ECONOMIC IMPACT OF COVID-19
IMPLICATIONS FOR HEALTH FINANCING IN ASIA AND PACIFIC

DISCUSSION PAPER SEPTEMBER 2020

Ajay Tandon
Tomas Roubal
Lachlan McDonald
Peter Cowley
Toomas Palu
Valeria de Oliveira Cruz
Patrick Eozenou
Jewelwayne Cain
Hui Sin Teo
Martin Schmidt
Eko Pambudi
Iryna Postolovska
David Evans
Christoph Kurowski

Public Disclosure Authorized

/

WORLD BANK GROUP
Health, Nutrition & Population

ECONOMIC IMPACT OF COVID-19

Implications for Health Financing in Asia and Pacific

Ajay Tandon, Tomas Roubal, Lachlan McDonald, Peter Cowley, Toomas Palu, Valeria de Oliveira Cruz, Patrick Eozenou, Jewelwayne Cain, Hui Sin Teo, Martin Schmidt, Eko Pambudi, Iryna Postolovska, David Evans, and Christoph Kurowski

September 2020

Health, Nutrition, and Population (HNP) Discussion Paper

This series is produced by the Health, Nutrition, and Population Global Practice of the World Bank. The papers in this series aim to provide a vehicle for publishing preliminary results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations, or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character.

The World Bank does not guarantee the accuracy of the data included in this work. The boundaries, colors, denominations, and other information shown on any map in this work do not imply any judgment on the part of the World Bank concerning the legal status of any territory or the endorsement or acceptance of such boundaries.

For information regarding the HNP Discussion Paper Series, please contact the Editor, Martin Lutalo at mlutalo@worldbank.org or Erika Yanick at eyanick@worldbank.org.

Health, Nutrition, and Population (HNP) Discussion Paper

Economic Impact of COVID-19:
Implications for Health Financing in Asia and Pacific

Ajay Tandon,[a] Tomas Roubal,[b] Lachlan McDonald,[b] Peter Cowley,[c] Toomas Palu,[a] Valeria de Oliveira Cruz,[d] Patrick Eozenou,[a] Jewelwayne Cain,[a] Hui Sin Teo,[a] Martin Schmidt,[a] Eko Pambudi,[a] Iryna Postolovska,[a] David Evans,[a] and Christoph Kurowski[a]

[a] Health, Nutrition, and Population Global Practice, World Bank, Washington, DC, US
[b] Health Systems and Services, World Health Organization, Geneva, Switzerland
[c] Health Policy and Financing, World Health Organization, Geneva, Switzerland
[d] Health Systems Development, Regional Office for South East-Asia, World Health Organization, New Delhi, India

Abstract: COVID-19's impact has gone far beyond its direct effect on morbidity and mortality. In addition to adversely impacting non-COVID health care utilization, the pandemic has resulted in a deep global economic contraction due to lockdown policies and declining demand and supply of goods and services. As a result, most countries are experiencing lower levels of GDP, rising unemployment, higher levels of impoverishment, and increasing income inequality. Some countries are more vulnerable to the economic contagion resulting from COVID-19, including those implementing more stringent lockdowns and those that are more globally integrated due to their dependence on trade, tourism, and remittances. In addition, countries with "preexisting conditions" of fiscal weakness due to higher dependence on external grant financing, low tax revenues, and large precrisis debt levels are struggling to implement countercyclical mitigative fiscal and monetary policies. In addition to declining economic activity, government revenues have declined, government borrowing is increasing, and public debt levels are projected to skyrocket globally. Higher debt levels will likely imply fiscal tightening for years to come. Implications for health financing are potentially dire, dependent in part on the combination of domestic government, external, and out-of-pocket financing for health that is extant across countries. Tentative projections indicate that, in the absence of reprioritization, growth in public spending for health could decline across most low- and middle-income countries in the region, including becoming negative in some cases, risking reversal of gains made toward expanding universal health coverage in recent years. To reduce the likelihood of such a scenario, and with the caveat that protecting levels of financing will not be effective if resources are not used properly to begin with, ministries of health will need to pay careful attention to planning and budgeting—demonstrating where waste can be reduced and efficiency enhanced—and prioritize within their outlays interventions that are the most cost-effective and equitable. At the same time, ministries of finance should improve the adequacy and predictability of outlays for the sector, taking a multiyear programming perspective and include potential additional resources that will be necessary to procure and deliver a COVID-19 vaccine, once an effective one becomes available. In doing so, they should consider augmenting resources via increasing the scope and breadth of health taxes and proactively seeking out debt relief opportunities, especially if these can be tied to efforts to reprioritize health within overall government budgets where this might be necessary. Whereas there is the perception that the health sector has been flooded with new resources to respond to the pandemic, it remains unclear to what extent these have been additional and not a result of reprogramming of outlays from other areas within health. To the extent COVID-19 presents an opportunity, it is one for removing any doubts that health and the economy are inextricably linked, nudging both ministries of health and finance to reevaluate their priorities, accountabilities, and performance to sustain improvements in both population health, including for ensuring pandemic preparedness, and economic performance.

Keywords: Health financing, COVID, economic impact, Asia and Pacific, public expenditure on health

Correspondence Details: Ajay Tandon, MC 11-841, 1818 H Street, NW Washington, DC 20433, USA; tel. 202-473-6338; e-mail: atandon@worldbank.org; website: http://www.worldbank.org.

Table of Contents

ACKNOWLEDGMENTS

The authors are grateful to the World Bank for publishing this report as an HNP Discussion Paper. They are also grateful for comments and feedback received from Reem Hafez, Hideki Hagashi, George Schieber, Jack Langenbrunner, Joe Kutzin, Owen Smith, Michael Borowitz, and Emiko Masaki. The paper also benefited from discussions between the World Health Organization, Asian Development Bank, and the World Bank on this topic, and inputs from Patrick Osewe, Andrew Cassels, Baoping Shang, Manoj Jhalani, and Stefan Nachuk, among others, are gratefully acknowledged as are those from Somil Nagpal and webinars hosted by the Joint Learning Network collaborative on Domestic Resource Mobilization.

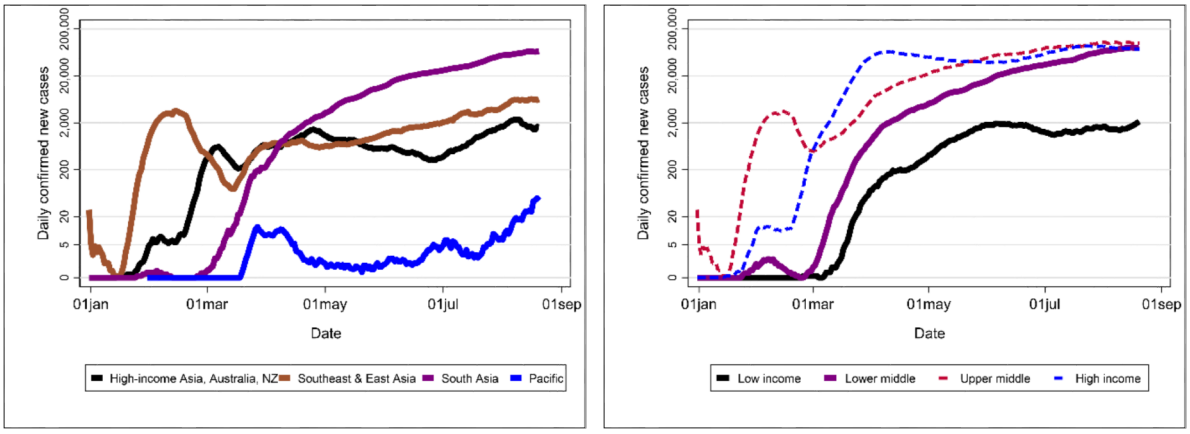
PREFACE

This paper has been prepared by a team comprising staff and consultants from the World Health Organization Western Pacific (WPRO) and Southeast Asia (SEARO) Regions, and the World Bank South Asia (SAR) and East Asia and Pacific (EAP) teams in conjunction with the World Bank's Health Financing Global Solutions Group under the overall guidance of Aparnaa Somanathan (Practice Manager for the EAP Region); although the note summarizes some global trends as well, a fuller landscaping of trends and implications for health financing across all low- and middle-income countries is forthcoming later in the year, after current projections have been updated in October. Current projections reported in this paper reflect best available forecasts from the International Monetary Fund and the World Bank. These data are subject to change and are meant to be indicative; results need to be interpreted with caution; and the findings are designed to stimulate policy dialogue around potential challenges related to the economic impact of COVID-19 on health financing.

