dimensions highlighted in the TAPIC framework. The governance behaviours can be described as a way to govern in practice and move from frameworks to actionable governance (Box 3).

While we do not attempt a direct mapping of case studies with all of the governance domains and behaviours featured in these two frameworks, the latter acts as a lens to spotlight important governance opportunities and challenges encountered by public authorities within the featured private sector engagements.

Box 2. The TAPIC governance framework

Five dimensions pinpoint the sites of potential governance problems:

- **Transparency** provides relevant information for decision-making and about those making the decisions. It also concerns questions about the quality of information and mechanisms for making information available, ensuring that decisions and the grounds on which they are being made are clear and known to the public.
- **Accountability** comprises the ability of one actor to demand an explanation or justification from another actor for their actions (Rubin, 2005). It involves answerability, liability for actions and enforceability: being responsible for actions and outcomes. For example, accountability ensures that allocated resources are used appropriately and provides enforceable ways to correct poor performance or not abiding to agreed rules. In simple terms, accountability considers who is accountable to whom and for what.
- **Participation** aims to ensure that affected legitimate interests are consulted in a way that reaps information and understanding, fosters legitimacy and ownership, and improves implementation.
- **Integrity** means that the processes of representation, decision-making and enforcement should be clearly specified. Individuals and organizations should have a clear allocation of roles and responsibilities and be involved in procedures that are clear and transparent. For example, these procedures include rules to ensure that hiring and promoting are meritocratic and contracts are awarded without favouritism, hence reducing the scope for corruption and cronyism.
- **Policy capacity** is the competence of policy-makers at the centre. This requires expertise and capacity to monitor, understand and evaluate the work of both government partners, such as contractors and consultants, as well as of government, policy and strategic priorities. Policy capacity involves the capacity to translate evidence and data into policy, and thus supports government stewardship in the health sector.

Source: Greer et al., 2019

Box 3. WHO Advisory Group Strategy for promoting successful private sector engagement in health care

Six governance behaviours to improve private sector engagements in health care:

- **Deliver strategy:** government establishes a strategic public policy framework which sets out the vision, priorities, principles and values for the health system, and works out how to translate these priorities, principles and values into practice.
- **Align structures:** government takes the required actions to align public and private structures, processes and institutional architecture to create a fit between policy objectives, organizational structures and culture.
- **Building understanding:** government facilitates information-gathering and sharing about all elements of service provision in the health system to provide intelligence to contribute to better health system outcomes.
- **Enable stakeholders:** government ensures that tools exist for implementing health policy to authorize and incentivize health system stakeholders and, where necessary, impose sanctions to align their activities and further leverage their capacities towards national health goals.
- **Foster relations:** government should establish mechanisms that allow all relevant stakeholders to participate in policy-making and planning and forge partnerships.
- **Nurture trust:** government leads the establishment of transparent, accountable and inclusive institutions at all levels to build trust, ensuring that all health system actors, public and private, are accountable for their actions to a country's population.

Sources: Clarke et al., 2023; WHO, 2020b

3. What kinds of private sector engagement were conducted during the COVID-19 pandemic?

Table 1 presents a qualitative selection of the different types of private sector engagement carried out within the WHO European Region in 2020–2021. The selection is derived mainly from information available from the COVID-19 Health Systems Response Monitor (Box 4; Tille et al., 2023). It is not meant to be an exhaustive inventory but rather is designed to convey the range and types of activity that were implemented with the cooperation of private sector partners during the initial two years of the pandemic.

This overview of examples makes clear the extent to which the private sector was involved in countries' pandemic response strategies, including as suppliers of needed equipment, such as ventilators, or consumables such as surgical masks and other items of PPE through public procurement. Another crucial area of procurement focused on the purchasing of newly developed COVID-19 vaccines, often through APAs. The private sector also delivered a wide selection of COVID-19-related services, such as acute and intensive care unit hospital services for the treatment of COVID-19 patients through their own facilities and health personnel. Other services focused on mitigation efforts, such as the development of digital health and other surveillance tools to support contact tracing, as well as the provision of diagnostic and laboratory services to upscale COVID-19 testing among the population. Private enterprises were also used as quarantine facilities and as vaccination sites, as well as to provide non-health services such as information helplines or telephone hotlines for contact tracing. Finally, the private sector played a central role in conducting research and clinical trials that produced the array of COVID-19 vaccines that emerged with unprecedented speed.

It is worth noting that none of the engagements involved classic examples of public-private partnerships (PPPs) as, by definition, PPPs mostly consist of high-cost infrastructure or service delivery projects with long time-horizons of several years and sometimes decades.² In contrast, the enlistment of the private sector during the COVID-19 pandemic was more often than not shaped by urgent needs and limited supplies, unprecedented *modus operandi* and significantly truncated timelines compared to what would be expected in non-emergency times.

The shaded cells in Table 1 indicate the case studies featured in the next section.

Box 4. The COVID-19 Health Systems Response Monitor

The Health Systems Response Monitor (HSRM) was designed in response to the COVID-19 pandemic to collect and organize information on how countries were responding to the crisis between 2020 and early 2022. The regular updates over this period have been converted into an archive of country evidence. It focuses primarily on the responses of health systems but also captures wider public health initiatives. Complementary cross-country analyses highlight responses in key policy areas and lessons learnt. The Monitor is a joint undertaking of the WHO Regional Office for Europe, the European Commission and the European Observatory on Health Systems and Policies.

Further information is available from:
<https://eurohealthobservatory.who.int/monitors/hstrm>.

² A PPP is an arrangement between a public authority and a private partner designed to deliver a public infrastructure and service under a long-term contract. Under this contract the private partner bears significant risks and management responsibilities. The public authority makes performance-based payments to the private partner for the provision of the service, or grants the private partner the right to generate revenues from the provision of the service. Private finance is usually involved (European PPP Expertise Centre, 2022).

Table 1. Sampling of private sector engagement by countries in the WHO European Region during the COVID-19 pandemic, 2020–2021

	Procurement of publicly funded health care equipment and consumables from private sector suppliers		Private development and delivery of publicly funded health services by the private sector					Research
	Procurement of medicines and vaccines, including APAs	Procurement and purchase of PPE and other relevant medical equipment	Private development of digital health and other surveillance tools with public funding	Private providers supplying publicly funded health services	Publicly funded testing and/or genome sequencing in private laboratories	Use of private enterprises as quarantine facilities, vaccination sites	Contracting private enterprises for other non-health services (e.g. hotlines or telephone contact tracing)	Publicly funded research and clinical trials for medicines and vaccines by private companies
Albania					✓			
Armenia					✓	✓		
Austria			✓		✓			
Azerbaijan		✓	✓		✓	✓		✓
Belgium	✓	✓	✓		✓	✓	✓	✓
Bulgaria		✓	✓		✓			
Czechia	✓	✓			✓	✓	✓	
Denmark	✓	✓	✓	✓	✓	✓		
Estonia	✓	✓	✓		✓	✓		
Finland			✓	✓	✓		✓	
France		✓	✓	✓	✓			
Georgia				✓				
Germany		✓	✓		✓	✓		✓
Greece	✓	✓		✓	✓	✓		
Hungary		✓		✓				
Iceland					✓		✓	
Ireland			✓	✓	✓	✓		
Israel	✓	✓	✓		✓	✓	✓	✓
Italy	✓	✓	✓	✓	✓	✓		✓
Latvia		✓						
Lithuania		✓			✓			
Luxembourg		✓						
Malta	✓			✓	✓	✓		
Montenegro				✓	✓			
Netherlands (Kingdom of the)			✓	✓	✓	✓		
Norway	✓	✓	✓		✓	✓		
Portugal		✓			✓			
Slovenia		✓						
Spain	✓	✓	✓	✓	✓	✓		
Sweden		✓		✓	✓			✓
United Kingdom	✓	✓			✓			✓

Note: Shaded cells indicate the case studies featured in Section 4.

Source: COVID-19 Health Systems Response Monitor

4. Governance lessons derived from COVID-19 private sector engagements

In this section we discuss some of the key findings on governance that emerge from the private sector activities that took place under an emergency situation during the COVID-19 pandemic. Although these findings are based on an illustrative sample of case studies, they nevertheless provide valuable insights into the beneficial outcomes that arose from private sector engagements during the pandemic, as well as the various governance challenges that were presented.

