

Financing health care in the WHO South-East Asia Region: time for a reset

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Abstract

The coronavirus disease 2019 (COVID-19) pandemic is having a devastating impact and continues to take its toll in the World Health Organization South-East Asia Region. In addition to its direct impact on morbidity and mortality, the pandemic is adversely affecting economic activity as a result of lockdowns and voluntary social distancing. The average per capita economic contraction among South-East Asia Region countries is currently projected to be 5.3% in 2020, suggesting severe consequences for financing for health and sustaining progress towards universal health coverage. Health financing systems in many countries of the region – characterized by extremely low levels of public financing and a predominance of out-of-pocket spending – have contributed to weaknesses in primary health care (PHC), including in relation to pandemic preparedness and containing COVID-19. Without sustained countercyclical public spending and an increased priority for health in government budgets, countries will be likely to see a slowdown or even reversal in growth in public financing for health, which is already at a low level in several countries of the region. In the face of this economic adversity and fiscal tightening, efforts to improve the efficiency and equity of public spending on health will be key, especially for strengthening PHC and enhancing cost-effectiveness in terms of the choice and delivery of interventions. To this end, countries must emphasize the public health focus, improve targeting of public financing towards the poor and vulnerable, reduce fragmentation and duplication of financing flows, leverage strategic purchasing and cut wasteful spending. The COVID-19 pandemic also presents an opportunity to reset how health systems and PHC are prioritized and adequately financed in the countries of the South-East Asia Region, as areas of core public investment that not only contribute to better health outcomes but also are critical for ensuring a sustained economic recovery.

Keywords: COVID-19, economic impact, health financing, primary health care

Introduction

The coronavirus disease 2019 (COVID-19) pandemic is having a devastating impact globally. As of 2 December 2020, there have been more than 63 million confirmed cases worldwide and almost 1.5 million deaths, with the elderly and those with comorbidities suffering the most.¹ Because of weaknesses in testing and the registration of deaths, the actual numbers of cases and deaths are likely to be much higher. In addition to the direct impact of COVID-19 on morbidity and mortality, there are concerns about its longer term health impact among those who have recovered.² Although some countries have managed to contain the spread of COVID-19 using lockdowns combined with testing, tracing and isolation protocols, cases continue to rise in other countries. In addition, even among some countries that had initially contained the disease, subsequent waves are being observed, such as the one presently being experienced in the northern hemisphere, where colder weather is correlated

with higher rates of indoor mixing of people. These challenges are expected to remain until vaccines are widely available and an effective treatment is found. Lockdown- and fear-induced declines in utilization of routine health services – especially those delivered at the primary health-care (PHC) level such as immunization, antenatal care, and the detection and management of communicable and noncommunicable diseases – have also been recorded.^{3,4} Despite utilization levels returning to pre-crisis levels, these declines are likely to have a longer term impact on population health.

COVID-19 lockdown policies, as well as voluntary social distancing, have resulted in steep declines in economic activity globally. Consumption and trade have declined, followed by investment. As a result, the world is experiencing one of the largest declines in gross domestic product (GDP) in almost a century, unprecedented in magnitude and scale, with most countries expected to see negative economic growth – and all seeing a slowdown in economic growth – in 2020. Countries

that implemented more stringent lockdown policies and failed to contain the virus appear to have taken the biggest economic hit, as have those whose economies are more dependent on the services sector (including tourism), given that sector's greater dependence on face-to-face contact. Even those countries that have remained virus free to date, for example some Pacific countries, have not been immune to the economic contagion of COVID-19.⁵ Declining economic activity, including lower remittances, have resulted in a rise in poverty and a decline in employment, hitting those in the informal sector especially hard.⁶ As lockdown policies are slowly being reversed and the first phase of vaccine deployment begins, there have been early signs of recovery in many countries, with economic growth rates expected to rebound in 2021, albeit from a much lower GDP base; however, this remains subject to great uncertainty.

This paper focuses on the economic impact of COVID-19 on health financing in countries of the World Health Organization (WHO) South-East Asia Region. We argue that, although COVID-19 presents risks, it also provides an opportunity to reset health financing systems in many countries of the region, especially for financing PHC, sustaining progress towards universal health coverage (UHC) and improving future pandemic preparedness.

The remainder of this paper is organized as follows. The next section provides a brief summary of health financing systems in South-East Asia Region countries, underscoring the diversity of the region. This is followed by a summary of what is known about and predicted to be the economic impact of COVID-19 in the region and a discussion of some of the medium-term implications for health financing, especially for PHC. The paper ends with a brief summary and conclusions, including a discussion of possible mitigative policy options.