INTRODUCTION

COVID-19 continues to extract a heavy health toll in terms of its impact on morbidity and mortality, with countries across Asia and the Pacific being at very different stages in the evolution of the pandemic. Initially identified and reported in China's Hubei Province, the coronavirus has now spread to almost all countries in the world.[1] Globally, as of August 15, 2020, more than 20 million individuals are confirmed to have been infected and >750,000 have died as a result of the infection, with most deaths occurring among the elderly and among those with comorbidities; globally, new infection rates remain in the vicinity of almost 250,000 per day.[2] Whereas the pandemic peaked in China in February 2020, within the region its locus appears to have now shifted to South Asia (SA) with a large number of cases continuing to increase in India.[3] Cases also continue to increase among several middle-income Southeast and East Asian (EA) countries, including in the Philippines and Indonesia.[4] The outbreak appears to be plateauing among most high-income (HI) countries in the region, including Australia and New Zealand, despite isolated outbreaks that are continuing to happen (Figure 1 also shows comparisons with global incidence by income category).[5] To date, Pacific (PA) countries—almost all of which are small island states—continue to be largely spared the direct health effects of the pandemic.[6]

Figure 1. Daily Confirmed New Cases of COVID-19



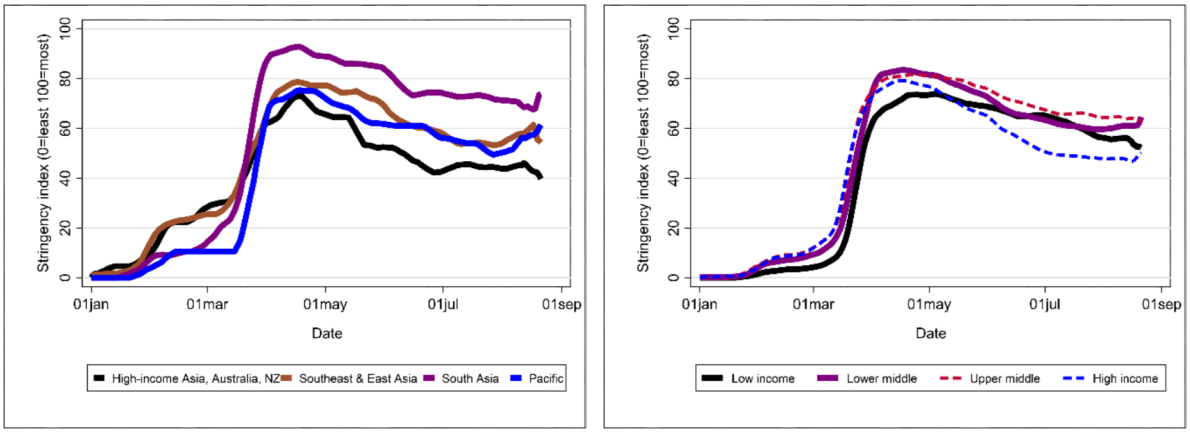
Source: Roser et al. (2020).

Several mitigation and suppression policies—collectively dubbed the "great lockdown" of 2020—put in place by governments to stem the spread of the pandemic are now slowly being removed (IMF 2020a). These have included closure of schools and nonessential businesses and restaurants, limitations on retail activities, cross-border and intracountry travel and trade restrictions, social distancing mandates against public events and gatherings, stay-at-home orders, as well as curtailment of public transportation, among other restrictions. The intention of lockdown measures has been not only to slow the spread of the pandemic but also to reduce the burden on health systems, given estimates that roughly 20 percent of all cases appear to require hospitalization and 5 percent require intensive care. The stringency of the lockdown—summarized in the form of a "stringency index" derived from an ordinal scale

1. At the time of writing Kiribati, Marshall Islands, Micronesia, Nauru, Democratic People's Republic of Korea, Palau, Samoa, Solomon Islands, Tonga, Turkmenistan, Tuvalu, and Vanuatu were the only countries that had not reported any cases.
2. In many countries, the number of cases is likely to be undercounted due to poor testing rates.
3. SA countries include Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka.
4. EA countries include Cambodia, China, Indonesia, Lao People's Democratic Republic, Malaysia, Mongolia, Myanmar, the Philippines, Thailand, Timor-Leste, and Vietnam.
5. HI countries include Australia, Brunei, Japan, New Zealand, Singapore, and the Republic of Korea.
6. PA countries include Fiji, Kiribati, Marshall Islands, Micronesia, Nauru, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

capturing the nature and extent of the lockdown across countries with 0 representing no lockdown and 100 representing the most stringent lockdown measures, as summarized in Figure 2—shows an easing of restrictions across most countries (Hale et al. 2020).

Figure 2. Lockdown Stringency Index



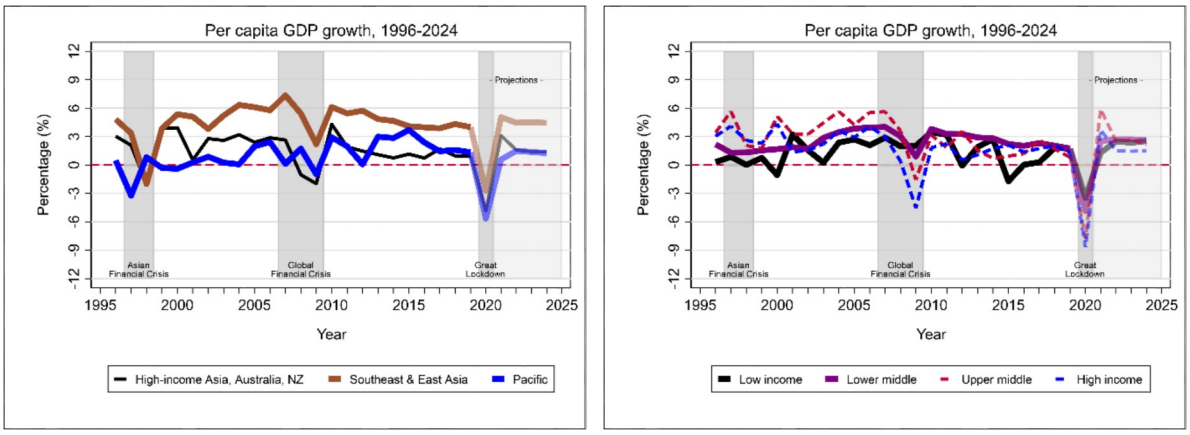
Source: Hale et al. (2020).

This paper summarizes some of the projected collateral economic damage expected to result from COVID-19 and discusses implications for health financing. We summarize the projected economic impact of COVID-19 and discuss potential implications for public and other sources of health financing across countries in Asia and the Pacific. The data presented are based on the latest available information at the time of writing.

PROJECTED ECONOMIC IMPACT OF COVID-19

COVID-19 is resulting in a deep global economic contraction. The full extent of the economic "shock"—which is affecting both the demand and supply of goods and services—remains unclear, but indications are dire. Sharp declines in capital and remittance flows in low- and middle-income countries (LMICs) have occurred, along with declines in oil and commodity prices. Latest projections indicate that declining consumption, investment, and trade is resulting in a global contraction of gross domestic product (GDP) across most countries, regardless of the extent to which the coronavirus spread within their borders (Figure 3). Globally, economies are expected to contract on average by -6.7 percent in per capita terms in 2020.[7] Across Asia and the Pacific, PA countries—with an expected contraction of -5.7 percent—are expected to be the hardest hit followed by -4.8 percent among HI countries, -4.0 percent among SA countries, and -2.7 percent among EA countries.[8] The economic shock in 2020 is likely to be more severe than those that occurred both during the 2007–2009 Global Financial Crisis and the 1997–1998 Asian Financial Crisis.[9] As a result of this contraction, unemployment, poverty, and income inequality rates are projected to rise across the region as well as globally (World Bank 2020a).

Figure 3. Longer-term Trend of per Capita GDP Growth, 1996–2024



Source: IMF (2020a).

Some countries in the Asia and Pacific region are far more vulnerable to the economic contagion from COVID-19 than others. Economic vulnerabilities can take several forms, but two that are key in the current context are the degree of external integration with the global economy (e.g., dependence on commodity and other exports, tourism, foreign investment, etc.) and the degree to which countries are fiscally vulnerable (e.g., have low revenues, high debt levels, high inflation, etc.) (World Bank 2020a). Countries such as Cambodia, Fiji, Maldives, Thailand, and several PA countries—all with tourism revenues greater than 10 percent of GDP in recent years—are facing challenges. Exports as share of GDP are high—>50 percent of GDP—in Cambodia, Fiji, Malaysia, Mongolia, Solomon Islands, and Thailand. Levels of external debt (both public and private) are high in Lao People's Democratic Republic, Mongolia, and Papua New Guinea. Although levels of external debt are not that high, short-term external debt levels—those expected to be paid within a year—are particularly high in China, Malaysia, Thailand, and Timor-Leste. Large balance of payment deficits—that is, countries that are importing goods, services, and capital more than they are exporting—increase vulnerabilities for Cambodia, Fiji, Lao People's Democratic Republic, and Mongolia. Lao People's Democratic Republic, Mongolia, Papua New Guinea, Solomon Islands, and Timor-Leste are highly dependent on commodity

7. These are based on the latest data from the IMF's World Economic Outlook update.
8. These are simple country averages, not weighted by population. PA countries, due to issues of scale, tend to have volatile numbers, which should be interpreted with caution because even small changes can cause big fluctuations.
9. Unlike previous global and regional crises, which were caused by problems in financial markets, it is not entirely clear what the recovery from the current crisis will look like; hence, projections remain subject to much uncertainty.

exports. And remittances exceeding 10 percent of GDP exacerbate vulnerabilities in Marshall Islands, Nepal, the Philippines, Samoa, Tonga, and Tuvalu. Overall, countries with the highest levels of external vulnerability across several of the abovementioned dimensions include Cambodia, Fiji, Mongolia, Solomon Islands, and Thailand. Countries in SA are relatively less integrated with the global economy compared to those in EA and PA.