The chosen case studies cover three broad areas of activity: the delivery of health services, namely of hospital and ICU beds for COVID-patients and the provision of vaccination sites for the administration of COVID-19 inoculations; procurement of PPE and upscaling of COVID-19 laboratory testing; and APAs for COVID-19 vaccines. Each case study is designed to outline the objective of the private sector engagement and how it was carried out. Where particular governance challenges arose, the aim of the case studies is to show how countries responded with solutions and the resulting impacts, with implications for policy.

4.1 Capitalizing on the co-benefits of private sector engagements in delivering health services

During the pandemic private sector engagement boosted capacity at crucial junctures when public facilities and services would not have been able to cope on their own. These included the provision of medical care in hospitals for patients presenting with COVID-19, as well as health services for non-COVID patients and contributing to the implementation of vaccination rollouts. The examples presented here illustrate the value of policy capacity, bolstered by good governance behaviours, to support the successful deployment of private sector resources in alignment with public partner policy goals. They also underline the important role that trust plays in maintaining successful relationships and securing desired outcomes, particularly in difficult and fast-changing circumstances.

An established track record of using private providers to deliver health services demonstrates the value of fostering relationships and aligning institutional structures to achieve common goals

The health care system in the Lombardy region has earned a reputation as one of the highest-performing regional health systems in Italy, providing integrated health services delivery to nearly 10 million residents. In addition, the high standards of care and quality attract patients from other Italian regions. For over three decades the regional health system has followed a mixed delivery model that heavily relies on private accredited providers in the hospital sector: such accredited providers have already undergone the process of public licensing necessary to provide services for the National Health Service, meeting a wide range of technical and quality criteria. Among the myriad challenges that confronted the regional health system during the pandemic, this established component of the regional health system

was rapidly deployed, and most private providers agreed to provide hospital beds and intensive care units (ICUs) in joint efforts with public sector facilities to respond to the health emergency (Box 5). Relatedly, the policy capacity to engage with private sector partners amassed over the years was a resource that decision-makers could readily draw on.

Box 5. The Lombardy region's use of private sector capacity to rapidly deploy health services during the COVID-19 pandemic

The delivery of COVID-19 and non-COVID hospital care during the pandemic



What was the objective of the private sector engagement?

The Italian region of Lombardy was one of the first areas in Europe to be heavily impacted by the COVID-19 emergency. Hospitals played a central role in delivering health care services during the various waves of the pandemic, requiring an urgent upscaling of capacity in acute and intensive care hospital beds.



What kind of private sector collaboration was carried out?

The Lombardy region was able to rapidly reorganize its hospital network, drawing on the significant resources of accredited private sector facilities in order to redistribute beds to treat COVID-19 patients. In total the region has 132 acute care hospitals, with 78 public hospitals and 54 (both for-profit and not-for-profit) private accredited hospitals. Additionally, there are 20 research hospitals known as IRCCS (Istituto di Ricovero e Cura a Carattere Scientifico), consisting of 5 public institutions and 15 private institutions, all accredited with the National Health Service. Overall, the existing hospital infrastructure consisted of 55% (83 out of 152) public facilities and 45% private. Accredited private hospitals play a significant role, with approximately 28% (9632 out of 34 818) of beds managed by these institutions. These private hospitals accounted for 18% (157 613 out of 870 992) of acute care hospitalizations in the region in 2021 (ISTAT, 2021; Ministry of Health Italy, 2023). During the first wave of the pandemic in early 2020, the mobilization of hospital and ICU beds was very rapid. On 13 March 2020, at the onset of the pandemic, the Lombardy hospital network had a total of 29 308 acute care beds, with 20 688 (71%) in public hospitals and 8620 (29%) in private hospitals. The number of intensive care beds totalled 900, with 630 (70%) in public hospitals and 270 (30%) in private hospitals. By 30 March 2020, just two weeks later, the number of designated acute beds for COVID patients had reached 12 306, with 7331 (60%) in public hospitals and 4975 (40%) in private hospitals. The number of intensive care beds nearly doubled to 1755, with 1271 (73%) in public hospitals and 484 (27%) in private hospitals.

The use of private sector entities to support the region's COVID-19 vaccination rollout

In Lombardy, private health care facilities, such as hospitals and medical centres, were actively engaged by the region in early 2021 to establish dedicated COVID-19 vaccination centres. Here we provide some examples of prominent vaccination hubs that were established in the Milan Metropolitan Area and surrounding areas during the 2021 COVID-19 mass vaccination campaign.

The largest contribution was provided by *Gruppo San Donato*, the leading private health care group in Italy, with its main COVID-19

vaccination hub located in Novegro (responsible for 314 741 administered doses between April and August 2021), its hospitals, *Istituti Ospedalieri Bergamaschi*, located in Bergamo (about 140 000 doses), and its many smaller outpatient clinics, which were active throughout the COVID-19 vaccination rollout (about 100 000 doses).

The vaccination hub located in Novegro highlights how health professionals were marshalled for the immunization drive: when the vaccination campaign in Italy was at its peak, almost 250 medical residents and junior doctors working in private health care providers were assigned to the vaccination centre, and their involvement significantly bolstered the available medical workforce for immunization activities, enabling a larger number of individuals to be vaccinated efficiently (Signorelli et al., 2021). Others private centres, which are worth mentioning for the large number of administered doses, were the hubs implemented by *IRCCS Humanitas Research Hospital* in Rozzano (554 587 doses), *IRCCS Auxologico* in Meda (about 110 000 doses) and by *Gruppo Ospedaliero MultiMedica* (about 100 000 doses).

In 2021, in Lombardy about 19 million doses of the COVID-19 vaccine were administered in total. The private vaccination hubs mentioned above contributed to this effort, with over 1.3 million doses administered. Alongside these activities, it is important to consider the significant contribution made by many smaller private vaccination centres located throughout the region.

In many countries during the pandemic, the use of private pharmacies became the most used mechanism for vaccination following the initial campaigns. In Lombardy, private pharmacies also played an important role in the administration of COVID-19 vaccines, providing widespread accessibility for the public. Leveraging their extensive presence throughout the region from mid-2021, private pharmacies have become crucial vaccination points for booster doses, offering convenient and local options for residents.

The efficient mobilization of hospital beds from the private sector in the initial heavy surge of COVID-19 cases, and the reorganization efforts throughout the pandemic, focused on the region's existing health system assets, i.e. the highly developed and specialized hospital network, and also benefited from the integration of public and private hospital entities built up over a number of years. As the epidemiological situation evolved and more evidence was collected, many countries, including Italy and the Lombardy region, were able to shift treatment protocols for people with mild or non-life-threatening COVID-19 symptoms into primary care or home settings, in keeping with the available structures and resources of their primary care systems. From a governance perspective, Lombardy's ability to capitalize on the established relationships and institutionalized contracting model of private accredited providers within the hospital network, particularly during the onset of the pandemic emergency, serves as an example of aligned structures and the capacity to deliver high-priority policy and operational goals along with private sector partners.

The Lombardy region also provides an example of how the private sector contributed infrastructure and valuable health workforce support for the COVID-19 vaccination campaign (Box 5). The engagement of the private sector in vaccination delivery in Lombardy has been instrumental in achieving the campaign's goals, expanding the region's overall capacity for vaccine administration, improving accessibility and ensuring

widespread immunization against COVID-19. This example also serves to demonstrate an alignment of structures to deliver policy strategy, highlighting the value that private sector entities can contribute to meeting health system needs.

Consistency and predictability of commitments are key elements for maintaining trust and building successful public-private relationships

Fostering and maintaining relationships that support mutual trust are crucial to successful private sector engagements. Part of this process involves delineating with precision the terms of agreements so that roles and responsibilities are clear, expectations are stable and predictable, and each party is certain about their commitments and obligations. Wherever possible, carefully crafted contingency clauses can be added to solidify contractual obligations. Additionally, clear channels of communication and procedures for dispute resolution can be established to discuss permissible recourse actions and options in the event that conditions change, the needs or aims of either partner diverge, or obligations are no longer able to be met. Together, these good governance practices provide an enabling environment that respects the autonomy of actors and their decision-making capacities within the established agreement framework of the collaboration.