Health financing systems in the South-East Asia Region

The South-East Asia Region countries – Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-

Leste – are collectively home to over one quarter of the world's population. Most countries of the region are classified by the World Bank as being lower middle income, with national incomes per capita ranging between US\$ 1026 and US\$ 3995; the region is also home to three upper middle-income countries, that is, those with national incomes between US\$ 3996 and US\$ 12 375, namely Indonesia, Maldives and Thailand. The region is home to the second-, fourth- and eighth-largest countries in terms of population size (India, Indonesia and Bangladesh, respectively) as well as some of the smallest and least populated countries in the world (e.g. Bhutan, Maldives and Timor-Leste). Pre crisis, the estimated purchasing power parity (PPP) US\$ 1.90-per-day poverty rate was more than 20% in India and Timor-Leste and around 15% in Bangladesh and Nepal;⁷ over half of the population lived on less than PPP US\$ 3.20 per day in these countries.⁸

Health systems in the region are diverse. Private provision is relatively significant – accounting for 60–80% of outpatient visits and 40–60% of inpatient cases – in Bangladesh, India and Indonesia.^{9–11} In contrast, public provision dominates in Bhutan, Sri Lanka and Timor-Leste. The region is home to countries with some of the best health systems and health outcomes globally (e.g. Sri Lanka and Thailand) as well as those that have made tremendous progress in recent decades (e.g. Bangladesh and Nepal). Nevertheless, health system challenges – a hospital-centric focus, weaknesses in PHC, a relatively low density and maldistribution of health workers, suboptimal quality of care, and geographic and socioeconomic inequalities in access and outcomes, including deficiencies related to gender and urban health – remain in several countries, many of which have been made more visible as a result of the COVID-19 pandemic.

In terms of financing, health spending in most countries of the region is “small” relative to GDP. Current health spending as a percentage of GDP is the lowest of all WHO regions, at 4.4%, considerably lower than the 2018 global average of 6.6% (Table 1). Over the past decade, per capita health expenditure in the South-East Asia Region has increased from an average of US\$ 150 in 2009 to US\$ 195 in 2018, an annual growth rate of 3.0%, which was lower than the corresponding

Table 1: Public spending share of GDP and out-of-pocket (OOP) share of current health spending in WHO regions

WHO region	Per capita current health spending (US\$)		Current health spending share of GDP (%)		Public spending share of GDP (%)		OOP share of current health spending (%)		External share of current health spending (%)	
	2009	2018	2009	2018	2009	2018	2009	2018	2009	2018
Regional Office for Africa	112	133	5.7	5.6	1.7	1.8	40.4	36.6	22.3	22.1
Regional Office for the Americas	923	1063	6.9	7.2	3.7	4.1	34.6	32.4	3.6	2.0
Regional Office for the Eastern Mediterranean	531	642	5.0	5.4	2.4	2.6	39.7	36.0	2.5	3.0
Regional Office for Europe	2240	2447	7.7	7.6	5.1	4.9	28.6	29.8	1.1	0.4
Regional Office for South-East Asia	150	195	3.8	4.4	1.7	2.1	45.1	40.1	9.9	6.3
Regional Office for the Western Pacific	915	1078	7.8	7.1	4.3	4.4	19.3	19.1	16.9	12.9
All countries	1009	1138	6.6	6.6	3.4	3.5	33.2	31.6	9.5	8.5

Per capita health expenditures are reported in constant 2018 US dollars.
Source: Global Health Expenditure Database.¹⁶

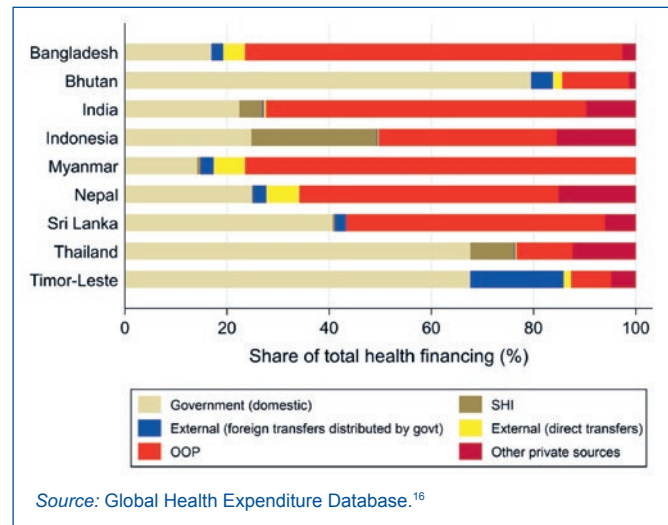
rate of per capita economic growth of 7.3% over the same period, consistent with global patterns.¹² At 2.1% of GDP, public spending on health is the second lowest across all WHO regions and far below the UHC benchmark of 5% of GDP.¹³ As a region, the South-East Asia Region has the highest share of out-of-pocket (OOP) spending for health, at 40%; this is far greater than the recommended UHC benchmark of 15–20% of current health spending.¹⁴ As a result, although service coverage has improved, the region's performance in terms of financial protection has lagged. The South-East Asia Region had the highest number of people, as well as percentage of the population, who incurred catastrophic spending across all WHO regions, with an estimated 16% of the population, or about 310 million people, spending more than 10% of their budget on health.¹⁵ In addition, the South-East Asia Region is the only WHO region that, despite a decline in the aggregate OOP share of current health spending, has seen an increase in OOP-induced impoverishment in recent decades using the PPP US\$ 1.90-per-day poverty line.

When it comes to the sources of financing, there is considerable variation between countries within the region. In Bhutan, Maldives and Thailand, public sources provide the predominant share of current health spending, while in Bangladesh, India and Myanmar OOP financing is the largest contributor of resources for health. External financing also plays a significant role in countries such as Myanmar, Nepal and Timor-Leste. Social health insurance (SHI) contributions are relatively minor in the region but growing in importance in countries such as Indonesia (Fig. 1).