Pre-COVID fiscal vulnerability was also already high in several countries, constraining their ability to implement countercyclical fiscal and monetary policies. Over one-third of government revenues are from external grants in Kiribati and Tuvalu, putting them at risk given the economic impact from COVID-19 is also affecting HI countries. Revenue shares of GDP were low relative to comparators in Bangladesh, Indonesia, Pakistan, and Timor-Leste. India, Lao People's Democratic Republic, Maldives, Pakistan, Sri Lanka, Timor-Leste, and Vietnam were already running large deficits before the pandemic. Pre-COVID gross debt levels were in excess of 60 percent of GDP in Bhutan, India, Lao People's Democratic Republic, Maldives, Nauru, Pakistan, and Sri Lanka.[10] And many countries in the region—including Bangladesh, India, Indonesia, Myanmar, Pakistan, Papua New Guinea, the Philippines, Fiji, and Sri Lanka—had debt service shares that averaged more than 10 percent of general government expenditures, higher than the share of the budget going to health. Inflation rates were relatively high in Bangladesh, Mongolia, and Nepal. Across all the abovementioned indicators, Fiji, India, Lao People's Democratic Republic, Malaysia, Pakistan, and Sri Lanka appear to be the most fiscally vulnerable countries in Asia and the Pacific. And unlike the case for external vulnerabilities, fiscal vulnerabilities were generally higher in SA versus EA and PA countries.

Country-specific economic impacts are expected to vary significantly. Fiji, Maldives, and Palau are expected to be among the worst hit, with an expected contraction of >10 percent in 2020 (Figure 4). Others including Afghanistan, India, Malaysia, the Philippines, Solomon Islands, Thailand, Timor-Leste, and Vanuatu are projected to contract between 5 to 10 percent. Five countries in the Asia and Pacific region—Bhutan, Brunei, China, Myanmar, and Vietnam—will not see an economic contraction but will still see a slowdown in economic growth rates relative to trends. The remainder will see contractions of less than 5 percent. Across Asia and the Pacific, per capita GDP growth rates are expected to be -7.3 percent lower in 2020 compared to the trend over 2009–2019 (Table 1). Given that it was a high-growth region precrisis, SA countries will see some of the largest declines relative to trends, down by -8.1 percent.

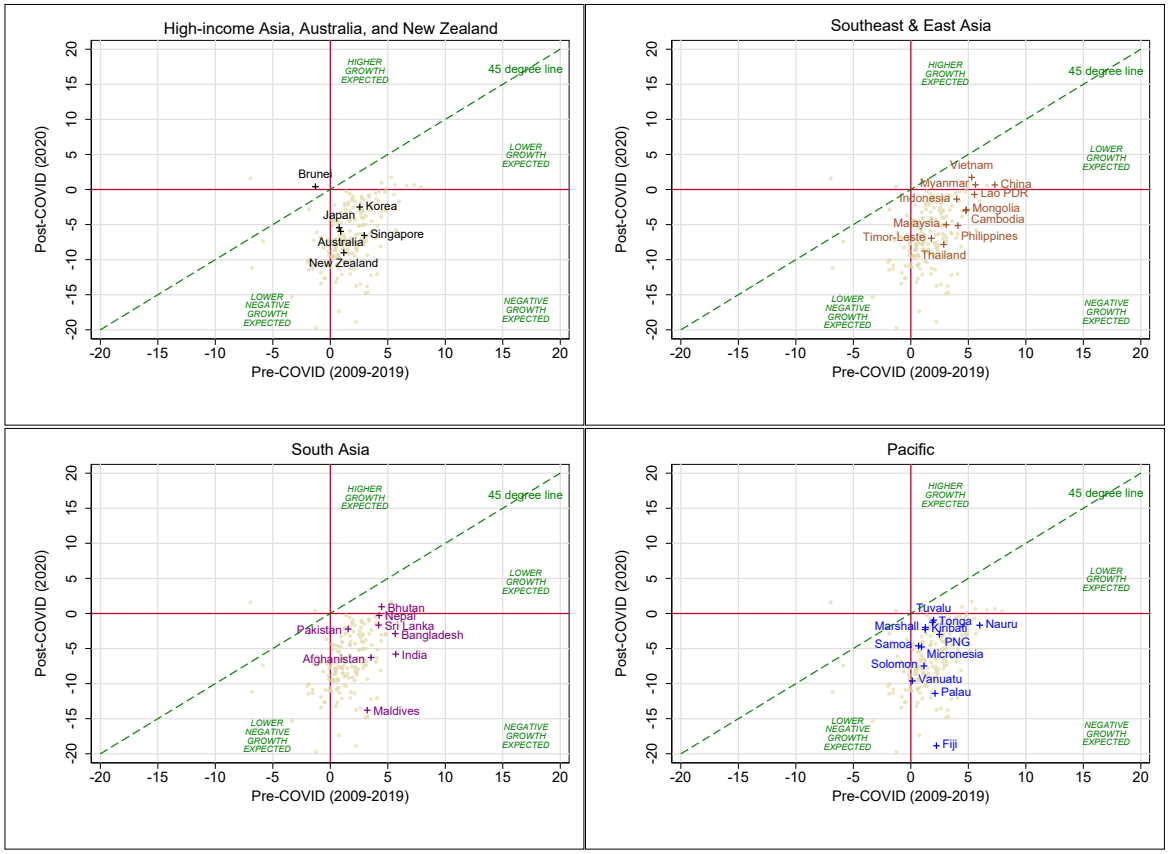
Table 1. Projected Impact on per Capita GDP Growth, 2009–2020

Classification	N	Average 2009–2019 (%)	Projected 2020 (%)	Difference (%)
High-income Asia, Australia, NZ (HI)	6	1.2	-4.8	-6.0
Southeast & East Asia (EA)	12	4.5	-2.7	-7.2
South Asia (SA)	8	4.1	-4.0	-8.1
Pacific (PA)	11	1.8	-5.7	-7.5
All Asia & Pacific	*37*	*3.0*	*-4.3*	*-7.3*
Low-income countries (LICs)	26	1.3	-3.4	-4.7
Lower-middle-income countries (LMICs)	49	2.5	-4.8	-7.3
Upper-middle-income countries (UMICs)	54	1.7	-7.6	-9.3
High-income countries (HICs)	61	1.0	-8.7	-9.7
All countries	*190*	*1.6*	*-6.7*	*-8.3*

Source: WB/IMF staff estimates; *Note:* NZ = New Zealand.

10. The WB-IMF debt sustainability framework considers public debt to GDP ratios ranging from 35 to 70 percent as being potentially problematic among low-income countries (LICs) and 60 percent as a trigger for deeper assessment for market access and advanced countries.

Figure 4. Projected per Capita Economic Growth in 2020 Relative to 2009–2019 Trends



Source: IMF (2020a).

Government revenue shares of GDP are projected to decline as a result of the pandemic. Across Asia and the Pacific, the average decline in the projected revenue (including grants) as share of GDP is expected to be -4.1 percent relative to precrisis levels, with reductions in both tax and nontax revenues expected due to a slowdown in economic activities as well as declining oil/commodity prices; tax revenues are expected to decline by -1.8 percent as share of GDP. There are notable differences across regional subgroupings: PA countries are expected to see particularly large declining revenue shares, assuming these projections bear out.[11] Projected declines in government revenues as share of GDP across the region are expected to be larger in magnitude relative to the average declines projected globally (Table 2).

11. Note that PA countries, on average, tend to have relatively large shares of nontax revenues, relative to GDP, compared with EA and SA countries. In large part, this reflects PA countries' small scale plus their relative dependence on grant revenues from development partners, property income (e.g., sales of fishing licenses in exclusive economic zones), and even sales of citizenship, as in the case of Vanuatu. See OECD (2020).

Table 2. Projected Impact on General Government and Tax Revenues as Share of GDP, 2017–2020

Classification	N	Precrisis levels		Projected 2020		Difference	
		Total (%)	*Tax* (%)	*Total* (%)	*Tax* (%)	*Total* (%)	*Tax* (%)
High-income Asia, Australia, NZ (HI)	6	28.9	20.4	27.3	18.7	-1.6	-1.7
Southeast & East Asia (EA)	13	24.1	13.1	21.6	11.5	-2.4	-1.6
South Asia (SA)	8	20.6	14.3	18.0	12.2	-2.6	-2.4
Pacific (PA)	16	65.0	20.2	57.2	18.2	-7.8	-1.6
All Asia & Pacific	*43*	*37.4*	*16.9*	*33.3*	*14.9*	*-4.1*	*-1.8*
Low-income countries (LICs)	29	18.4	11.3	18.0	10.6	-0.4	-0.7
Lower-middle-income countries (LMICs)	50	27.0	17.2	24.4	15.7	-2.6	-1.6
Upper-middle-income countries (UMICs)	56	31.1	19.1	30.0	17.7	-1.0	-1.3
High-income countries (HICs)	81	37.6	22.4	36.1	21.4	-1.5	-1.0
All countries	*216*	*30.4*	*18.5*	*28.9*	*17.2*	*-1.5*	*-1.2*

Source: WB/IMF staff estimates; *Note*: NZ = New Zealand.