One example from Greece, concerning its cooperation agreements with private hospitals during the pandemic, serves to highlight the centrality of these principles for private sector engagements, particularly maintaining consistency in upholding agreements and nurturing trust. Up until November 2020 the emergency hospital management plan in Greece had been working successfully with private clinics treating non-COVID patients whenever required. Thanks to public health and social measures, the country did not experience a large number of cases during the first wave of the pandemic but this changed dramatically after the summer of 2020 when public facilities came under intense pressure with a rapid surge in cases and COVID-related deaths (Box 6).

Box 6. Changing conditions posed difficult challenges in mobilizing private sector hospital beds to treat COVID-19 patients in Greece



What was the objective of the private sector engagement?

Under its crisis management plan the Ministry of Health sought to secure adequate numbers of acute and ICU hospital beds during the pandemic by utilizing private sector hospitals as needs arose.



What kind of private sector collaboration was carried out?

In 2020 the Ministry of Health entered into cooperation agreements with private hospitals and clinics for them to provide non-COVID acute beds and non-COVID ICU beds if required. These resources would join the nationally scaled-up hospital bed stock that included National Health Service hospitals and military hospitals designated to treat COVID patients.



How governance challenges arose

In November 2020 Greece saw a steep rise in the number of COVID-19 cases, with very large numbers of patients needing hospital treatment across the country. The situation was particularly acute in Thessaloniki, Greece's second largest city, and other parts of Northern Greece, where despite significant increases of bed numbers, public hospitals treating COVID-19 patients had reached near-saturation point in both COVID-19 wards and in ICUs (COVID-19 HSRM Greece, 2021). As the number of hospitalizations increased rapidly and pressure on public facilities and their staff intensified, the Ministry of Health requested that the owners of two private hospitals in Thessaloniki voluntarily provide 200 'simple COVID beds' for the duration of two weeks. It argued that the fast-moving emergency situation on the ground now necessitated that the two private hospitals also make available their beds and staff to treat COVID-19 patients.

The owners of the private hospitals declined to provide the beds, citing a number of safety reasons for staff and existing patients related to the transmission of the virus, lack of staff experience in treating COVID-19 patients, inappropriate physical amenities to designate separate COVID and non-COVID wards and inadequate notice to prepare. They also pointed out that the cooperation agreement with the Ministry of Health was to use private hospital facilities to treat non-COVID patients in order to alleviate pressure on public hospitals, which were tasked with handling COVID cases. Thus, the Ministry's current request was not envisaged under the previously agreed arrangements. The association of private clinics added that during the previous month alone, approximately 250 non-COVID patients from public hospitals had been treated in Thessaloniki's private clinics (Euractiv, 2020).

After pressurized negotiations failed to reach agreement and an ultimatum to provide the beds lapsed, the Ministry of Health passed legislation on 20 November 2020, as part of a new contingency plan, to enable the temporary requisitioning of the hospital beds and staff in the two specific private clinics in Thessaloniki. During the period of administrative management by the Ministry of Health, the two private hospitals transferred their current inpatients, as well as those undergoing day kidney dialysis treatment, to another private clinic in the city (Iefemerida, 2020). The Ministry of Health paid the private hospital clinics for the use of their facilities for the period they were used.

This example highlights the complex and highly challenging circumstances that precipitated a sudden change in the terms of the original agreement between the Ministry of Health and the private hospitals, undermining their relationship, eroding trust and escalating the dispute which was played out in the national media. With very little time available to discuss the requested change or negotiate alternative logistical solutions, communications channels were less than ideal. The urgent, high-pressure negotiations highlighted that while the parties shared the same objective – to support the need for additional COVID-19 beds during the current surge in hospitalizations – they fundamentally disagreed on the solution: the Ministry of Health maintained that utilizing additional (private) beds in Thessaloniki to treat COVID-19 patients would contain the risk of increasing virus transmission across the country, while the private clinics proposed that they could accept non-COVID patients from other prefectures to relieve pressure on the public hospitals there, enabling the latter to treat spillover COVID patients from Thessaloniki (Green Attica, 2020).

Although the arrangement was temporary and short term, the fact that the government authorities reverted to a sanction of last resort – the legal requisitioning of the required private hospital beds – in order to solve the bed capacity issue presents lessons on how a previously successful collaboration with private sector partners can go awry as a result of deviations from established agreements and obligations, and emphasizes the importance of having adequate procedures for resolving disputes.

Governance-enhancing lessons for entering into private sector engagements for the delivery of health services

Leveraging private sector resources and expertise holds the potential to enhance the effective delivery of health goods and services. Private sector engagements deliver value when they are in alignment with health system goals and priorities. It is important to note that:

- whether private sector engagements are part of mature mixed-delivery systems or are being contemplated as part of a policy solution to fill a health services gap, being able to draw on policy capacity to enter into such engagements is an important asset;
- setting clear objectives for both public and private actors helps to identify shared goals as well as appropriate incentives. It also makes clear the rationales for entering into collaboration and supports the monitoring and achievement of outcomes; and
- well structured agreements that reflect the health system's strategic objectives, and define respective roles, responsibilities and expectations, provide the necessary solid basis for engagements with private sector partners. They are also the basis for nurturing trust between partners and setting out avenues for resolving disputes.

4.2 Open, transparent and accountable procurement practices

Procurement was one of the major areas of private sector engagement during the pandemic. During this crisis, most countries had very limited capacity to produce face masks and other items of PPE domestically. At the same time, demand in both national and international markets was exceptionally high and disruptions to global supply chains led to widespread shortages. In this context, policy-makers saw the need to act swiftly in order to secure purchases to protect public health. Similarly, the centrality of COVID-19 testing as part of "test, trace and isolate" strategies to stem transmission of the virus required a massive ramping-up of laboratory processing of COVID-19 tests. "Crisis contracting" often involved relaxing or removing some administrative or procedural requirements that characterize normal channels for procurement of medical goods or contracting required services.

In this section we derive some insights from case studies from Lithuania, Germany and the United Kingdom, where private sector engagements played a big role in the supply of PPP. The case study from Estonia showcases how private sector capacity was used to provide critical laboratory testing and diagnostics during the pandemic.

Swiftly addressing governance challenges is beneficial and can lead to targeted improvements in procurement practices

Lithuania's efforts to secure PPE in the first year of the pandemic is a good illustration of how transparency and accountability are cornerstones of robust governance, and how upholding effective practices in these domains led to improved functioning of public procurement in health care (Box 7).

Box 7. Fast-tracked procurement to secure supplies of PPE in Lithuania



What was the objective of the private sector engagement?

During the very early onset of the COVID-19 pandemic, Lithuania found itself struggling to ensure sufficient supplies of PPE, such as masks and surgical gloves, and medical products to protect its health workers and population (Webb et al., 2022). COVID-19 crisis leaders took a number of immediate actions to make the procurement process with private companies more flexible and agile in order to ensure adequate supplies of PPE in a timely manner.



What kind of private sector collaboration was carried out?

In March 2020 the Lithuanian Parliament amended the Law on Public Procurement, simplifying the requirements for contracting: it waived the need to conduct public tenders for extremely urgent cases, allowed contracting with a private provider without submitting a written proposal, and did not require the list of mandatory terms and conditions that usually accompany public-sector contracts (OECD, 2020a). These changes enabled the government and health care providers to create fast-tracked purchasing agreements to secure massive shipments of PPE and disinfectants from China, as well as from European and local manufacturers (LRT, 2020; Ministry of Health Lithuania, 2020a).

Multiple players were involved in the Lithuanian procurement and purchasing strategy for PPE and medical products, each fulfilling a different task. These included needs assessment and coordination of purchasing (Ministry of Health); electronic cataloguing of authorized existing suppliers and identification of potential new ones (Ministry of the Economy and Innovation's Central Purchasing Organization (CPO) and its *Enterprise Lithuania* experts; Ministry of Foreign Affairs); entering into centralized purchasing agreements with suppliers (CPO) or direct agreements (individual health facilities); supporting delivery logistics (Ministry of Transport and Communications); and supervising and implementing procurement policy and legislation (Public Procurement Office (PPO)) (OECD, 2020a; CPO, 2023; Government of the Republic of Lithuania, 2020; Ministry of Health Lithuania, 2020b).

