Fifth Annual Health Financing Forum
Part I: July 2020
Health Financing Resilience

Background Note

Introduction. The COVID-19 (Coronavirus) pandemic has forcefully reminded countries that health shocks can suddenly increase the need to spend on health services while at the same time reducing the capacity of governments to raise revenues. This double shock – on health and the economy – is unprecedented, at least in the last 100 years.

Immediately the virus started to spread domestically, governments needed to find additional funds for testing, treatment and containment. At the same time, they needed to try to maintain coverage with other essential health services while ensuring that financial protection levels did not fall.

This has been challenging. Containment strategies - including lock-downs, social distancing, closure of all but essential businesses and travel bans - reduced economic activity, international trade and employment. Both the IMF and the World Bank Group (WBG) predict that real GDP per capita will contract in most countries in 2020 and government revenues are expected to fall more than the declines in GDP.[1]

The purpose of this year's annual health financing forum, and this background note, is to explore key issues of health financing resilience in the face of COVID-19, what it means, what steps countries have taken in response, and what lessons have been learned to date.

Resilience to a sudden shock is, of course, only one part of the wider health financing agenda. Vulnerability recognizes that the capacity of some countries to be resilient in the face of shocks as great as COVID-19 is limited, and understanding how to identify which countries will have the greatest difficulty and how to best assist them during and immediately after the crisis is critical.

Health financing sustainability is the capacity to continue to progress towards UHC – doing what is known to work in health financing - while adapting to a set of more predictable long-term processes that will increase the need to spend on health or reduce the capacity to raise revenues. Examples are rising non-communicable disease burdens, more people surviving to older ages, and labor market changes such as a slower rate of formalization than expected and the growth of the digital economy.

[1] IMF currently expects real GDP in low-income countries to grow at 0.4%, while the WBG is predicting an increase of 1.5%. Taking into account population growth rates, however, both predictions of real GDP growth imply a fall in real GDP per capita.

The questions of health financing vulnerability and sustainability will be explored in Part II of this year's Annual Health Financing Forum, when countries hopefully enter into the recovery phase. Part I focuses on resilience.

What is health financing resilience? Resilience in health financing can be defined as the ability to absorb and respond to unpredictable shocks that immediately increase the need for health spending and reduce the capacity to raise revenues (Kurowski et al. 2020a).

The terms "absorb and respond" to a shock covers all areas of health financing – revenue generation, pooling to spread financial risks and ensure access to needed health services with financial protection, and purchasing or provision of needed health services. Table 1 summarizes the key immediate requirements for resilience cutting across the three health financing functions, ordered according to the key policy questions or actions. The relevant health financing function is shown in italics. The table also outlines some of the policy options relating to health financing that countries can consider and which can contribute to the immediate requirements.

Table 1: Requirements for health financing resilience

	Immediate requirements	**Possible policy decisions to facilitate immediate requirements[2]**
1.	Increase access to health funding, immediately and for the duration of the emergency (*Revenue Generation*) (*Purchasing – what to purchase or provide*) (*Revenue Generation*)	**Government level** a. Release any emergency funding (contingency funds, disaster funds). b. Fiscal and monetary policy decisions that allow increased government spending in the face of declining revenues – e.g. deficit financing, increased government borrowing, lowering of interest rates.[3] c. Fiscal policy to increase the share of government spending to health. **Health sector** d. Shift financial and other resources, including health workers, from other services to emergency services. **External sources** e. Release international emergency or disaster funds, increase DAH or shift development assistance from other health areas to health.
2.	Rapidly deploy and use available emergency funds (*Supports Purchasing and Pooling*)	a. Ensure treasury functions and PFM rules work, possibly requiring interim amendment of rules to facilitate more rapid, timely and flexible disbursement and use.
3.	Increase health service capacity and quality for the response phase (*Purchasing*)	a. Increase financing of public health functions in addition to clinical services: for example, to prevention, monitoring, data analysis and use.

[2] Not all are applicable to every country. These are options for countries to consider.
[3] There are many more – see Kurowski et al. (2020b) for a discussion of fiscal and monetary policies during the pandemic and their possible impact on health financing.