For countries where data are available, average per capita PHC expenditure in the region was US\$ 42, ranging from US\$ 24 to US\$ 58 (from 38% to 73% of current health expenditure, respectively).^a While there is no target for what PHC expenditure “should” be, public spending on PHC is generally viewed as insufficient, accounting for less than 40% of the entire PHC budget in low- and middle-income countries. It has been recommended that public spending on PHC should increase by at least 1% of GDP to realize the Alma-Ata Declaration.¹⁸ When it comes to essential service packages, several countries of the region have adopted these in recent years, such as Bangladesh and Sri Lanka, to be offered largely at the PHC level. However, although such packages have been developed, reforms that would enable their effective implementation, for example to address weak supply-side readiness, improve capacity for the reallocation of existing resources, and enhance managerial accountability, have, by and large, not taken place.¹⁹

Purchasing is largely passive in many South-East Asia Region countries, with resources being allocated based on norms following historical patterns and without active monitoring and management of providers. In countries such as Bangladesh, Myanmar and Timor-Leste, where public resources are pooled by ministries of health, traditional public financial management rules are used, which in some cases are plagued with challenges such as low execution rates, heavy reliance on input-based, line-item budgeting structures, and vertical programme financing flows, which tend to be

Fig. 1: Variations in sources of financing for health spending in the South-East Asia Region, 2018



rigidly designed with limited flexibility.^b In countries that follow a decentralized governance model, key resources are controlled at subnational levels. These include India and Indonesia and, more recently, Nepal and Timor-Leste. Notable exceptions to passive purchasing in the region include Indonesia and Thailand, both of which have created strong institutional arrangements to carry out strategic purchasing functions. These include the setting up of provider payment mechanisms and tariffs that are results oriented as part of large-scale demand-side insurance schemes. India is also moving in this direction: the recently launched Pradhan Mantri Jan Arogya Yojana (PMJAY) scheme has established rules to empanel providers only when they meet certain criteria, and the new National Health Authority not only processes claims but also actively monitors quality indicators.^{20,21}

Economic impact of the COVID-19 pandemic

The South-East Asia Region was one of the regions with the highest number of new cases in the last week of November (Fig. 2). Within the region, India had the highest number of cumulative cases, with more than 10 million; as of 1 December, Maldives, with 24,050 cases, had the highest number of cumulative cases per million population.²² In addition to the health impact, the COVID-19 pandemic is having a severe economic impact on countries of the region. Before the crisis, the South-East Asia Region was the fastest growing region in the world. From 2009 to 2019, the annual economic growth rate in the region averaged 5.4% (4.2% in per capita terms), with Bangladesh, Bhutan, India and Myanmar posting some of the fastest annual GDP growth rates in the world, in excess of 6.0% per year (Table 2). Current projections indicate that the COVID-19 pandemic will result in a country-averaged economic contraction of –4.2% (–5.3% in per capita terms)

a The definition of PHC follows Xu et al.¹⁷

b The health sector is subject to the same set of public financial management rules as other government sectors.