How governance challenges arose



The cooperation of all the stakeholders enabled the speedy procurement and purchase of medical products, particularly protective equipment, but at the expense of the regular tender processes. Health agencies became good at "smart and quick buys", which at first satisfied the primary goals of securing the availability of products. However, due to the amendment of the Law on Public Procurement, details of purchase terms became available only after the contracts were already signed and published, which hindered transparency. Public trust in political integrity related to government spending was also undermined, as the criteria for spending of public funds was not clear (Open Contracting Partnership, 2021).



Governance-related actions and outcomes

To counteract the negative outcomes of emergency contracts and maintain trust among the population, a number of remedial actions were taken to bolster transparency and accountability:

- In June 2020 the PPO reviewed contracts retrospectively and comprehensively revised all emergency agreements signed between January and May 2020 (Dvorak, 2020; Open Contracting Partnership, 2021).
- The terms of over 1200 COVID-19-related purchase contracts were published on the PPO website, putting them into the public domain.
- The PPO made it mandatory for all contracting public agencies to publish data on new COVID-19 contracts signed from June 2020 onwards in a timely manner (maximum 15 days after signing the agreement).
- Public agencies were also required to include in future contracts a clause regarding sanctions for low-quality supplies (OECD, 2020a).
- The experience inspired the creation of the *Karštos pėdos* ("Hot feet") dashboard, led by the investigative journalism agency *Siena*, a public database that provides insights into the interconnections between Lithuanian politicians, high-ranking civil servants and business (Karštos Pėdos, 2020).

It is important to note that national legislation and, in the case of EU countries, EU guidance on the options and flexibilities under public procurement frameworks allowed actions such as truncated timeframes for tendering or direct contracting in situations such as the COVID-19 emergency (European Commission, 2020). Nevertheless, from a governance perspective, pivoting to more flexible but non-standard procurement practices poses potential problems for transparency and accountability that need careful management.

In Lithuania, prompted by concerns raised about public spending and procurement practices from civil society actors, journalists and NGOs (such as Transparency International, Lithuania) the administrative authorities acted quickly and implemented an evaluation of the contracts that had been awarded so far. They also published the procurement register containing details of the awarded contracts on the PPO website, making them widely available.

The initial goal of the evaluation was to learn about the challenges of the first wave of procurement, and this revealed a number of lessons that could be used to inform future practices (Box 7). For example, the analysis disclosed that a total of €84.4 million had been spent on COVID-19-related medical supplies but the purchases were not diversified enough among suppliers: the top 10 contracts accounted for 49% of the value of all contracts awarded and 45% of the total went to two foreign suppliers (Open Contracting Partnership, 2021). Further evaluation of the data detected instances of dishonest firms selling fake, substandard and unverified PPE (Belford et al., 2020) and served as evidence for a criminal investigation. Thus, these findings also led to a call to diversify the supply chain and raised awareness among public-sector buyers. In addition,

the PPO started working on improving the Central Public Procurement Information System (e-public procurement) to turn it into a more efficient automated system – called SAULE IS (PPO Lithuania, 2020).

Apart from these specific benefits for the procurement system, on a wider societal level the PPO's strengthened governance actions promoted broader anti-corruption initiatives in the country, highlighting efforts to improve accountability at all levels and particularly at the interface between the public and private sectors (heads of departments and institutions in the public and private sectors) (Open Contracting Partnership, 2021).

Lack of transparency in procurement and in awarding contracts can make public authorities vulnerable to corruption

Open and transparent information about collaborations with private providers is also closely linked to public trust and the need to safeguard the integrity of government bodies involved in dispensing large amounts of public funds. This is a particularly important issue with regard to alleviating concerns about potential corruption or preferential treatment in awarding contracts. Without a doubt, having appropriate transparency and accountability mechanisms in place is crucial to ensure robust governance of contracting with private sector providers, not only in following clear processes to identify and consider potential private sector partners but also to justify the choices made when determining the awarding of contracts.

Two case studies from Germany and the United Kingdom provide strong examples of how processes meant to facilitate rapid and flexible procurement produced situations which fostered conflicts of interest and exposed lapses in procedural integrity. Both examples involve the role of personal connections of people in public office to secure supply contracts for companies that they were associated with or were recommended by them. In both instances, judicial proceedings were instigated that exposed weaknesses in corruption safeguards – which the authorities have addressed in a number of ways.

In the case of Germany (Box 8) both the implementation of internal party disciplinary procedures and the referral of the cases to the federal high court of justice demonstrate that functional accountability measures did exist at the time. Although the courts found that under current laws no corruption took place, it did identify the need for parliament to clarify rules applying to those in public office. The experience led to stricter rules and regulations on the declaration of financial interests of parliamentarians, which have strengthened accountability mechanisms even further (Bundestag, 2021; Ziet online, 2021). Just as importantly, the remedial steps taken address some of the ambiguity that surrounded the roles of parliamentarians at federal level, providing a better understanding of conduct and responsibilities, particularly with regard to lobbying on behalf of enterprises in which they have a financial stake.

Box 8. Fast-tracked procurement of face masks in Germany during the COVID-19 pandemic



What was the objective of the private sector engagement?

Private sector capacity was required to rapidly acquire protective face masks that were to be distributed immediately across Germany's population, to protect against the transmission and spread of COVID-19 infections.



What kind of private sector collaboration was carried out?

A variety of avenues was used to source the required quantities of face masks. However, from March 2021 onwards there were several high-profile cases of German politicians and parliamentarians being directly involved in securing contracts with private sector firms to supply face masks for government agencies, paying with public funds (DW, 2021). There is only very limited public information on how the procurement processes for the face mask contracts were carried out and to what extent they differed from regular procurement processes owing to the urgency that the pandemic presented.



How governance challenges arose

The main concerns that dominated public and media attention focused on allegations of inappropriate lobbying for mask suppliers, corruption and bribery, and on the legality of receiving financial rewards (commissions) from private companies for securing the contracts. Two such cases involved reports that politicians were said to have earned very large commissions for brokering activities within protective mask businesses. In one of the cases Germany's federal high court of justice heard evidence that a company headed by one of the politicians as CEO had received €660 000 through mask procurement, and in the second case the politician was closely affiliated with a company that had received €1.2 million for protective mask businesses from the German federal and the Bavarian state governments.

In its judgments in 2022, the court ruled that under current laws both politicians were acting in the interest of the companies they were working for and were involved in the mask deals as part of their company roles, and not in their capacities as parliamentary mandate holders. Thus, their actions were not unlawful and the accusations of bribery were not substantiated (MRD, 2022). Importantly, however, the court also ruled that if parliament considered that the cases exposed a gap in criminal law, it would have to take actions to address this omission.



Governance-related actions and outcomes

Actions were taken to introduce new accountability mechanisms and strengthen integrity. The need to rebuild public trust was a major impetus.

- Both cases were investigated and were referred to the courts to determine whether the activities were unlawful. Public funds paid out to the companies were confiscated while the investigations were ongoing, but were subsequently released after the court issued its judgments.
- While the investigation was occurring, the politicians involved, who denied any wrongdoing, were required to resign from their parliamentary mandates and their party posts.
- The political parties that the politicians belonged to instigated internal efforts to increase transparency and restore trust; these included a new policy for its members to declare any possible financial benefits in connection with pandemic-related transactions.

- As a direct consequence of this experience, the actions to increase public scrutiny were extended to Germany's federal parliament, which revised and adopted a new law mandating detailed declarations on all emoluments (fees, salaries and any other profits from employment or office) for all its members. Additionally, indirect engagements with corporations and private companies now have to be declared starting at 5% of the company's stock (previously, the threshold for declaring such an interest was an engagement of 25% or more).
- The minimum penalty for parliamentarians convicted of bribery and for persons trying to bribe parliamentarians has been increased to a sentence of one year in prison, with both of these violations now classified as criminal offences.