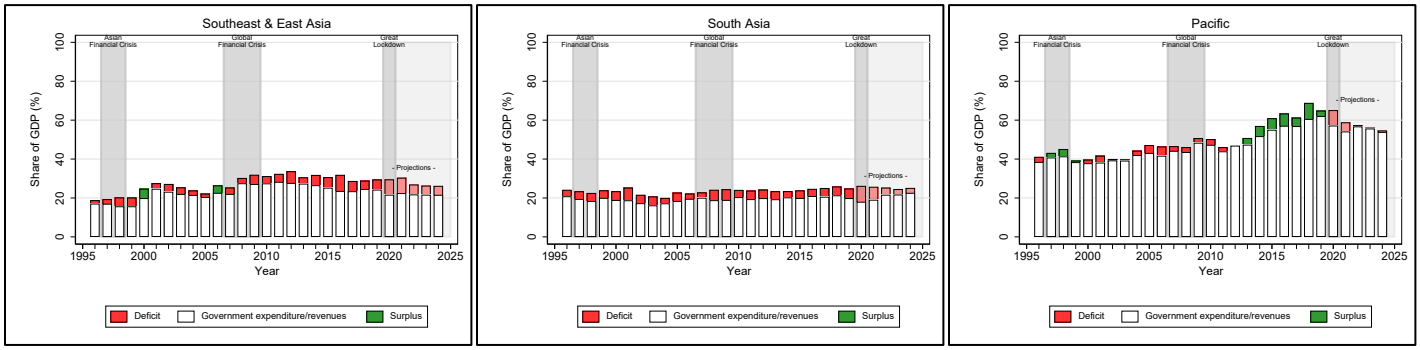
Despite declining general government revenues, government expenditures are expected to rise as a share of GDP across most countries in 2020, fueling a massive increase in deficits. Part of this increase in government spending has been to finance the immediate response to the pandemic—in terms of increasing the capacity of health systems to manage the COVID-19 outbreak—as well as to increase spending on social protection programs and to finance other government efforts designed to stimulate the economy and mitigate the adverse economic effects of the lockdown (Table 3) (IMF 2020b). Across EA, SA, and PA the average government deficit is projected to increase to roughly 8 percent of GDP as a result of a projected increase in government expenditure share of GDP (Figure 5). And gross public debt levels are projected to rise to over 60 percent of GDP on average across EA and SA countries (Figure 6).

Table 3. Projected Impact on General Government Expenditures as Share of GDP, 2017–2020

Classification	N	Precrisis levels (%)	Projected 2020 (%)	Difference (%)
High-income Asia, Australia, NZ (HI)	6	30.0	38.8	8.8
Middle-income Southeast & East Asia (EA)	13	29.0	29.5	0.5
South Asia (SA)	8	25.2	26.2	0.9
Pacific (PA)	16	59.8	65.1	5.3
All Asia & Pacific	*43*	*38.3*	*41.8*	*3.5*
Low-income countries (LICs)	29	21.8	24.3	2.5
Lower-middle-income countries (LMICs)	50	30.2	31.5	1.3
Upper-middle-income countries (UMICs)	56	33.3	38.0	4.8
High-income countries (HICs)	81	38.2	45.7	7.5
All countries	*216*	*32.6*	*37.0*	*4.4*

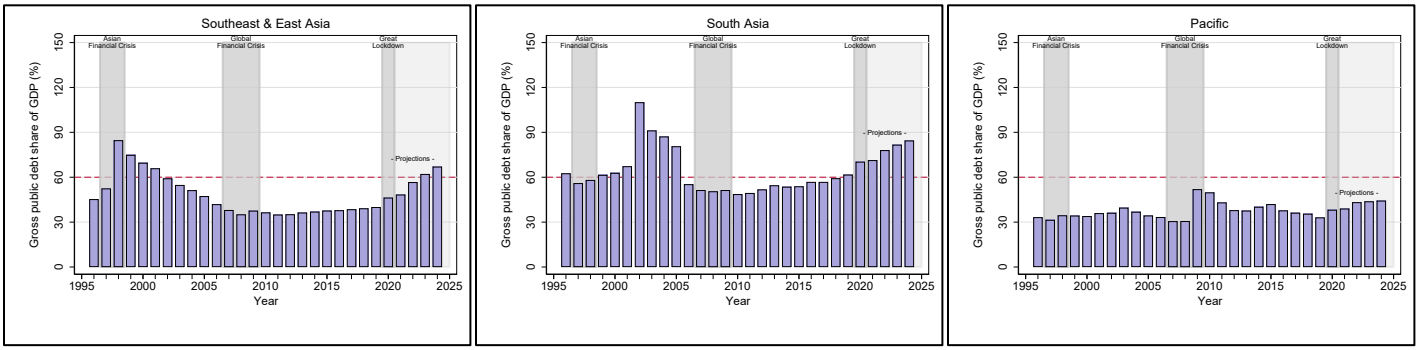
Source: IMF/WB staff estimates; *Note*: NZ = New Zealand.

Figure 5. Government Revenues/Expenditures Share of GDP, 1996–2024



Source: WB/IMF staff estimates.

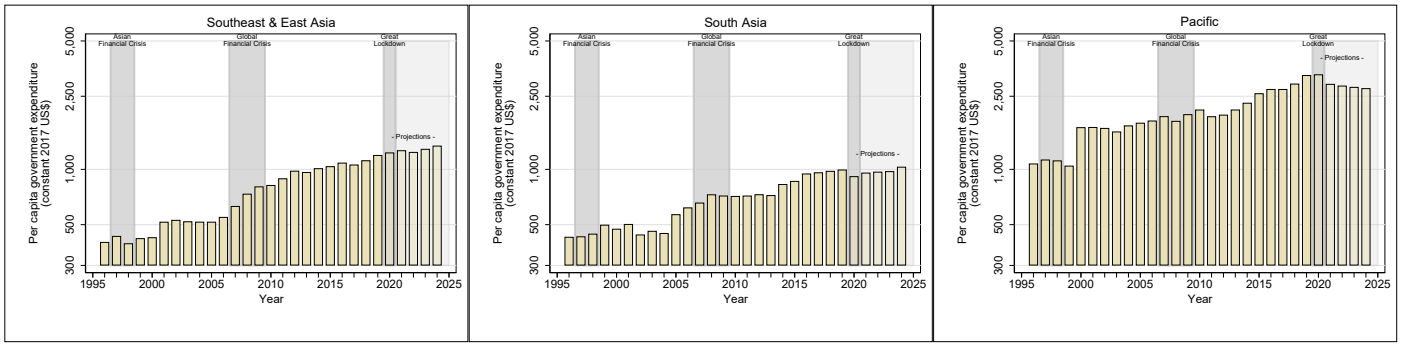
Figure 6. Gross Public Debt as Share of GDP, 1996–2024



Source: IMF/WB staff estimates.

As with any crisis, the interplay between declining economic activity and countercyclical fiscal and monetary policies will eventually determine levels of government spending across countries. Higher government spending as share of GDP could still imply a lower level of per capita government spending if the numerator does not rise enough to offset the decline in the denominator. For example, SA countries are expected to see a decline in real per capita government spending on average despite implementation of countercyclical expenditure policies (Figure 7). Bangladesh, Maldives, and Sri Lanka are expected to see lower government spending levels despite an increase in government spending as share of GDP. Per capita government spending levels are expected to stay roughly the same in EA and PA countries between 2019 and 2020. However, Lao People's Democratic Republic and Timor-Leste are at risk of seeing a decline in per capita government spending in 2020. Fiji, Kiribati, Nauru, and Papua New Guinea are similarly at risk among PA countries. Even in countries where government spending is not expected to contract, it is projected to grow at rates far lower than compared with precrisis trends.

Figure 7. Per Capita Government Expenditures, 1996–2024



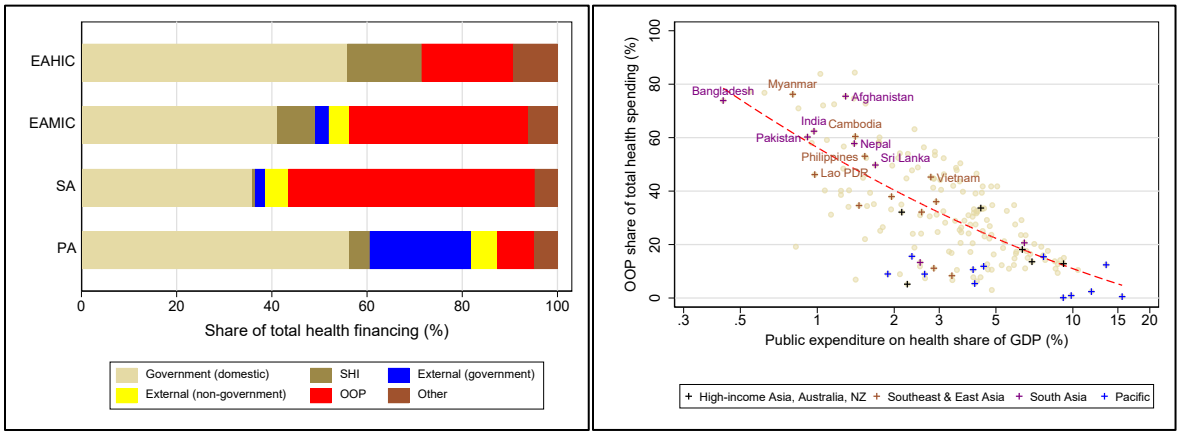
Source: Authors' estimates; *Note*: log *y*-scale.

HOW MIGHT COVID-19 AFFECT HEALTH FINANCING?

Health is typically financed by a combination of three primary sources: public, household out-of-pocket (OOP), and external. Within public sources, financing is via general government revenues, which, in some countries, is combined with compulsory social health insurance (SHI) contributions in the form of earmarked payroll taxes or income-based premiums. External financing can flow either via the government budget or directly to nongovernmental organizations (NGOs) and health care providers. Health financing—along with governance and service delivery—is a core "building block" of all health systems: How much? How raised? and How used? dimensions of health financing are important not only for universal health coverage (UHC) but also for sustaining population health, improving welfare, and stimulating the economy.[12] Key lessons in the importance of public financing for UHC, of reducing fragmentation in risk pooling and service delivery, and of ensuring flexibility and accountability in how resources are utilized have emerged from experiences across countries in recent years (Kutzin, Yip, and Cashin 2016).