Fig. 2. COVID-19 in the South-East Asia Region and other WHO regions

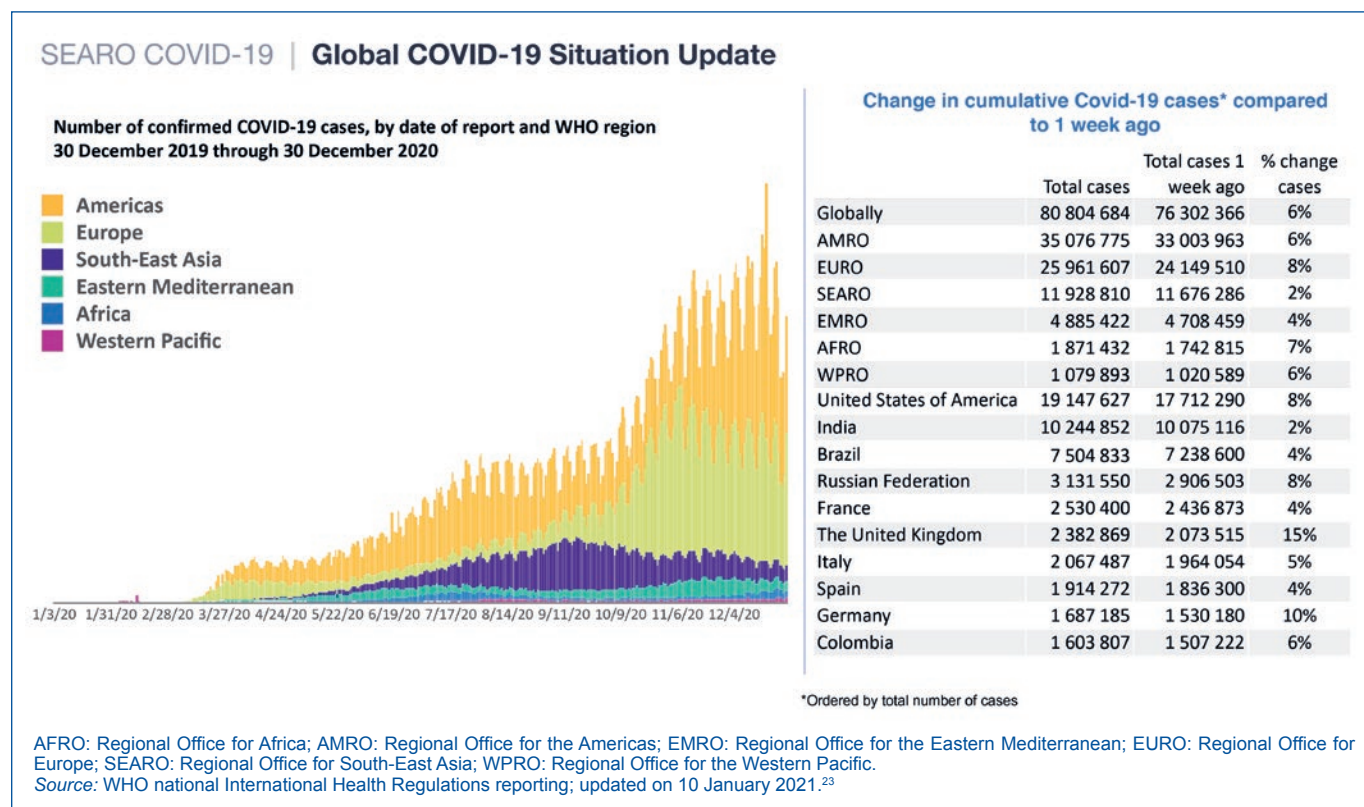


Table 2: GDP growth across WHO regions

WHO region	Average 2009–2019 (%)		Projected 2020 (%)		Projected 2021 (%)	
	GDP	Per capita GDP	GDP	Per capita GDP	GDP	Per capita GDP
Regional Office for Africa	4.0	1.6	-2.9	-5.1	3.7	1.3
Regional Office for the Americas	2.0	1.0	-8.3	-9.1	4.5	3.5
Regional Office for the Eastern Mediterranean	3.0	0.4	-9.4	-11.5	6.5	4.7
Regional Office for Europe	2.1	1.7	-5.9	-6.3	4.8	4.4
Regional Office for Asia	5.4	4.2	-4.2	-5.3	5.3	4.2
Regional Office for the Western Pacific	3.9	2.6	-4.1	-5.2	3.4	2.4
All countries	3.1	1.7	-5.7	-6.9	4.5	3.2

Source: International Monetary Fund.²⁴

across the South-East Asia Region countries in 2020. Although the region will not be the worst hit – Regional Office for the Eastern Mediterranean, Regional Office for the Americas and Regional Office for Europe countries are expected to fare much worse in terms of average economic impact – the 2020 contraction in the region will be especially deep relative to the 2009–2019 trend in growth rates and far greater than the impact of previous regional and global crises, such as the 2009 global financial crisis and the 1997–1998 Asian financial crisis. Despite current projections of an expected rebound in economic growth in 2021, on average, South-East Asia Region countries will lose several years of economic output and it may take as many years again for economic activity to return to pre-crisis levels (Fig. 3).

The country-level economic impact of the COVID-19 crisis is expected to be highly variable. Maldives is currently expected

to be among the worst hit globally, with a projected decline of 19.9% in per capita GDP in 2020 (down from an average growth of 3.2% over 2009–2019), primarily because of a decline in tourism. This is followed by India, which is expected to contract by 11.2%, down from an average economic growth rate of 5.9% over 2009–2019 (Fig. 4). On the demand side, India's contraction is driven by a decline in both consumption and investment; on the supply side, the contraction has occurred in both the manufacturing sector and the services sector.²⁵ Sri Lanka, Thailand and Timor-Leste are expected to see their economies contract by between 5% and 10%. On the other hand, both Bangladesh and Myanmar are projected to be among the few countries in the world not to contract in 2020; nevertheless, they too will still see considerable slowdowns in economic growth relative to trends. Bangladesh has seen a steep decline in exports, including garment exports, but robust