In the United Kingdom (Box 9) the use of a "VIP Lane" to expand the supply of PPE prompted the same high-level public and media debate as in Germany. A National Audit Office investigation found several shortcomings with the high-speed procurement practices undertaken during the first year of the pandemic, including the "VIP lane" initiative. Key issues were a lack of transparency and inadequate documentation for decisions on why particular suppliers were chosen, how potential conflicts of interest were managed and the fact that some contracts were retrospectively awarded after work had already begun (National Audit Office, 2020). Subsequently, in 2022 the use of the VIP lane was ruled to be illegal by the High Court, with the judge establishing that its operation was "in breach of the obligation of equal treatment" [of potential suppliers] (Guardian, 2022). This COVID-era experience led to a comprehensive review and reform of public procurement in the United Kingdom.

Box 9. The use of a "VIP Lane" to expand the supply of PPE in the United Kingdom



What was the objective of the private sector engagement?

During the initial outbreak of the COVID-19 pandemic, which saw skyrocketing demand and limited supply of PPE, the UK government sought active cooperation with the private sector to secure supplies.



What kind of private sector collaboration was carried out?

In March 2020 the UK government established new supply structures aiming to rapidly source and distribute PPE from a combination of existing and new suppliers. These new structures used streamlined procurement procedures, with the competitive dimension of tendering reduced or eliminated, and simplified oversight within government. In this context, a so-called "High Priority Lane", also referred to as the "VIP Lane", was created under the procurement programme to assess and process leads for potential suppliers of PPE recommended by ministers, Members of Parliament and other senior officials and through an online portal (UK Government, 2021; UK Parliament, 2022). This VIP Lane sat alongside a normal lane to process over 15 000 offers of support to provide PPE. The total value of contracts awarded to suppliers through the VIP Lane was approximately £1.7 billion (BMJ, 2021; House of Commons Public Accounts Committee, 2021).



How governance challenges arose

The VIP Lane resulted in the awarding of PPE contracts for a much higher proportion of suppliers from this group than from those identified through standard procedures (National Audit Office, 2020). The cost of the PPE purchased was also significantly higher than before the pandemic, although it remains unclear how much of this was due to the greater competition for limited supplies, and how much due to the purchasing approach taken (Tille et al., 2021).

Arguably, the streamlined procurement process enabled public payers to act in a more expedient and agile way. At the same time, the use of the VIP Lane ignited a heated public debate on the government's procurement practices during the COVID emergency, lack of transparency, particularly in the use of government-recommended suppliers, and the potential risk of fraud in the disbursement of public funds (Transparency International, 2021; UK Parliament, 2022). Reviews found shortcomings in the awarding of contracts, often without competitive tendering or publication of tender calls within the normal timelines, and the inadequate vetting of the chosen VIP Lane suppliers' experience in PPE markets or the quality and usability of their products (National Audit Office, 2020; House of Commons Public Accounts Committee, 2021).



Governance-related actions and outcomes

Actions to increase the transparency of past and future procurement processes, as well as improving integrity safeguards, included:

- an investigation by the National Audit Office, which produced its report in November 2020; and
- the experience prompted a Government Green Paper on reforming procurement processes (Cabinet Office, 2020, 2021) and subsequently a new Procurement Act in 2023.

Accountability mechanisms can still operate in situations where limited choices of providers are available

Choosing qualified private sector providers to collaborate with sometimes encounters barriers owing to very limited choices. The case of Estonia, which needed to significantly upscale its laboratory testing during the COVID-19 pandemic, illustrates the concrete operational and governance challenges facing public authorities when there is no real competitive market in a sector (Box 10).

Box 10. Using private sector capacity to upscale COVID-19 laboratory testing and diagnostics in Estonia



What was the objective of the private sector engagement?

In order to obtain a more accurate epidemiological overview of COVID-19 transmission, in April 2020 Estonia's Health Board updated its testing strategy to include people with symptoms as well as suspected cases. Having more people eligible for testing required the agency to expand testing capacities through private sector involvement.



How was the collaboration carried out?

In March 2020 testing capacity in the country was about 1000 tests per day, which included the Health Board's laboratory of infectious diseases, four national hospital laboratories and a private laboratory, Synlab, the largest medical laboratory operating in Estonia). The private sector played an

important role in scaling up Estonia's testing strategy and capacity. From late March 2020, using emergency situation provisions under the Public Procurement Act, and in line with European Commission guidelines (2020/C/108 I/01), the State Shared Service Centre (SSSC) entered into contracts with private testing companies through the direct negotiated procurement procedure (Riigi Teataja, 2017; Delfi Media AS, 2020).

During 2020 the contracts were short-term. For example, the first purchase contracts were signed in March for a total amount of €2.6 million and concluded on 16 April 2020. In practice, Synlab and Medicum carried out a lot of subcontracting for sampling and many health care providers were involved in actual testing. At that point, the private firms performed over 70% of COVID-19 tests (Delfi Media AS, 2020). In 2020 Synlab alone conducted over 750 000 PCR tests (Eri laid, 2020).

During 2021 the Health Board procured more COVID-19 sampling and testing services to further expand the country's capacity. This time the contracts ran for the entire year. Procurement calls, with a total final contract cost of €100 million, included a variety of services such as:

- 1) establishing and running sampling sites across the country;
- 2) providing mobile sampling brigade services for testing patients at home;
- 3) forming testing brigades in institutions such as nursing homes;
- 4) collecting COVID-19 samples and analysing them 24/7 in the laboratory;
- 5) transmitting results into the digilugu.ee patient portal; and
- 6) issuing results and test certificates to patients (digital or paper-based). (Health Board, 2020; Whyte, 2020)



How governance challenges arose

Two companies, Synlab and Medicum (the largest privately owned outpatient health care facility), were the only contractors bidding to provide the services and acted as joint suppliers in all the contracts (Riigihangete Register, 2020). In theory, the absence of other suppliers can potentially raise concerns about competitive pricing of the services to be provided.

In 2021 extending the contracts for testing services over a longer period of time (a year instead of 2–4 months) enabled Synlab to build on infrastructure assembled during 2020. Moreover, the very high number of COVID-19 cases and the flow of patients through sampling sites, as well as the laboratory working at full capacity, contributed to economies of scale during the peak of operations. Testing prices were able to fall – for example, the price per test decreased from €65 on average in 2020 to €49 in 2021 – contributing to higher efficiency in testing provision (Eri laid, 2020; Synlab Eesti, 2021).



Governance-related actions and outcomes

To increase transparency, new monitoring rules mandated the publication of contracts awarded under direct contracting in the digital *Public Procurement Register* within 30 days.

Register within 30 days.

The Estonian authorities took higher financial risks during the initial procurement and purchase agreements for the supply of laboratory services owing to the urgent need to increase testing capacity. Normally, openly negotiated procurement helps to achieve the desired level of competition and therefore has an impact on the final cost of contracts (OECD, 2020b). However, in a small country like Estonia, the competition is limited or non-existent in some economic fields. Therefore, direct procurement with the only contractors that had made a bid became the only way to meet the increased demand for testing. To increase transparency, new monitoring rules consolidated during the first year of the pandemic required contracts awarded under direct contracting to be published in a publicly available digital register within 30 days of concluding the procurement contract (OECD, 2020a). In addition, the Estonian government initially based its spending on testing services on short contracts. Due to the ongoing development of the pandemic and the continuity of extensive testing activities, the Health Board then turned to annual contracts and achieved higher cost-effectiveness per test (Health Board, 2020; Whyte, 2020).