The levels and mix of financing sources for health vary significantly across countries in Asia and the Pacific.[13] Per capita levels of health financing are highest among HI countries (~US$3,169) followed by PA (~US$492), SA (US$191), and EA countries (~US$162). Health in HI countries is mostly financed by public sources: on average, a mix of general government revenues and SHI contributions (Figure 8). PA countries have large shares of external financing combined with domestic government revenues and relatively low levels of OOP financing. SA countries—and to a lesser extent, EA countries—are largely financed by OOP sources. There is a strong negative relationship between the public financing share of health vs OOP: countries where public spending on health is below 3 percent of GDP—due to low levels of general government revenues or low priority for health in government budgets or both—tend to also have OOP spending shares in total health spending that exceed 40 percent, as in Afghanistan, Bangladesh, India, Myanmar, and Pakistan, among others.[14] Other sources—including private health insurance—account for a relatively small share of financing for health across most countries.

Figure 8. Sources of Financing for Health across Asia and Pacific, 2017



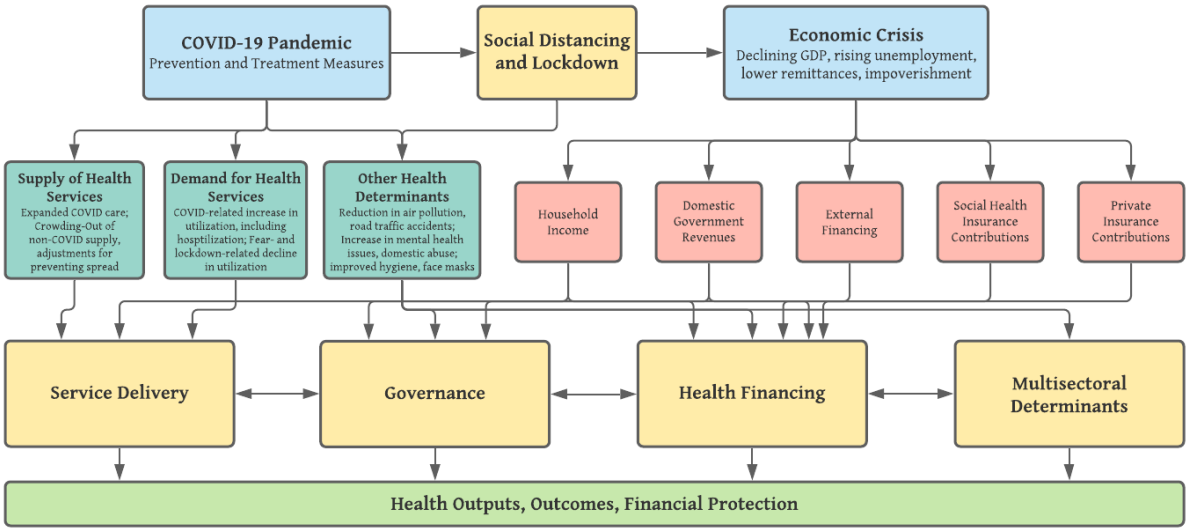
Source: WHO (2020); *Note:* EAHIC = East Asian High-income Country; EAMIC = East Asian Middle-income country; SA = South Asia; PA = Pacific; SHI = Social health insurance; OOP = Out-of-pocket.

12. Although health financing refers to revenue generation, pooling, and purchasing of health services, in this paper we focus more on the first, in terms of potential implications of COVID-19 on availability of resources.
13. As countries grow and develop, there is an empirical trend that has recently been characterized as a "health financing transition" toward higher levels of health spending with greater shares coming from public sources. See Fan and Savedoff (2014).
14. High levels of out-of-pocket (OOP) spending are often a risk factor for impoverishment except in countries such as Sri Lanka, where they are largely incident on the well-off.

Much remains unknown about how the health and economic impact of COVID-19 will impact levels and sources of health financing. Based on what is currently known and projected, and depending on how the "hammer and dance" between new infections and the extent of lockdowns evolve across countries, the economic shock may continue into 2021 or even longer; considerable uncertainty remains, and is likely to be higher, the more vulnerable countries are to both the direct and indirect effects of the pandemic. In addition to the impact from COVID-19, Hou et al. (2013) outlined three channels on how economic recessions impact health and health systems: the first channel pertains to the supply of health care services: recessions impact government resources and will intensify fiscal constraints. As a result, governments tend to reduce the level and composition of spending, including public services on health. For example, Hopkins (2006) documented a significant cut in government health budgets in Indonesia, Malaysia, and Thailand due to the Asian Financial Crisis in 1997–1998. The decline in household income exposes the other two channels through which recessions affect health according to Hou et al. (2013). One is through household consumption and nutritional intake. Reduced income leads to reduction in food consumption, which especially affects poor families whose half of household expenditure is on food items (Brinkman et al. 2010). As a result, Bhutta et al. (2009) document increases in maternal anemia rates, prevalence of low birthweight, childhood stunting rates, and wasting across EA and PA countries due to the 1997–1998 crisis. Recessions also affect mental health and, in some instances, lead to adverse health behavior. During the Global Financial Crisis of 2007–2009, Kwon et al. (2010) noted that cigarette and alcohol consumption increased in Bangladesh and Nepal, especially among low-income groups and the unemployed. The third channel through which recessions impact the health sector is household interaction with the health sector, which is also due to reduced household income. Hou et al. (2013) also pointed out significant declines in health service utilization, especially preventive care visits, may result due to diminished household income and lack of health insurance. Certain increases in inequities have occurred as well. In the Republic of Korea, for example, Yang, Prescott, and Bae (2001) reported larger decreases in the proportion of health expenditure in the household budget in lower-income groups compared to higher-income groups due to the 1997–1998 Asian Financial Crisis. In Nepal, health status was worse among the unemployed compared to the employed after the Global Financial Crisis of 2007–2009, and the proportion of people who reported worse health was significantly high in the low-income group (Kwon et al. 2010).

Implications for health financing will depend on how different sources of financing will be impacted, as well as how the demand for health services and associated needs for health spending change due to the pandemic, underscoring the need to look at not only how health financing is being impacted but also how health financing, service delivery, and governance—the three pillars of health systems—interact to cope with the crisis (Figure 9). For example, during the 2007–2009 Global Financial Crisis, factors that helped to build resilience among European countries included countercyclical fiscal policies, especially countercyclical public spending on health and other forms of social protection; adequate levels of public spending on health; no major gaps in health coverage; relatively low levels of out-of-pocket payments; a good understanding of areas in need of reform; information about the cost-effectiveness of different services and interventions; clear priorities; and political will to tackle inefficiencies and to mobilize revenue for the health sector (Thomson et al. 2015).

Figure 9. Multiple Transmission Paths from the Pandemic to Health Financing and Other Determinants of Outcomes



PUBLIC FINANCING

Public financing is key for countries to make progress toward UHC. Countries that are in the highest quintile of WHO-WB's universal health service coverage index—which measures the proportion of a country's population with access to health services and with lower risk factors—are so based on higher levels of public financing for health: in levels, as share of GDP, as share of the government budget, and as share of total health spending (Table 4).[15] Higher levels of public financing also crowd out OOP financing for health: the average OOP share of total health spending in countries that are in the highest quintile of the UHC index is about 20 percent; low levels of OOP financing, when combined with higher service coverage, also imply reduced risk of impoverishment resulting from catastrophic health-related expenditures.

Table 4. Public Financing Is Key for Universal Health Coverage

Public financing for health					
UHC index of service coverage	Per capita public spending (US$)	Public spending share of GDP (%)	Health share of public spending (%)	Public spending share of total health spending (%)	OOP spending share of total health spending (%)
Lowest quintile	32	2.3	8.5	39.2	41.9
Second-lowest quintile	108	2.8	9.5	51.5	32.2
Middle quintile	252	3.2	10.3	53.1	39.9
Second-highest quintile	566	3.8	12.2	61.3	30.4
Highest quintile	2,512	6.1	15.0	69.1	20.8

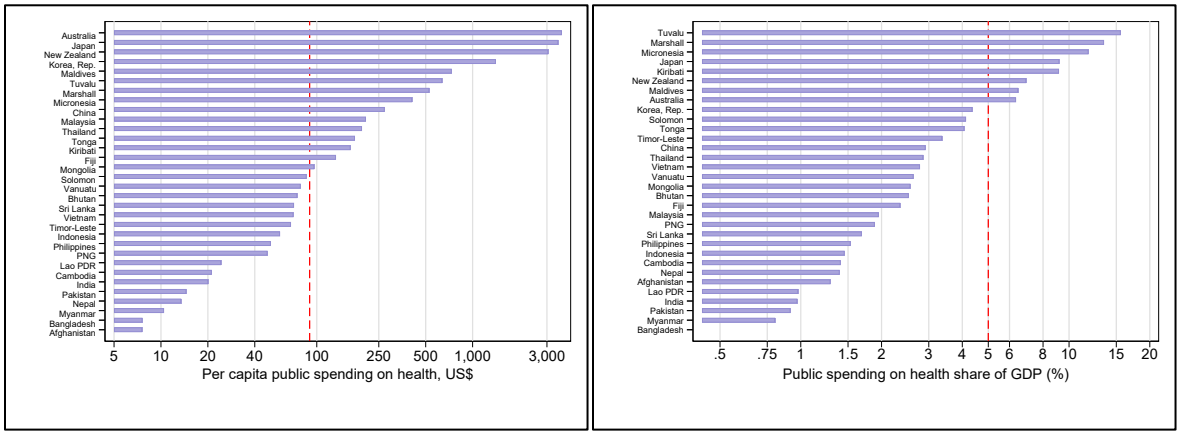
Source: Authors' estimates; *Note:* UHC = Universal health coverage; OOP = Out-of-pocket.