Fig. 3: The economic impact of COVID-19 in the South-East Asia Region

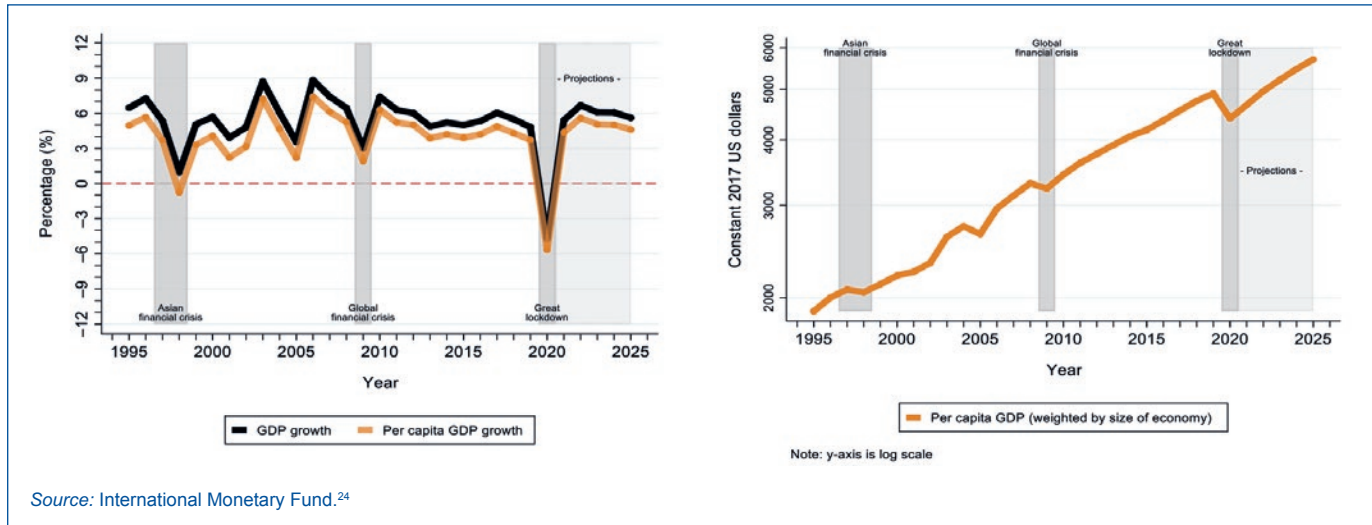


Fig. 4: The economic impact of COVID-19 across South-East Asia Region countries

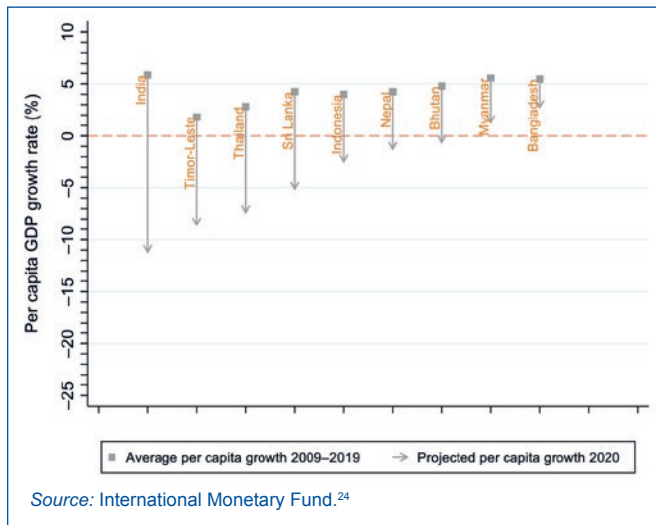
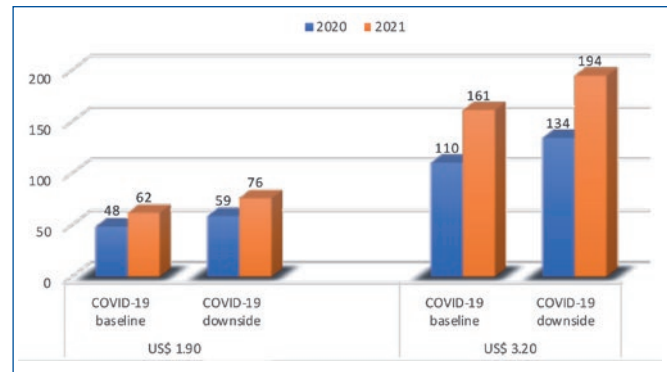


Fig. 5: Number of additional poor as a result of the COVID-19 crisis



remittances have bolstered consumption. Manufacturing is expected to contract in Myanmar, but the impact on the services sector has been less severe than expected.

The extended economic slowdown as a result of the COVID-19 pandemic has resulted in a deceleration in remittances to countries of the region. For example, downward projections, based on assumptions that the control of the epidemic and resumption of economic activities will take 1 year, have been made for India (9%), Sri Lanka (9%), Nepal (12%), Thailand (15.8%), Myanmar (17.7%), Timor-Leste (17.7%) and Indonesia (21.4%) in 2020.^{26,27} The pandemic has also worsened unemployment in the region, with a substantial estimated decline in global working hours during the first three quarters of 2020, resulting in an average of 30 million full-time equivalent jobs lost in the South-East Asia Region and about 100 million jobs lost in the South-East Asia and South

Asia regions.^{c 28} The crisis has disproportionately affected jobs in some sectors, such as the retail and wholesale trade, hospitality, recreation, manufacturing, and accommodation and food services sectors, with migrant and informal workers being among the worst-hit groups.²⁹ With a greater proportion of women working in some of the most affected sectors, the pandemic also threatens to derail efforts made to reduce work-related gender inequalities.

The COVID-19 crisis is estimated to push an additional 48–59 million people living in this region into extreme poverty in 2020. This could rise to as many as 62–76 million by 2021, depending on the severity of the projected economic contraction, comprising more than half of the world’s total⁷ (Fig. 5). Extreme poverty, defined as living with less than PPP US\$ 1.90 per day, is likely to affect between 7.2% and 7.7% of the entire region’s population this year, reversing two decades of a declining trend observed since 1998 (left side of Fig. 6). Measuring the impact against the PPP US\$ 3.20-per-day international poverty line, which is more appropriate for lower-middle-income countries, the picture becomes graver. Fig. 6 describes three scenarios: the “pre-COVID-19” scenario

c As categorized by the International Labour Organization of the United Nations.