Lessons for robust governance of procurement with the private sector

The specific COVID-era experiences on procurement showcased in the four case studies on Lithuania, Germany, the United Kingdom and Estonia highlight some major governance challenges that arose in these types of engagements with the private sector. They illustrate that open and transparent procurement practices – particularly in time-sensitive scenarios – strengthen accountability and safeguard against potential risks of corruption in contracting. Some key areas for the development of good practices in public procurement that could be put in place to secure transparency and accountability and maintain integrity include:

- as part of future emergency preparedness plans, establishing guidelines for emergency procurement and the legal basis upon which it is based; governments could take the opportunity to review and revise public procurement procedures generally, with a view to strengthening due diligence, as occurred in the United Kingdom with the government's Green Paper on reforming the procurement processes (Cabinet Office, 2020, 2021) and new legislation;
- as part of longer-term arrangements, building up stocks and reserves of PPE and other medical consumables to be deployed quickly in the event of emergencies and relieve pressure on "crisis contracting";
- pre-vetting companies and private health services providers in order to establish lists of preferred suppliers for medical goods and equipment and of private providers (Transparency International, 2021). Pre-planned agreements could be put in place with private health actors to be activated when necessary;

- instigating vetting processes that ideally would involve consultations with qualified professional bodies which can aid government authorities and advise on selection criteria that would ensure the inclusion of qualified candidates with established track records in the respective market or field, thus building up a reserve of trusted sources (Transparency International, 2021). Such processes provide a concrete opportunity to involve stakeholders with the necessary expertise and know-how to participate in the effective implementation of private sector engagements in procurement; and
- publishing public procurement guidelines, lists of pre-vetted companies and registers of procurement contracts so that they are in the public domain and widely available.

4.3 Equitable risk-sharing

In the period before vaccines were developed and made available, the COVID-19 pandemic forced countries to impose non-pharmaceutical interventions to protect their populations from infection, including border controls and closures, physical distancing, lockdowns and face covering (Rajan et al., 2022). These measures had heavy social and financial costs to society. The accelerated development of vaccines was expected to provide an effective means of mitigating the worst impacts of the pandemic and end the health crisis.

The pandemic demonstrated that during emergencies governments were prepared to take more risks than usual when entering into supply agreements with contractors, not only because of time pressures but also because the uncertainties and risks associated with not acting could also extract high costs. APAs for COVID-19 vaccinations provide some of the most salient examples and highlight all the key reasons why equitable risk-sharing should be addressed clearly and in detail when entering into private sector engagements. The case study examples from Israel, the United Kingdom and the European Union underline that sharing risks in an equitable manner is an important accountability requirement that needs to be explicitly addressed within private sector engagements.

APAs for COVID-19 vaccines illustrate the complexity of risk-sharing and how uncertainty presents particular challenges for accountability and transparency

Inevitably, there are complexities and trade-offs involved in balancing risk-sharing, achieving transparency and weighing accountability in vaccine procurement processes, particularly in times of emergency. The example of Israel's APA for the COVID-19 vaccine with Pfizer/BioNTech (Box 11) highlights the need for speed that underlined the decision to enter into APAs rather than proceed with more commonly used and lengthy vaccine assessment and authorization strategies (Gianfredi et al., 2021). In these circumstances, the Israeli government had the required technical capacities and experience to manage these agreements and to implement this policy priority (Rosen, Waitzberg & Israeli, 2021).

Box 11. Israel's APA with Pfizer/BioNTech to supply its COVID-19 vaccination rollout



What was the objective of the private sector engagement?

Israel's aim was to purchase and secure the supply of enough COVID-19 vaccine doses to vaccinate its population as soon as an approved vaccine was available from a producer.



What kind of private sector collaboration was carried out?

Israel signed APAs with several vaccine manufacturers to prepare for a mass vaccination rollout and ensure enough doses for the entire eligible population. In addition to securing the stipulated vaccine supplies, the contract with Pfizer/BioNTech included an Epidemiological Research Collaboration Agreement with the objective "to determine whether herd immunity is achieved after reaching a certain percentage of vaccination coverage". As part of this agreement, the government committed to collect and provide anonymized, aggregated epidemiological data about all residents (Real-world Epidemiological Evidence Collaboration Agreement, 2020; Waitzberg & Davidovitch, 2021), while assuring rapid distribution, deployment and use of the vaccine. Pfizer/BioNTech provided researchers and data analysts to jointly analyse and publish the results in peer-reviewed scientific journals.

Both parties fulfilled their respective commitments as expected: after December 2020 all Israeli residents who wished to be vaccinated had access to the vaccine, and Israel went on to consistently record among the highest vaccination rates in the WHO European Region (Rosen et al., 2021; Rosen, Waitzberg & Israeli, 2021). Moreover, many academic papers were published jointly by the Israeli Ministry of Health and Pfizer (Polack et al., 2020; Bar-On et al., 2021; Dagan et al., 2021; Haas et al., 2021; Burki, 2022).

Two decisions facilitated the signing of APAs. The first is somewhat unique to Israel in that the country does not usually run its own regulatory approval process for health technologies, and relies instead on the US Food and Drug Authority (FDA) or EU regulatory approval structures for this function. Once the FDA issued an emergency approval for the Pfizer/BioNTech vaccine on 11 December 2020, Israel moved to immediately license the vaccine through Regulation 29(a)(9) of the Israeli Pharmacist Regulations (Medical Preparations), 1986.³ The second factor was Israel's willingness to pay higher than the market price, reportedly US\$30 per dose in the case of the Pfizer/BioNTech vaccine (Dyer, 2021; Guzman et al., 2021; Winer, 2021). It is important to note that the race for the vaccine occurred in the context of "vaccine nationalism", where globally countries generally competed (instead of collaborated) for the vaccine (Wong et al., 2021).



How governance challenges arose

There were a number of risks and uncertainties within Israel's APAs for the COVID-19 vaccine:

Purchasing an unapproved product

Israel signed APAs with various vaccine manufacturers, including Pfizer/BioNTech, before the products received regulatory approval. The theoretical and concrete risk existed that the purchased vaccines could end up not being approved, or that they would not be cost-effective or safe. Specifically with Pfizer/BioNTech, the first Statement of Principles Agreement was signed on 13 November 2020, a month before the vaccine was approved by the FDA (11 December 2020). The Vaccine Purchase Agreement (Manufacturing and Supply Agreement) was signed on 1 December 2020, also before the vaccine

³ Notably, Israel decided to roll out the third (booster) dose of the Pfizer/BioNTech vaccine on 13 July 2021 before the FDA approval was issued (Ash, Triki & Waitzberg, 2023).

was approved; while the Epidemiological Research Collaboration Agreement followed on 6 January 2021 (Vigilance for human rights, 2022).

Purchasing a product that potentially would not be used

The vaccines that were purchased from the pharmaceutical companies Moderna and AstraZeneca were never used because the research collaboration agreement with Pfizer/BioNTech required the exclusive rollout of their vaccine for research purposes. Although having a diversified portfolio of vaccine supply options was a legitimate way of spreading the risk and ensuring that at least one of the vaccine producers would receive regulatory approval, it also means that part of the investment did not pay off. In practice, Pfizer/BioNTech became the monopoly supplier. In the end, some of the unused COVID-19 vaccine doses were donated to the Palestinian Authority and some resold to other countries.

Limited data for health technology assessment

The rapid pace of vaccine development and the lack of historic safety, efficacy and pricing data also made it difficult for all governments to make informed procurement decisions to ensure equitable and affordable access. There was no time for priority-setting mechanisms to review the evidence, measure costs and benefits or to conduct evidence-based comparisons between vaccines, and between vaccines and other COVID-19 interventions. Israel was the first country in the WHO European Region to roll out its mass vaccination campaign, when the levels of safety and efficacy in a real-world population rollout were not yet clear. At the time, this was a risk facing all governments and international institutions, such as the European Union, entering into APAs to secure vaccine supplies (European Court of Auditors, 2022).



Governance-related actions and outcomes

To raise the level of transparency, information on medical data provided to the pharmaceutical company under the Epidemiological Research Collaboration Agreement was published, although other parts of the agreement, as well as the main purchasing contract, are covered by commercial confidentiality and are not in the public domain.

The emergency context of the pandemic involved several uncertainties that make accountability and transparency particularly challenging. Equitable risk-sharing between partners aims to balance the potential impacts when dealing with a number of uncertainties, and in doing so ensure accountability. In the Israeli APA for COVID-19 vaccines, the desired aim of securing enough doses for the population was achieved but it also entailed a number of risks and uncertainties taken by the government: namely financial uncertainty on whether the products purchased in advance would receive regulatory approval for use, and uncertainty over the levels of safety and efficacy of the vaccines (Box 11).