Levels of public spending on health vary significantly across countries in Asia and the Pacific. Latest available data prior to COVID-19 indicate almost a 300-fold difference between per capita public spending on health in Afghanistan (<US$10) versus Australia (>US$3,000).[16] As noted earlier, where levels are low, these are "made-up" in part by high levels of external financing (e.g., Afghanistan) or high levels of OOP financing for health (e.g., India) or both (e.g., Cambodia), in addition to showing up as lower effective service coverage. There is no specific socially optimal normative level or share of public spending for health across countries, even though there are numerous references in the literature to such benchmarks. Some have argued in the literature for public spending on health to be at least 5 percent of GDP (McIntyre, Meheus, and Røttingen 2017). Others have estimated a minimum public spending on health of US$90 per capita.[17] Many countries in the region are below these benchmarks, sometimes significantly so (Figure 10).[18] Nevertheless, despite low levels of government spending, several low- and middle-income countries in the region—including Afghanistan, Bangladesh, Nepal, and others—have made progress in improving coverage for key interventions such as immunization, antenatal care, and institutional deliveries, in reducing under-five and maternal mortality rates, and in increasing life expectancies (WHO 2019). Continued progress, however, is at-risk of being hampered due to the COVID-19 epidemic, both due to fear- and lockdown-related reductions in utilization of health

15. There is some nuance to this: recent evidence seems to suggest that public spending appears to matter more for the financial risk dimension for UHC and for effective service coverage, especially among the poor.
16. Increases in public spending on health in the past can largely be accounted for by economic growth; see Tandon et al. (2020).
17. US$90 is an inflation-updated number for 2017 that was initially reported in McIntyre and Meheus (2014).
18. We do not recommend the use of such benchmarks in informing country-specific policy dialogue on health financing, given the complexities in identifying what an optimal level or share of public financing for health ought to be with enormous diversity in country contexts. In addition, the idea is not just for countries to attain specific benchmark targets but more so to ensure that lack of adequate public financing is not a bottleneck to making progress toward both the service coverage and financial protection dimensions of UHC. Notably, countries should ensure a smooth and predictable trajectory for public spending on health in real per capita terms, not just in nominal aggregate terms. This would make it easier for policy makers to plan, budget, and proactively take corrective action if an adverse situation is expected. In doing so, one of the objectives of reprioritization would then also be to attain some degree of smoothing in real per capita public spending trends, at least to the extent that fluctuations in such trends are not reflecting changes in health-related needs; see Tandon et al. (2018).

services, due to fiscal pressures that may halt or even reverse levels of public financing for health, and because lower household incomes could constrain the ability to pay OOP to access care.

Figure 10. Precrisis per Capita Public Spending on Health in Asia and Pacific



Source: WHO (2020); *Notes: Log scale; PNG = Papua New Guinea: Lao PDR = Lao People's Democratic Republic.*

In the past, public spending on health has tended to be procyclical across countries. Based on data from 1996 to 2017, the median income elasticity of public spending on health is estimated to be 1.1: that is, for a 1 percent change in per capita GDP, public spending on health tends to change by 1.1 percent on average (model 1 in Table 5).[19] Elasticity estimates are slightly higher (1.2) when per capita GDP is contracting versus when it is rising, as evidenced by the positive sign on the contraction dummy. If public spending on health responds to the current economic shock the same way it has in previous years, per capita public spending on health can be expected to decline as a result of the economic contractions projected to occur across most countries, even after controlling for changes in the government spending share of GDP and accounting for debt servicing's share of government spending (model 3 in Table 5).[20] For the same level of income, levels of per capita public spending on health are higher at higher levels of government spending as share of GDP and lower for a higher debt servicing burden. In a baseline scenario—given current projections of per capita GDP, government spending's share of GDP, and debt service share of government spending—per capita public spending could contract across several countries in the region: by -0.9 percent in EA countries, -1.8 percent in SA countries, and -3.5 percent across PA countries (these "model-based" baseline projections are summarized in Table 6). Even if governments protect health's share of the budget by keeping health's share of government spending at precrisis levels, and other than in HI countries, per capita spending on health will grow at rates far lower than in precrisis years (these "health-protected" projections are summarized in Table 6).

19. Elasticity is estimated by running a log-log model with per capita public spending on health in constant US$ as dependent variable and per capita GDP in constant US$ as independent variable.
20. Elasticities estimated from historical data may not be the best way to project what could occur in the current health-triggered contraction; these estimates from cross-country data are meant to be indicative of what could happen, not definitive.

Table 5. Median Regression Results for Estimating Income Elasticity and Projections of Public Spending for Health

Dependent variable: Per capita public spending on health	(1)	(2)	(3)	(4)
Per capita GDP	1.135***	1.125***	1.010***	1.005***
	(0.0354)	(0.0384)	(0.0323)	(0.0430)
Interaction (per capita GDP and contraction)		0.0448***	0.0156*	0.0140
		(0.00984)	(0.00841)	(0.0101)
Government spending share of GDP			0.754***	0.695***
			(0.0354)	(0.0459)
Interaction (government spending and contraction)			0.0415	0.0530
			(0.0303)	(0.0379)
Debt service share of government spending				-0.0262***
				(0.00818)
Interaction (debt service and contraction)				0.00132
				(0.0103)
Contraction dummy		-0.372***	-0.274***	-0.299**
		(0.0911)	(0.0981)	(0.127)
Observations	3,740	3,740	3,740	3,575

Standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.10; variables in logs.

Table 6. Model-based and Health-protected Projected Impact on per Capita Public Spending on Health, 2009–2020

Classification	Precrisis levels (2017–2019) (US$)	Precrisis growth (2009–2019) (%)	Projected growth (2019–2020)	
			Model-based (%)	*Health-protected (%)*
High-income Asia, Australia, NZ (HI)	2,274	4.6	3.7	7.7
Southeast & East Asia (EA)	98	9.0	-0.9	3.3
South Asia (SA)	118	5.0	-1.8	2.8
Pacific (PA)	372	3.1	-3.5	0.7
All Asia & Pacific	*544*	*5.5*	*-1.3*	*3.0*
Low-income countries (LICs)	14	3.6	4.2	8.9
Lower-middle-income countries (LMICs)	67	3.5	-1.9	1.5
Upper-middle-income countries (UMICs)	262	4.1	-1.5	2.9
High-income countries (HICs)	1,968	2.9	-0.8	6.7
All countries	*727*	*3.5*	*-0.6*	*4.5*

Source: Authors' estimates*; Note:* NZ = New Zealand.

Increasing the priority of health in government budgets will, therefore, be necessary for many countries in the region to maintain trend growth in per capita spending on health. To maintain growth rates in per capita public spending on health over 2009–2019—and given projections of GDP, government spending share of GDP, and debt servicing share of government spending—health will need to be reprioritized upward: on average by 0.2 to 0.3 percentage points (increases on average in levels of US$10–15 per capita) among EA and SA countries (Table 7). Without this, several countries will experience a decline or slowdown in the growth of per capita public spending on health, often from already low levels. For example, health as share of government budget in Cambodia has averaged 6.2 percent in recent years: this would need to increase to 6.6 percent to maintain trends. Similarly, Sri Lanka would need to increase from 8.9 to 9.6 percent and Papua New Guinea from 9.1 to 9.7 percent.

Table 7. Protecting Trend Growth in per Capita Public Spending for Health, 2009–2020

Classification	Precrisis health share of government spending (2017–2019) (%)	Projected health share of government spending (2020) (%)	Difference (%)
High-income Asia, Australia, NZ (HI)	16.4	19.1	2.7
Middle-income Southeast & East Asia (EA)	8.0	8.2	0.2
South Asia (SA)	7.0	7.3	0.3
Pacific (PA)	11.9	11.2	-0.7
All Asia & Pacific	*10.4*	*10.2*	-0.2
Low-income countries (LICs)	9.4	9.2	-0.2
Lower-middle-income countries (LMICs)	9.4	9.9	0.5
Upper-middle-income countries (UMICs)	12.0	12.1	0.1
High-income countries (HICs)	13.7	13.5	-0.2
All countries	*11.5*	*11.5*	0.0

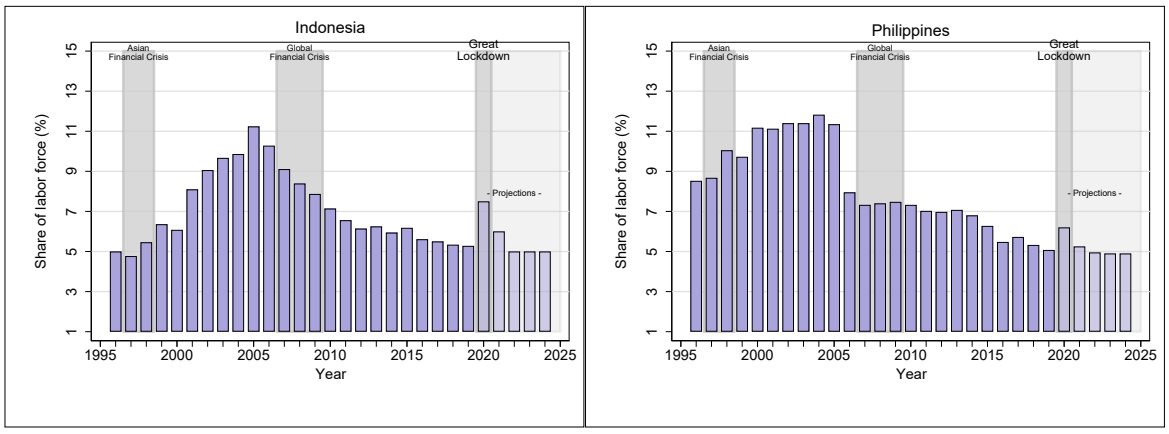
Source: Authors' estimates*; Note:* NZ = New Zealand.