Fig. 6: The impact of COVID-19 on the poverty rate in the South-East Asia Region

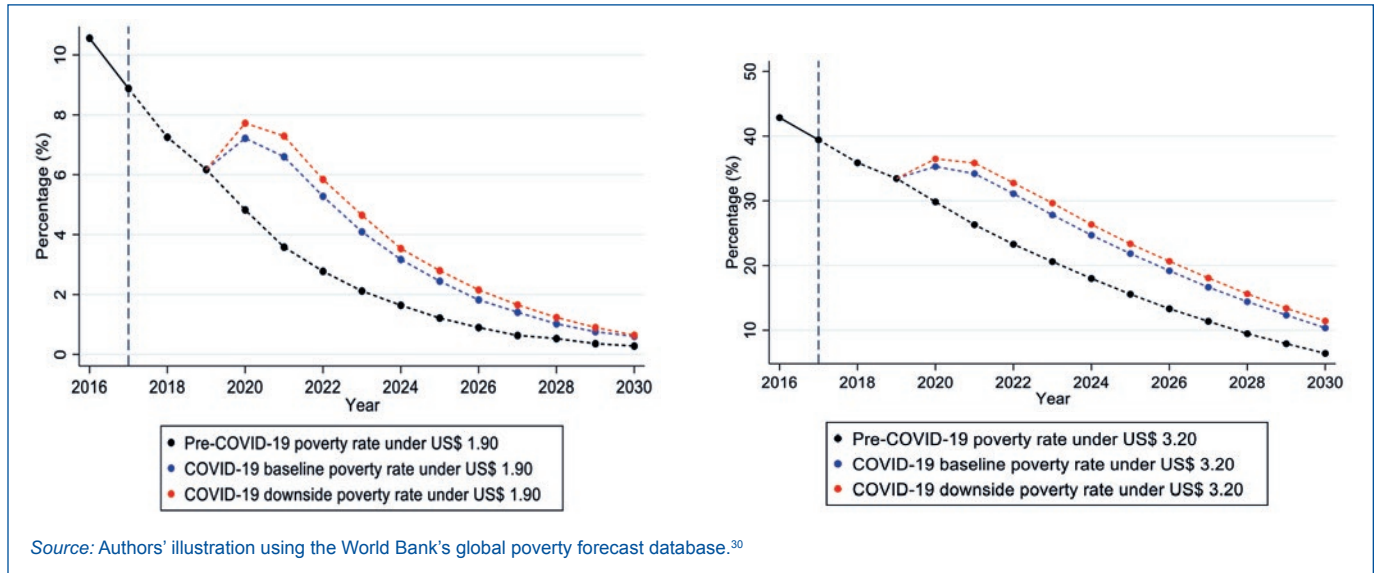
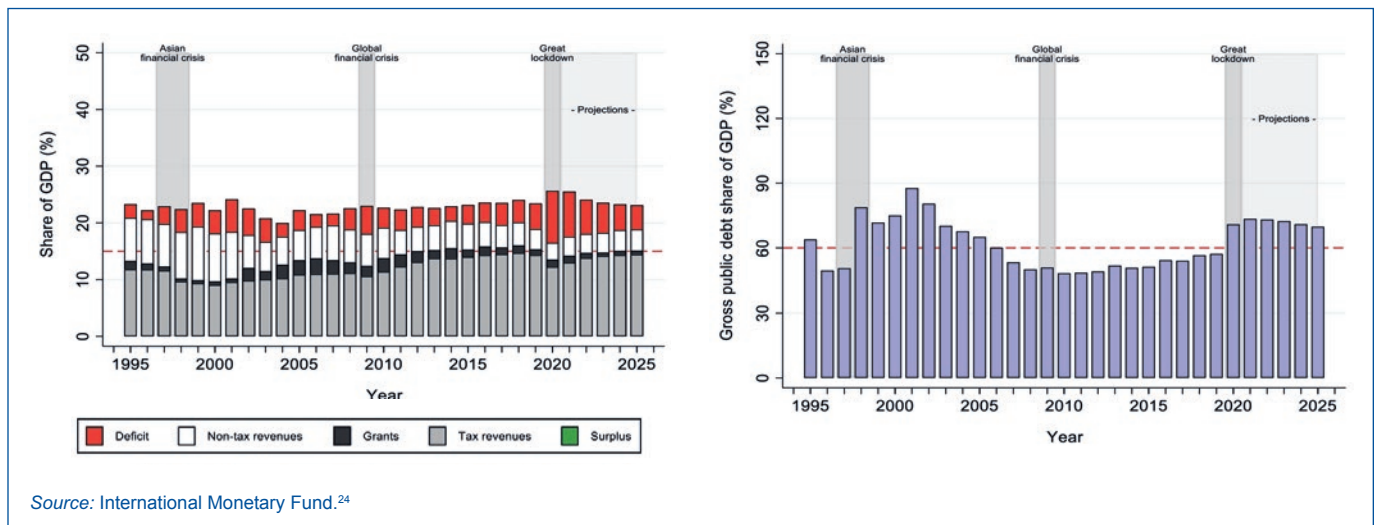


Fig. 7: Government spending by source of financing and gross public debt as a share of GDP across South-East Asia Region countries



depicts the would-be poverty levels had the COVID-19 crisis not occurred, while the “COVID-19-baseline” and “COVID-19 downside” scenarios were developed under the assumptions that the global economy will contract by either 5% (blue line) or 8% (red line) in 2020, respectively. Before the pandemic, more than one third of the region’s population lived below the PPP US\$ 3.20 poverty line, and the deceleration in economic activity intensified by the pandemic is projected to push an additional 110–134 million people below this line in 2020 (Fig. 5). Thus, without policy interventions, the COVID-19 crisis could induce greater income inequality in a region where income inequality was already considerably high before the crisis.

The economic slowdown has also resulted in declining government revenues, with the tax revenue share of GDP

– already low in the region relative to global benchmarks – declining by about 2% of GDP on average. The grant financing share of GDP is expected to remain largely unchanged, but overall government revenues will decline. Most countries have dramatically raised borrowing and, as a result, government expenditures as a share of GDP have risen (Fig. 7), primarily to finance the emergency pandemic response, for expanding social protection programmes and for countercyclical government spending.^d Consequently, public debt levels are projected to rise across the region – with levels already elevated prior to the crisis in some countries such as India, Maldives and Sri Lanka – to exceed 60% of GDP on average (Fig. 7). Higher public debt levels will imply higher debt servicing in the future and the potential for continued fiscal tightening, at least in the medium term.