In the Israeli case, by publishing the Epidemiological Research Collaboration Agreement, both the government and Pfizer/BioNTech were made accountable for their commitments for this aspect of the collaboration, with most of their respective responsibilities being a matter of public knowledge. Nevertheless, the section on “indemnification – limitation of damages and liability” has not been made public, and therefore it is not possible to assess the respective concessions made in the negotiations or the extent to which the parties are accountable for any faults.

For example, if the real-world epidemiological data had shown that the vaccine was not safe, it is not clear which of the two parties would be accountable to the population.

Commercial confidentiality clauses impose legal limits on what can be publicly shared

Confidentiality clauses are often an integral part of commercial agreements and pose particular governance challenges for private sector engagements in terms of meeting transparency expectations. However, steps can be taken to mitigate at least some of these concerns. Israel's Vaccine Purchase Agreement with Pfizer/BioNTech was consolidated and signed confidentially between the government and the company, as was the case for the Epidemiological Research Collaboration Agreement. As the vaccination rollout began, the population raised concerns regarding the level and type of data to be shared with Pfizer/BioNTech, as well as over individual data privacy and protection. To address this concern and increase the level of transparency, the Ministry of Health published most parts of the agreement on the Ministry's website on 17 January 2021, less than a month after the start of the vaccination rollout. While many parts of the published text were (and still are) redacted, all the information regarding the medical data to be shared has been put in the public domain. Two civil organizations sued the Ministry of Health, requesting access to the full agreement, but an Israeli court rejected the request, arguing that the omitted parts were justified by commercial confidentiality (Vigilance for human rights, 2022).

Equitable risk-sharing also includes measures to guarantee supply obligations

The COVID-19 pandemic also underscored the importance of establishing accountability and remedial measures in the event that private sector partners do not meet supply commitments. Box 12 provides a very cogent example of the importance of explicitly addressing supply disruptions in APAs, in this case the ones signed by the European Commission and the United Kingdom with AstraZeneca to supply the COVID-19 vaccine to their populations.

Box 12. The COVID-19 vaccine APAs signed by the European Commission and the United Kingdom with AstraZeneca



What were the objectives of the private sector engagement?

To secure large quantities of COVID-19 vaccines for their respective populations as part of the planned vaccination campaigns in the United Kingdom and European Union Member States respectively.



What kind of private sector collaboration was carried out?

In August 2020 both the United Kingdom government and the European Commission signed their respective APAs with the pharmaceutical company AstraZeneca for the purchase of the COVID-19 vaccine it was developing with Oxford

University. At the time the vaccine had not yet been approved by the United Kingdom's Medicines and Healthcare products Regulatory Agency or the European Medicines Agency. Under the APAs the buyers shared the development risk of the vaccine with the manufacturer, supporting scale-up of production capacity through down-payments. Emergency market authorization for the AstraZeneca vaccine was subsequently granted in the United Kingdom on 30 December 2020 and in the EU on 29 January 2021.



How governance challenges arose

The European Commission centralized its vaccine procurement in order to ensure fair distribution among the 27 Member States and to ensure supplies for the rapid launch of national vaccination campaigns that were starting at the beginning of 2021. Throughout 2020–2021 the European Commission signed APAs with a number of potential pharmaceutical suppliers developing a COVID-19 vaccine; the AstraZeneca contract was the first such APA concluded, committing to supply a total of 300 million doses once regulatory approval was received, with an option for a further 100 million. In January 2021 AstraZeneca informed the European Commission that it would only be able to deliver one quarter of the first consignment of 100 million doses the Commission was expecting to receive by March 2021, citing problems with production facilities and supply chains. In parallel, vaccine supplies to the United Kingdom under its APA were unaffected and were to be delivered as scheduled.

The significant shortfall in doses led to a legal dispute between the European Commission and AstraZeneca over the prioritization of vaccine supplies to the United Kingdom and the failure to deliver the required quantities to the European Commission. Part of the dispute revolved around lack of clarity and differing interpretations over the wording of delivery obligations and schedules in the APA (Isaac & Deutsch, 2021). Although the APAs signed with AstraZeneca by the United Kingdom and the European Commission were similar, a 2022 report by the European Court of Auditors found that unlike the United Kingdom, the European Commission's contract did not contain specific remedies to address production and supply chain disruptions. Additionally, the United Kingdom's APA included "priority delivery" clauses that ensured that their orders with the manufacturer were prioritized over any others, whereas the European Commission APA lacked a similar priority access clause (European Court of Auditors, 2022).



Governance-related actions and outcomes

Following a Belgian court ruling in June 2021 that AstraZeneca had breached its contract with the European Commission in prioritizing its vaccine supply to the United Kingdom, new and binding delivery schedules were negotiated between the two parties covering the rest of 2021 to March 2022. The European Court of Auditors also notes that EU negotiators were able to secure stronger provisions on delivery schedules in later contracts signed with other vaccine manufacturers in 2021 (European Court of Auditors, 2022).

Lessons for robust governance to ensure equitable risk-sharing

Key governance lessons highlight that comprehensively addressing risks within agreements provides appropriate protection to public payers and strengthens accountability of private sector suppliers. The redaction of confidential information from documents in the public domain makes it difficult to fully ascertain the level of risk-sharing that, de facto, took place in the three case study examples presented here. Nevertheless, the available information is sufficient to provide valuable lessons that can be applied in similar cases in future. Ideally, APAs should set out respective risk-bearing responsibilities for:

- health risks: safeguarding the safety of the population or targeted subgroups receiving the medical goods or services in question;
- financial risks: adequately securing the expected returns on financial commitments against potential liabilities or losses; and
- fulfilment risks: ensuring recourse measures in the event of delays or failures to supply the goods or services stipulated in agreements and to the required quality standards.

Covering all of these points not only ensures that the interests of the public sector partner are adequately protected but also contributes to the robustness and comprehensiveness of agreements, minimizing loopholes and ambiguities, even if all the details of these safeguards may not be able to be disclosed publicly owing to commercial confidentiality clauses.

More generally, similar to WHO recommendations recently proposed for public private partnerships (WHO Regional Office for Europe, 2023), undertaking a dedicated risk assessment focusing on financial costs and other risks to the public sector would be an advisable undertaking before entering into private sector engagements, no matter what their size and scope. This ensures fairness within the collaboration and that risks are not inordinately borne by the public sector partner.

5. Conclusions and policy implications

The experiences of private sector engagements during the COVID-19 pandemic demonstrate that robust governance practices are essential in order to maximize the benefits and effectiveness of such collaborations. When viewed through the lens of ensuring good governance, the selected case studies generate broad lessons that can help countries to identify opportunities, but also to avoid potential pitfalls in future shared activities with private sector partners. Additionally, keeping governance concerns at the forefront focuses attention on achieving three very important goals for public sector actors: meeting policy objectives and health system needs; achieving operational success in the delivery of services or outcomes; and securing financial probity in the allocation and spending of resources.

Table 2 summarizes some of the key elements of these lessons, tying them back to the illustrative case studies and the governance domains and behaviours that guided the analysis. Many of the lessons reinforce and confirm similar findings of earlier work done in this area, particularly from the WHO Advisory Group for promoting successful private sector engagement in health care (WHO, 2020b; 2022). A key point is that there are many reasons why publicly funded health systems include private sector entities within their provision ecosystems, whether these private partners are established suppliers of services governed by extensive regulatory frameworks or whether collaborations occur on a more ad hoc basis, spurred by necessity, as exemplified by the emergency response to the COVID-19 pandemic. Of course, the key aim of **harnessing private sector capabilities** is to **enhance the delivery of health goods and services** – and to do so in a way that effectively engages the private sector in alignment with health system goals and priorities.

Thus, from a public policy perspective, **goal alignment and compatibility** should be key drivers in establishing potential private sector engagements (Clarke et al., 2019). This is a minimum requirement and can act as the bedrock for any further developments that may be pursued by policy-makers and implementers in aligning institutional and regulatory structures that either promote or more actively integrate private sector engagements in mixed-provision health systems. Explicitly setting out the respective objectives of public and private sector actors and how they can achieve them within the collaboration crystalizes the shared goals and reasons for the collaboration, weighing these against any other means of achieving the stated objectives, such as using existing public structures, resources and capacities (WHO, 2020b).