	b. Increase purchasing from private sector services, with development of appropriate payment mechanisms. c. Modify procurement or contracting arrangements with service providers as needed. d. Provide flexible resources to the facility or community levels to meet needs such as contact tracing. e. Finance quality improvement for services as part of the emergency response in both public and private facilities (e.g. protective materials, appropriate cleaning). f. Offer financial or other incentives for health workers addressing the emergency. g. Reduce barriers such as tariffs on imported medicines and health products needed for the emergency response.
4. Safeguard financing of essential health services not linked to the emergency (*Purchasing*).	a. Prioritize the health services that are essential to maintain and identify which ones can wait to the recovery phase. b. Ensure and sustain funding and other resources to essential services. c. Modifying or enforcing treasury and PFM rules (point 2) also supports financing for non-COVID-19 health services.
5. Improve health system efficiency related to the emergency response and other health services (*Mostly purchasing, but applies to all functions*).	a. Search for ways to improve efficiency – many options include: negotiate lower prices for medicines, use more generics, ensure treatment at appropriate level of care, use of digital technologies.
6. Ensure financial protection in health does not fall (and hopefully increases), and that care foregone due to out-of-pocket payments (OOPs) does not increase (hopefully falls).[4] (*Pooling*)	a. Include pandemic-related testing, treatment, rehabilitation costs in insurance packages, or free of charge to patients. b. Explore options to reduce OOPs (or at least ensure they do not rise, officially or unofficially). c. Increase coverage of financial transfers for the poor and vulnerable. d. Expand guaranteed health entitlements and financing.
7. Consider what mechanisms would "build back better" resilience in the event of subsequent shock. (*All financing functions*)	a. Review progress during the immediate response phase so that things that worked well can be maintained and things that did not work can be rectified.

Some of the key decisions related to health financing occur in the health sector – for example: shifting resources from other health services to the pandemic response; prioritizing other health services that are essential to maintain in the face of the crisis; payment mechanisms for increased use of private sector service delivery capacity; and decisions about OOPs charged at public facilities.

[4] Given the fall in disposable incomes, current levels of OOPs will either deter the use of needed services or result in higher rates of financial catastrophe or impoverishment.

Others require the ministry of finance and the central bank. The most important is the question of how to increase government spending in the face of declining revenues, requiring ministries of finance to borrow and, frequently, central banks to lend more to the ministry of finance and create more money to stimulate the economy.[5]

Still other decisions require interaction with other parts of government –the temporary amendment of treasury rules, increases in financial transfers to the poor which can compensate them ameliorate the impact of any OOPs on declining disposable income, and ensuring that testing, treatment and rehabilitation for the health emergency are covered by insurance are examples.[6] This highlights the importance of a whole-of-government approach to health financing resilience.

Country responses. Examples of all of the policies described in Table 1 can be found in the wide variety of responses to COVID-19 observed across countries. Countries at all income levels have increased government spending by running budget deficits funded by increased borrowing. Public debt to GDP ratios have, therefore, increased substantially. At the same time, many have shifted resources between sectors, giving more priority to health. The combined effect of these measures has allowed governments to increase the resources available for the health-related pandemic response, as well as to increase fiscal transfers to the poor, to people who have lost their jobs and to businesses which cannot operate among other things.

Central banks have supported the fiscal response by injecting money into the system to protect employment to the extent possible and support increased government spending. More details of the fiscal and monetary responses can be found in the IMF Tracker (IMF 2020) while their implications for health financing are discussed in Kurowski et al. (2020b).

As yet, evidence around the other areas of Table 1 is largely anecdotal, one of the reasons why the WBG and other agencies have developed tools to understand what is happening to health financing at the country level. For example, it is clear that many of the high-income countries deferred "non-critical" health procedures during the peak of the response to COVID-19. The pent-up demand is slowly starting to be addressed, but it is not clear whether there has been a cost in terms of increases non-COVID-19 mortality and morbidity, nor whether the same policies were followed in low- and middle-income countries. On the other hand, it is clear that in some countries people have chosen to stay away from health facilities, perhaps because of the fear of being infected with the virus, while hospitalizations because of traffic accidents have fallen due to the slow-down in economic activity and lock-downs.

A related question is whether countries have developed explicit criteria for deciding which non-COVID-19 services had to be protected and financed even during the crisis, and how they did this. This is important for understanding what could be done better if there are subsequent waves of COVID-19, or subsequent pandemics.

The extent to which DAH has increased in response to the epidemic is also important to understand. It did during the Ebola crisis of 2013, but then, only three countries required funds and none of the donor countries were suffering from the pandemic or suffering economic

[5] The central bank can "create" assets on its balance sheet to buy long term government bonds and, sometimes, commercial bonds, a process called **quantitative easing**. This allows commercial banks to lend more, injecting money into the economy. Other mechanisms include reducing the capital buffers and reserves commercial banks are required to hold, and reducing the discount rate which reduces commercial bank lending rates.

[6] Treasury rules can be regulated by the ministry of finance or a separate government department – e.g. a Treasury – depending on the country. Similarly, health insurance rules might be administered by a ministry of health, and ministry of social security, or a quasi-independent authority.

downturns. Whether donor countries feel capable of increasing DAH, or whether development assistance will be repurposed from one area to another, remains to be seen. On the other hand, many of the low- and lower middle-income countries have benefited from the release of global emergency or disaster funds, increased support from the international financial institutions, and debt relief (Malpas 2020; Saldinger 2020; World Bank 2020).