^d Countercyclical government spending refers to policies that increase government spending and reduce taxes during recessions.

Implications for health financing in the South-East Asia Region

The economic impact of COVID-19 on health financing – beyond the immediate emergency surge financing response to the pandemic – is difficult to predict. Public financing for health is a function not only of economic growth – more accurately, the additional revenues and borrowing that are facilitated by economic growth – but also of what happens to overall public spending and to health's share of overall public spending, that is, to the priority that health receives in government budgetary allocations and the ability of the sector to absorb and utilize allocations effectively.³¹ The increase in public spending for health in South-East Asia Region countries over 2000–2018 was largely the result of conducive macro-fiscal factors such as rapid economic growth.³² In other words, the experience in the past has been overwhelmingly one of “a rising tide lifting all boats” rather than “faring better with a larger share” when it comes to health. Globally, public spending on health during previous crises has tended to contract with declining GDP, at least on average.³¹ However, this was not always the case, and especially so when crises were triggered by adverse health events. For instance, public spending on health increased in affected countries during the 2014–2016 Ebola epidemic in West Africa despite declining GDP because of reprioritization of health.⁶ Similarly, during the 2009 financial crisis several Organisation for Economic Co-operation and Development and European Union countries protected public spending on health by expanding deficit-financed total public spending.

If governments are committed to prioritizing health, such as, arguably, in Sri Lanka and Thailand, there may be less concern about the impact of COVID-19 on public spending for health. In other countries, the combination of countercyclical increases in public spending and declining levels of per capita GDP may imply across-the-board tightening; in such settings, in the absence of reprioritization of health, growth in public spending for health is likely to decline or even become negative in some countries, putting at risk substantial gains made towards advancing UHC in recent decades. For example, pre-crisis per capita GDP in India was roughly US\$ 2000, the public spending share of GDP was approximately 27% (a combination of the government revenue share of 20% of GDP and borrowing of about 7% of GDP) and health's share of public spending was approximately 3% (average of national and state-level funding), yielding per capita public spending on health of about US\$ 20, about 1% of GDP. With India's expected economic contraction of 11.2% and with levels of per capita GDP taking several years to return to pre-crisis levels, public spending on health will have to increase as a share of GDP, through sustained countercyclical overall public spending or by increasing health's share of overall public spending, in order to protect levels of and growth rates in public spending on health from declining, which were already low to begin with.

In Indonesia, where one quarter of public financing comes from contributory SHI revenues, fiscal sustainability challenges as a result of deteriorating labour market conditions and rising rates of poverty could emerge. Rising unemployment means fewer employed members paying into SHI schemes, while weakening wages may also mean lower contribution rates. A larger pool of unemployed and impoverished individuals may also result in additional calls on the government budget for subsidizing contributions. Transferring contributory coverage to non-contributory coverage will be an administrative challenge, with many likely to fall “between the cracks”. In addition, SHI schemes such as those in Indonesia are facing additional demands to cover medical expenses for COVID-19, including for testing, community-based isolation of mild cases, and inpatient care of severe cases. On the other hand, social distancing measures and reduced economic activity may lead to fewer road traffic accidents and reductions and delays in seeking elective and non-urgent care, as well as declines in other environment-related reasons for ill health (e.g. because of lower levels of air pollution). The net effect of all these factors on SHI finances is difficult to predict with certainty. Unpublished preliminary projections indicate that an additional 8 million individuals will be either unemployed or impoverished in Indonesia as a result of the pandemic. Indonesia's unemployment rate is projected to rise to 7.5% of the labour force in 2020, up from 5.3% in 2019, which equates to an additional 3 million people.³⁵ In addition, declining economic growth is projected to push another 5 million people below the poverty line.⁵ Given current coverage and contribution rates, this could potentially mean additional outlays to manage the loss in contributions and an increase in the need to provide subsidized SHI coverage.

Globally, data suggest a nearly one-to-one relationship between growth in national income and growth in aggregate OOP spending.⁵ Given the nature and magnitude of the contraction expected because of the pandemic, levels of OOP spending could decline throughout the South-East Asia Region. This effect will likely be aggravated by fear- and lockdown-related declining utilization trends, which are being observed in many countries. On the other hand, increasing rates of self-medication and higher co-payments may have the opposite effect, leading to higher OOP spending. Declining OOP spending, declining consumption and declining utilization would be likely to result in improvements in commonly used financial protection metrics, for example OOP shares of income/consumption, even though these improvements would be deceptive as they would be caused by foregone care rather than improvements in effective coverage. Foregone care would adversely affect both population health and economic productivity. This implies that public financing may need to increase even further if it is to help offset declining OOP spending trends. This may be necessary not only to help stimulate utilization more generally by removing additional financial barriers to accessing care, but also to manage greater relative utilization at public facilities, which may be