Aside from securing goal alignment, the evidence gathered highlights some key lessons on how to foster successful private sector collaborations. Building and maintaining robust relationships with private sector partners, based on mutual trust, is facilitated if there is already a history and experience of using mixed-provider delivery models. But even in contexts where private sector involvement in the

health sector is more limited, key elements to **support trust and foster successful collaborations** can be developed through agreements that establish **clear roles and responsibilities, stable and predictable expectations and certainty over commitments and obligations**. Clear communication channels to discuss divergences or contingencies are also crucial, as is establishing avenues for resolving disputes. Together, these good governance practices provide an environment that respects the autonomy of actors and their decision-making capacities within the collaboration. But it also acknowledges that all partnerships are a relationship and need to be maintained through processes that are capable of finding solutions when problems arise.

Without a doubt, and in line with much of the academic literature on good governance, the cornerstone of robust and successful collaborations with the private sector is the implementation of mechanisms for **transparency and accountability**. Policy-makers should ensure that relevant details on contracting/procurement processes, tender registers and awarded contracts are in the public domain and able to be scrutinized. Promoting open and transparent information about private sector collaborations not only bolsters public trust but also **safeguards against potential risks of corruption or mismanagement of resources**. This includes following clear processes to identify and assess appropriate private sector partners, as well as to justify the choices made when determining the award of contracts.

Another essential requirement is to address **equitable risk-sharing** with private sector partners in an explicit and broad manner, so that potential risks to population health, as well as financial risks and those connected to fulfilling supply obligations and quality standards, are identified within collaboration agreements and fairly distributed between the contracting parties. In a nutshell, equitable risk-sharing protects public payers and strengthens accountability of private sector suppliers.

Taking stock of these lessons is a basis for building resources and developing focused tool kits for effective engagements with the private sector, such as the WHO web platform Country Connector on Private Sector in Health (<https://ccpsh.org>). This is all the more relevant since publicly funded health systems are likely to continue to draw on private sector capacity in the future. The fact that these lessons spring from the COVID-era engagements also highlights the importance of continual learning and adaptation: policy-makers should continuously learn from experiences and adapt governance frameworks accordingly. Embracing a learning mindset will enable health systems to improve and optimize private sector engagements for better outcomes.

Table 2. Governance-enhancing lessons emerging from private sector engagement during the COVID-19 pandemic

Governance domains and behaviours: opportunities and challenges	Case study examples	Lessons
Policy Capacity Delivering strategy	Lombardy region, Italy: 1) Upscaling of acute and ICU hospital beds 2) Supporting the COVID-19 vaccination rollout	<i>Harnessing Private Sector Capabilities</i> Leveraging private sector resources and expertise can enhance the effective delivery of health goods and services while engaging the private sector in alignment with health system goals and priorities.
Aligning structures	Lombardy region, Italy: 1) Upscaling of acute and ICU hospital beds 2) Supporting the COVID-19 vaccination rollout	<i>Prioritizing Goal Alignment and Compatibility</i> Establishing private sector collaborations based on clear objectives for both public and private actors ensures shared goals and appropriately targeted incentives, and supports the reasons for the collaboration and the achievement of stated
Enabling stakeholders Nurturing trust	Greece: Mobilizing private sector hospital beds to treat COVID-19 patients	<i>Building Trustworthy Partnerships</i> Relationships with private sector partners can be strengthened with well structured agreements that reflect the health system's strategic objectives, and clearly define roles, responsibilities and expectations – thus fostering trust. They can also establish effective avenues for resolving disputes.
Transparency Accountability Integrity Participation	Lithuania: Fast-tracked procurement of PPE Germany: Fast-tracked procurement of face masks United Kingdom: The use of a "VIP lane" to expand the supply of PPE Estonia: Upscaling COVID-19 laboratory testing and diagnostics Israel: APA for COVID-19 vaccines	<i>Embracing Transparency and Accountability</i> Policy-makers should ensure that contracting/procurement processes, tender registers and awarded contracts are publicly available. Promoting open and transparent information about private sector collaborations bolsters public trust and safeguards against potential risks of corruption/mismanagement of resources.
Transparency Accountability Policy Capacity	Israel: APA for COVID-19 vaccines United Kingdom and European Commission: APAs for COVID-19 vaccines	<i>Addressing Equitable Risk-Sharing</i> Explicitly addressing risk-sharing in private sector collaborations, covering health, financial and fulfilment risks, protects population health and secures expected outcomes while guaranteeing supply obligations and quality standards. It also provides protection to public payers and strengthens accountability of private sector suppliers.

Source: Authors

Annex. Governance frameworks

The literature on dimensions, modalities and principles of (good) governance is vast. It ranges from general analyses of governance within health-relevant policy-shaping and decision-making in the public sector (Greer et al., 2019); arrangements between the public and private sectors, such as PPPs, across different policy domains (United Nations Economic Commission for Europe, 2008; World Bank & Department for International Development of the United Kingdom, 2009; OECD, 2012; Interamerican Development Bank, 2019); and reports specifically focusing on engaging private actors in the field of health (Brinkerhoff & Brinkerhoff, 2011; Reich, 2018; WHO, 2020b; Tille et al., 2021).

It is striking that while no frameworks on good governance and its central principles are identical, there are two criteria that most scholars appear to agree are essential: transparency and accountability. Brinkerhoff and Brinkerhoff (2011) consider transparency to be one of the “international norms linked to good governance”. The World Bank & Department for International Development of the United Kingdom (2009) list both transparency and accountability, together with integrity, as good governance practices in PPPs, a view echoed by the Inter-American Development Bank (2019) and United Nations Economic Commission for Europe (2008), which considers them as two core principles when engaging the private sector in partnerships. Reich (2018) elaborates that transparency and accountability are the two core components of governance, and that these two dimensions are essential considerations for planning, assessing and improving the operations of partnerships between public and private actors in (global) health. He comments that transparency is important in its own right because it allows learning, contributes to accountability, and shapes organizational performance. Accountability provides a tool to ensure that engagement with the private sector is achieving its public interest goals, and in addition contributes to improved organizational performance.

Issues to do with good governance are by no means confined to these two principles. Safeguarding against unlawful practices such as corruption, fraud and misappropriation of funds, as well as against unethical behaviours, are also major concerns. Other common themes focus on positive processes that can be enablers of good governance, such as strong stakeholder participation and integration, and the achievement of key value-based aims, such as respect for human rights, inclusion, fairness, equity and efficiency (United Nations Economic Commission for Europe, 2008; Brinkerhoff & Brinkerhoff, 2011; OECD, 2012; Inter-American Development Bank, 2019).

The TAPIC framework, developed by Greer and colleagues (2016) is the result of an extensive mapping and synthesizing of the key principles of governance that have been identified and validated in the literature (Greer, Wismar & Figueras, 2016; Greer et al., 2019). In an attempt to provide a unified framework geared to policy concerns that is sensitive to context and applicable to public organizations

generally, the authors found considerable overlap, with many frameworks using different terms to refer to common preoccupations about governance and how to analyse it. Following a clustering exercise, the TAPIC governance framework identifies five dimensions where governance problems are likely to be sited. These are **transparency, accountability, participation, integrity** and **capacity**, abbreviated to the “TAPIC framework”. The approach focuses on identifying problems and troubleshooting existing policies.

The TAPIC framework stresses that while each of these domains has a positive connotation, these are dimensions of governance rather than imperative ingredients of *good* governance. From this perspective, the dimensions can provide a logic to identify, understand and provide solutions for governance problems, both in existing systems and in policies under consideration. It is important to note, however, that merely increasing the quantity of each of these individual domains does not necessarily translate into better governance (for example, too much accountability can translate into excess bureaucracy). Rather, viewing governance as discrete problems in one or more domains is a way to link it tightly to policy problems (Greer et al., 2019). This methodology can usefully be applied to asking relevant questions and analysing how the private sector has been engaged in providing health services and goods.

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