SOCIAL HEALTH INSURANCE

Countries dependent on contributory SHI revenues may face fiscal sustainability challenges for their schemes, while preserving comprehensive entitlements. Some of these countries—which in Asia include China, Japan, Mongolia, Indonesia, Republic of Korea, and Vietnam with more than one-quarter of public financing from SHI income-related contributions—are projected to see deteriorating labor market conditions and rising rates of poverty. 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 mean additional calls on the government budget for subsidized contributions. Transferring contributory to noncontributory coverage will be an administrative challenge, with many likely to fall between the cracks. In addition, SHI schemes may face additional demands to cover medical expenses from COVID-19, including for testing, community-based isolation of mild cases, and inpatient care of severe cases. Some SHI schemes have already widened their benefit packages to accommodate these expenses. On the flip side, social distancing measures and reduced economic activity may lead to fewer road traffic accidents, reductions and delays in seeking elective and nonurgent care, as well as declines in other environment-related reasons for ill health (such as due to lower air pollution). The net effect of all these factors on SHI finances is difficult to predict with certainty.

Unemployment and impoverishment rates are rising in the region as a result of COVID-19. Preliminary projections indicate an additional 8 million and 3 million individuals will either be unemployed or impoverished in Indonesia and the Philippines, respectively, due to the pandemic (World Bank 2020b). Indonesia's unemployment rate is projected to rise to 7.5 percent of the labor force in 2020, up from 5.3 percent in 2019: implying an additional 3 million unemployed (Figure 11). Similarly, unemployment in the Philippines is expected to rise to 6.2 percent in 2020, up from 5.1 percent in 2019: implying an additional 1 million projected to be unemployed. In addition, declining economic growth is projected to push an additional 5 million below the poverty line in Indonesia, and 2 million in the Philippines. Given current coverage and contribution rates, this could potentially imply additional outlays of US$200 million in Indonesia and US$70 million in the Philippines to manage the loss in contributions and potential increase in the need to provide subsidized coverage within their respective schemes (Table 8).[21]

Figure 11. Unemployment Rate in Indonesia and the Philippines, 1996–2024



Source: IMF (2020a).

21. This is calculated simply as the sum of lost contributions from unemployment and the additional contributions that would need to be paid by the government for those who are impoverished.

Table 8. Social Health Insurance Coverage and Contribution Rates in Indonesia and the Philippines

Country	SHI coverage (share of total population)		Contributions per member	
	Contributory coverage rate (%)	*Noncontributory coverage rate (%)*	*Premium contribution (employer, employee)(US$)*	*Government subsidized (poor, vulnerable) (US$)*
Indonesia	27	51	~ 50	~ 25
Philippines	52	41	~ 10	~ 30

Source: WB/WHO staff estimates; *Note:* SHI = Social health insurance.

HOUSEHOLD OUT-OF-POCKET FINANCING

Some countries in the region are highly dependent on household OOP financing for health. Despite being an inefficient and inequitable way to finance health, and despite being inimical to making equitable progress toward UHC, these OOP resources can and do represent a significant share of overall resources for health in many EA and SA countries including Cambodia, Myanmar, Lao People's Democratic Republic, India, Pakistan, the Philippines, Vietnam, and Bangladesh, among others. Low levels of public financing are often one reason why OOP financing is high across countries: due to low or shallow coverage, to make up for poor supply-side readiness in public facilities, or due to utilization at private facilities; the latter often triggered by better responsiveness, ease of access, and perceptions of receiving better quality care. OOP financing is a significant risk factor for impoverishment, and the need to pay to receive care contributes to deterring and delaying necessary utilization, particularly for the poor. WHO recommends countries aim to have OOP spending shares less than 15 to 20 percent of total health spending, similar to levels seen across Organisation for Economic Co-operation and Development (OECD) countries, most of which are closest to attaining UHC (WHO 2010). And if OOP spending is higher than this share, it should ideally be incident on the well-off (as in Malaysia and Sri Lanka) so it does not pose a risk for impoverishment; to the extent possible, limited public financing should be targeted to benefit the poor and vulnerable until fiscal space can expand to cover a higher share of the population.

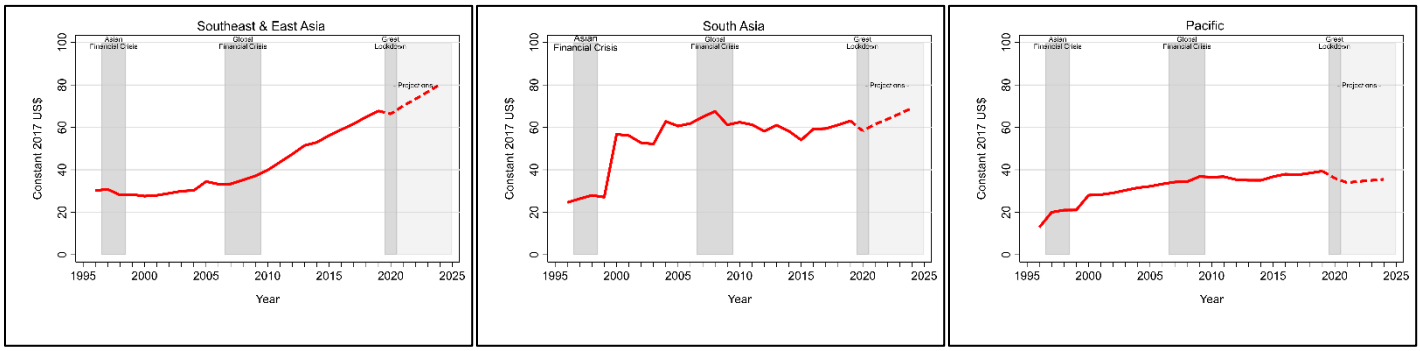
There is nearly a one-to-one relationship between growth in national income and growth in aggregate OOP spending. Based on data from 2000 to 2017, the median income elasticity of OOP spending was estimated to be 0.9; there was no significant evidence of the relationship being different during economic contractions (Table 9). The magnitude increased slightly after controlling for consumption expenditure's share of GDP. Given the nature and magnitude of the contraction expected due to the pandemic, levels of OOP spending will likely go down. On the one hand, this effect will likely be aggravated by declining fear- and lockdown-related declining utilization trends, which are being observed across many countries. On the other hand, increasing rates of self-medication and higher copayments may have the opposite effect: leading to higher OOP spending. Declining OOP, declining consumption, and declining utilization will likely cause commonly used financial protection metrics—for example, OOP shares of income/consumption—to improve, even though these "improvements" will 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. If these projections are realized, several EA, SA, and PA countries could see declining OOP in 2020 in addition to declining public spending for health (Figure 12).

Table 9. Quantile Regression Results for Estimating Income Elasticity of Out-of-Pocket Spending for Health

Dependent variable: Per capita OOP spending on health	(1)	(2)	(3)
Per capita GDP	0.912***	0.916***	0.980***
	(0.0278)	(0.0278)	(0.0275)
Interaction (per capita GDP and contraction)		-0.00855	-0.00597
		(0.00697)	(0.00795)
Per capita consumption spending			0.544***
			(0.0426)
Interaction (consumption and contraction)			0.0171
			(0.0527)
Contraction dummy		0.101	-0.0110
		(0.0622)	(0.267)
Observations	3,170	3,170	3,170

Standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.10; variables in logs.

Figure 12. Increased Public Financing May Also Be Needed to Offset Declining Out-of-Pocket Spending Trends



Source: Authors' estimates; *Note:* OOP = Out-of-pocket.