e Guinea, Liberia and Sierra Leone lost US\$ 2.2 billion in GDP during the Ebola outbreak.³³ However, general government health expenditure (GGHE) as a percentage of GDP nearly doubled in the three countries between 2010–2013 and 2014–2016. Similarly, the average GGHE per capita increased from US\$ 4 to US\$ 5 in Guinea, from US\$ 5 to US\$ 8 in Liberia and from US\$ 5 to US\$ 10 in Sierra Leone between 2010–2013 and 2014–2016. This corresponds to a substantial increase in the average external health expenditure per capita: from US\$ 5 to US\$ 9 in Guinea, from US\$ 21 to US\$ 23 in Liberia and from US\$ 15 to US\$ 57 in Sierra Leone between 2010–2013 and 2014–2016.³⁴

expected as a result of the economic shock resulting from the pandemic.^f The decline in OOP spending may also cause cash flow issues for providers, hence the need for increased public spending to sustain the survival of those who depend on such revenues. At the time of writing this paper, access to and allocation of vaccines against COVID-19 are still hotly debated and unaddressed issues. Governments should strive to make sure that financial barriers do not prevent the vaccines reaching those who are most in need.

Considerable uncertainty remains as to what might happen to external financing for health. Total levels of external financing have stagnated in recent years,⁹ at about US\$ 40 billion annually, and there is little evidence to suggest that the previous global financial crisis in 2008–2009 had any significant impact on external financing flows to low- and middle-income countries.³⁶ On the one hand, the fact that the economic shock is also affecting higher income countries may indicate an adverse impact on external financing flows; on the other hand, high-income countries are also the most likely to be able to weather the storm, at least in the short term, increasing government spending outlays by borrowing more, and, therefore, external financing may not be impacted as much. Given the communicable disease nature of the crisis, high-income countries have an interest in ensuring that COVID-19 is controlled not only within their own borders but also outside. As noted above, current projections indicate no significant changes in overall levels of grant financing provided to countries of the South-East Asia Region. It remains to be seen if these projections are borne out and, in addition, a lot of uncertainty remains as to the extent of the impact on health-specific grant financing not just in 2020 but also in 2021 and beyond. If external financing declines, public financing from domestic sources will need to increase even further to ensure that gains made in recent years are not lost as a result of the economic shock from the pandemic.

Summary and conclusions

The COVID-19 pandemic not only has had a direct impact on mortality and morbidity in South-East Asia Region countries but also will have indirect implications in the medium term for financing for health and for sustaining progress towards UHC, especially given the adverse economic impact that countries across the region are facing because of lockdowns and voluntary social distancing. The average economic contraction faced by countries of the region is currently projected to be 5.3% in 2020. GDP may take several years to recover to pre-crisis levels, with countries such as India, Maldives, Sri Lanka, Thailand and Timor-Leste being especially hard-hit. With lower levels of economic activity, public revenues have declined, and countries have ramped up deficit financing to increase public spending, leading to higher levels of public debt. Without sustained countercyclical public spending and increased priority for health in government budgets, countries will be likely to see a slowdown or even reversal of growth

in public spending on health, which is already low in several countries of the region. If previous trends are realized, OOP spending will also be likely to decline as a result of foregone care, and tremendous uncertainty remains around levels of external financing for health given that the economic shock from COVID-19 is also affecting high-income countries.

What might countries do during this period of economic adversity and fiscal tightening? Improving the efficiency and equity of public spending on health is key, now more than ever. Budgetary spending will need to be trimmed, without sacrificing outputs and outcomes – by strengthening PHC, enhancing cost-effectiveness, improving the targeting of public financing towards the poor and vulnerable, reducing fragmentation and duplication, and cutting other forms of waste – and it should be urgently prioritized, underscoring that a crisis can sometimes provide opportunities to implement necessary reforms. Such reforms could also facilitate reprioritization of health in countries where health has been historically underprioritized. In addition, the emergency surge financing response to COVID-19 in most countries of the region should also be directed towards strengthening health systems for routine health services, especially PHC, and bolstering core public health functions. This is an opportunity to be seized, rather than creating yet another vertical programme with its own parallel mechanisms, which could further undermine the capacity of already weak health systems in the region.

Where feasible, this may be an opportune time for countries to assess if health taxes – for example taxes on consumption that is harmful to health, such as the consumption of alcohol, tobacco, sugar, and taxes on carbon emissions – could be introduced or scaled up. Although the primary focus of such health taxes ought not to be to raise revenues but rather to improve health by addressing risk factors, during times of crisis they may play an important role in augmenting revenues.³⁷ Where there are concerns regarding the lack of progressivity of such taxes, some form of “soft earmarking” of additional revenues for pro-poor programmes could help mitigate their impact. Early debt relief is also an option as a form of provision of development assistance to countries most in need. Experience from countries that have participated in existing schemes, such as the Debt2Health initiative managed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, may offer a starting point.

As well as posing a challenge, the COVID-19 pandemic also presents an opportunity to reset how health systems and PHC ought to be prioritized and financed in countries of the South-East Asia Region, as areas of core public investment that not only contribute to better health outcomes but also are critical for ensuring a sustained economic recovery.

Disclaimer: The findings, interpretations and conclusions expressed in this paper are entirely those of the authors and do not represent the views of the World Bank, its Executive Directors or the countries they represent, nor of the World Health Organization, its Directors or its Member States.

f This will be important in several South-East Asian Region countries where the level of private provision is relatively high, such as Bangladesh, India and Indonesia.
g Even though the Institute for Health Metrics and Evaluation's estimates include financing from non-traditional donors (e.g. China), which are becoming increasingly important.

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