Many countries announced that COVID-19-related health services would either be free of charge or covered by health insurance. Whether OOPs are still being levied, officially or unofficially, for these services or whether they have changed for other types of health services is not yet clear. It is clear that the disposable income of many households will have fallen, not just because of unemployment but also because of reduced remittances (Ratha et al. 2020). This reduces the capacity to pay for any existing OOPs for other types of health services. Increased fiscal transfers might have compensated for this, though it is too early to know.

A range of steps have been taken to increase the health system's capacity to respond to COVID-19 testing and treatment, including compulsory or voluntary use of private sector capacity. Evidence of the type of payment mechanisms used is only now beginning to emerge, and will be considered further during the Forum. Similarly, any steps countries have taken to improve health sector efficiency will be explored during the Forum, building on anecdotal evidence of the increased use of both telemedicine and mobile phone technology for contact tracing (and telemedicine).

Some lessons on resilience. The situation with COVID-19 is still evolving, so fiscal and monetary policy and health financing responses are also still evolving. Definitive conclusions on the lessons learned cannot be made at this stage, but the Forum will be an opportunity to debate and discuss what has happened.

Four issues are worth mentioning at this stage to stimulate discussion. First, for future pandemics, it would be important for countries to have agreed, pre-shock, how they will decide which existing health services need to be maintained at all costs, and which ones can be put on hold. This needs to be translated into a way of ensuring that budgets are managed to ensure that the agreed prioritization is applied, perhaps by protecting specific budget lines. In many countries, anecdotal evidence suggests that individual health facilities decided which services they could continue given the availability of money, beds and staff, rather than countries or regions deciding on their priorities.

Second, there seem to be considerable difficulties getting funds rapidly to the frontline in many LICs and LMICs during the pandemic, hampering the provision of essential services at primary level. This is, of course, a long-standing problem in many countries, but modifications or enforcement of public financial management rules are not as yet effective. Perhaps some of the modifications to treasury rules could be considered for longer term application if they prove to be effective in getting funds to the pandemic response rapidly, and the funds are used appropriately.

Third, national legislation sometimes has not allowed disaster funds to be used for health emergencies, and parliamentary approval for other sources of funding has not been rapid.

Fourth, cash transfers as part of fiscal policy typically target the poor. In a health emergency such as COVID-19, households with high health risks need to be included as well – e.g. people with pre-existing health conditions.

Other lessons reinforce previous knowledge about the requirements for high performing health financing. For example, increased collaboration with private sector providers requires strong skills to negotiate and enforce prices and contracts, and sometimes changes in legislation.

More detailed analysis of individual countries will reveal additional lessons, and one of the purposes of this Forum is to explore them in more detail.

Implications for the Forum, Part I. Part one of the 2020 Forum will explore the meaning of health financing resilience. It will explore in more detail what countries have done in response to the COVID-19 (Coronavirus) pandemic, something that is evolving continually, and what lessons can be drawn at the moment. The objective is not just to foster mutual learning so that countries can gain inspiration during the response phase, but to begin consider and understand how countries can build back better in terms of stronger resilience to any future shocks.

Part II of this year's Forum will follow-up by examining country vulnerability to health shocks, and health financing sustainability questions associated more with the recovery phase.

References

IMF, 2020. Policy Tracker. https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19

Kurowski, C., D.B. Evans, A. Irwin and I. Postolovska, 2020a. COVID-19 (coronavirus) and the future of health financing: from resilience to sustainability. World Bank Blogs, 4 May, 2020. https://blogs.worldbank.org/health/covid-19-coronavirus-and-future-health-financing-resilience-sustainability

Kurowski, C., D.B. Evans, A. Tandon and I. Postolovska 2020b (forthcoming). Fiscal and Monetary Policy Changes in Response to the COVID-19 (Coronavirus) Pandemic: Implications for Health Financing. World Bank Brief.

Malpas, D., 2020. Debt relief for the world's poorest countries. World Bank blog, 1 May 2020. https://blogs.worldbank.org/voices/may-1-2020-end-week-update-debt-relief-worlds-poorest-countries

Ratha, D.K., S. De, E.J. Kim, S. Plaza, G.K. Seshan, N.D. Yameogo, 2020. COVID-19 Crisis Through a Migration Lens. Migration and Development Brief no. 32, Washington DC, World Bank. http://documents.worldbank.org/curated/en/989721587512418006/COVID-19-Crisis-Through-a-Migration-Lens

Saldinger, A., 2020. G20, IMF deliver on debt relief, but more is needed, experts say. Devex. Inside Development: Covid-19. https://www.devex.com/news/g20-imf-deliver-on-debt-relief-but-more-is-needed-experts-say-97021

World Bank, 2020. PEF allocates US$195 million to more than 60 low-income countries to fight covid-19. Press Release, 27 April 2020. https://www.worldbank.org/en/news/press-release/2020/04/27/pef-allocates-us195-million-to-more-than-60-low-income-countries-to-fight-covid-19