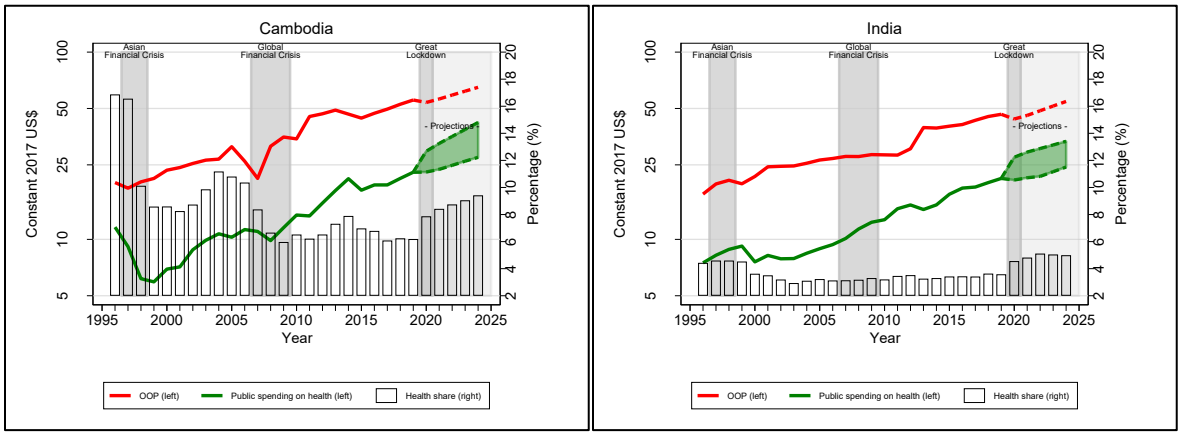
Public financing will need to increase even further if it is to help offset declining OOP spending trends. This may be necessary, not only to help stimulate utilization more generally by removing additional financial barriers to accessing care, but also to manage greater relative utilization at public facilities, which may be expected to occur as a result of the economic shock resulting from the pandemic.[22] The decline in OOP may also cause cash flow issues for providers, hence the need for increased public spending is also to sustain economic survival of those who depend on such revenues. On average, EA and SA countries would need to increase health's share of government spending between 1.0 and 1.2 percentage points (increases on average in levels of US$15–20 per capita) to offset tendencies for both public and OOP spending to decline as a result of the pandemic (Table 10). For the case of Cambodia—where precrisis public spending on health was 1.4 percent of GDP and OOP spending share was 60 percent of total health spending—this would imply an increase in health's share of the government budget from 6.2 to 7.9 percent (an increase of 0.6 percent of GDP). Similarly, for India—with public spending on health at 1 percent of GDP and 62 percent share of OOP in total health spending—health's share of the government budget would need to increase from 3.5 percent to 4.6 percent (an increase of 0.4 percent of GDP). Figure 13 shows the results for Cambodia and India. The bottom dotted green line represents projections of per capita public spending on health that are likely under the baseline "model-based" scenario if things react the way they have in the past. The top dotted green line are projections in case changes are made not only to preserve trend growth in per capita public spending on health but also to offset any declines in OOP spending. The shaded area in between shows other scenarios where health is protected as share of government spending and if only trend growth in per capita public spending on health is protected. The red line shows per capita OOP spending.

Table 10. Protecting Trend Growth in per Capita Public Spending and Offsetting Declining Out-of-Pocket for Health, 2009–2020

Classification	Precrisis health share of government spending (2017-2019) (%)	Projected health share of government spending (2020) (%)	Difference (%)
High-income Asia, Australia, NZ (HI)	16.4	19.5	3.1
Southeast & East Asia (EA)	7.9	8.9	1.0
South Asia (SA)	7.0	8.2	1.2
Pacific (PA)	11.9	11.3	-0.6
All Asia & Pacific	*10.4*	*10.7*	*0.3*
Low-income countries (LICs)	9.4	9.8	0.4
Lower-middle-income countries (LMICs)	9.4	10.6	1.2
Upper-middle-income countries (UMICs)	12.0	12.6	0.6
High-income countries (HICs)	13.7	14.0	0.3
All countries	*11.5*	*12.1*	*0.6*

Source: Authors' estimates; *Note:* NZ = New Zealand.

Figure 13. Per Capita Spending Trends in Cambodia and India, 1996–2024



Source: Authors' estimates; Note: OOP = Out-of-pocket.

22. This is particularly the case in EA and SA countries where private provision is relatively large.

EXTERNAL FINANCING

Considerable uncertainty remains as to what might happen to external financing for health. Total levels of external financing have stagnated in recent years, at levels of about US$40 billion annually, and there is little evidence to suggest that the previous global financing crisis in 2007–2009 had any significant impact on external financing flows to low- and middle-income countries (IHME 2020).[23] Precrisis, Cambodia, Nepal, Afghanistan, Solomon Islands, Papua New Guinea, and Lao People's Democratic Republic were some Asian countries where external financing represented more than 15 percent of all resources for health. External financing is a particularly important source of financing for health (and other sectors) across Pacific countries. On the one hand, the fact that the economic shock is affecting higher-income countries the most 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. One concern could be the push to channel financing toward financing of "common goods" such as vaccine development that may come at the expense of core financing for health provided to developing countries.

Current projections indicate no significant changes in overall levels of grant financing to countries across Asia. Precrisis, grant financing—excluding concessionary borrowing—amounted to over 20.0 percent of GDP among Pacific countries, 3.0 percent of GDP in SA, and 1.7 percent of GDP among EA countries. Current estimates are that these numbers will largely remain the same for 2020 across SA and PA countries, with some decline expected across EA. Some increase is expected globally among low-income countries (LICs), with a decrease among low- and middle-income countries (LMICs) (Table 11). It remains to be seen whether these projections bear out; considerable uncertainty also remains as to the extent of the impact on health-specific grant financing not just in 2020 but also in 2021 and later years. If external financing declines, public financing from domestic sources would need to increase even further to ensure that gains made in recent years are not lost as a result of the economic shock due to the pandemic.

Table 11. Grants as Share of GDP, 2009–2020

Classification	Precrisis share (%)	Projected share 2020 (%)	Difference (%)
High-income Asia, Australia, NZ (HI)	0.0	0.0	0.0
Southeast & East Asia (EA)	1.7	1.3	-0.4
South Asia (SA)	3.0	3.1	0.1
Pacific (PA)	19.9	19.8	-0.1
All Asia & Pacific	*8.1*	*7.9*	*-0.2*
Low-income countries (LICs)	3.1	4.0	0.9
Lower-middle-income countries (LMICs)	3.2	2.8	-0.4
Upper-middle-income countries (UMICs)	2.3	2.8	0.4
High-income countries (HICs)	1.2	1.4	0.2
All countries	*2.4*	*2.6*	*0.2*

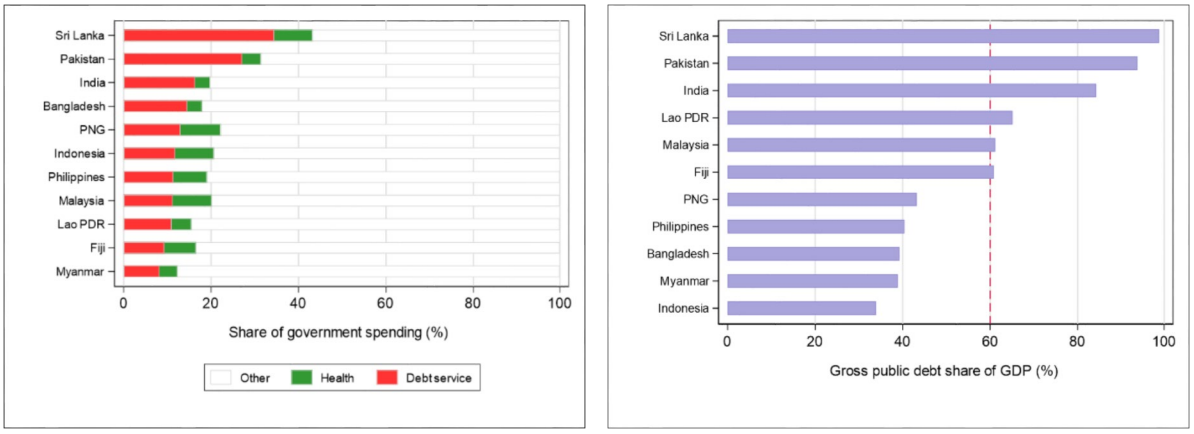
Source: Authors' estimates; *Note:* NZ = New Zealand.

Debt relief is also being proposed as an option for increasing fiscal space, including for health (World Bank 2020c). Even before the crisis, several countries in the region had debt service levels that far exceeded the share spent on health—SA countries such as Sri Lanka, Pakistan, and India prominent among them—constraining the discretionary ability of governments to increase public financing. Some countries such as Indonesia, Myanmar, and Bangladesh have debt servicing shares that are high despite having relatively low levels of gross public debt in GDP because of low government revenue generation and the overall size of the government more generally (Figure 14). Not all of this debt is held by bilateral or multilateral agencies, but some degree of debt cancellation or restructuring is being considered as a form of development assistance. G20 countries and several multilateral banks have already deferred

23. IHME's estimates include financing from nontraditional donors (e.g., China) that are increasingly becoming important.

interest payments, and other such debt relief measures are on the cards, especially for countries most in need. The overall increase in debt levels globally due to the pandemic is in and of itself increasing the overall vulnerability of the global financing system. Not all debt relief, if implemented, will mean more resources for health per se, however; this is an issue that merits further discussion.

Figure 14. Debt Service Share of Government Spending and Gross Debt Share of Gross Domestic Product



Source: Authors' estimates; *Notes*: PNG = Papua New Guinea; Lao PDR = Lao People's Democratic Republic.

FINANCING HEALTH FOR COVID-19 and BEYOND:
SUMMARY and RECOMMENDATIONS

COVID-19 risks eroding gains made in recent years in expanding effective coverage and improving financial protection. Without proactive interventions, the adverse economic effects from COVID-19 are expected to result in lower levels and growth rates in health financing from several sources across most countries in the region. Negative effects across all core sources—especially public and household OOP spending—can be expected, with some countries being far more vulnerable than others and with a greater adverse impact projected among the poor within countries. Many developing countries in the region already suffered from low levels of public financing for health and, as a consequence, had high levels of OOP financing. The speed with which countries can get back on track will depend on the extent to which they have had to go into debt to pay for increased public spending in 2020, and whether the need to repay debt in the future will reduce their capacity to spend subsequently. It also depends on what happens to development assistance and to the ability of countries to raise additional domestic revenues.

Growth in public spending on health per capita is likely to fall or become negative if trends remain as they did in previous contractions. This is because increased government spending from deficit financing and increased borrowing is not going to be enough to offset the falls in GDP per capita and in government revenues in some countries. There is considerable variation across countries, with some at much greater risk of large contractions, particularly those reliant on tourism and trade, or those that are oil or commodity exporters. Increasing levels of public debt could threaten future public spending on health in many countries. Debt service ratios—the share of debt service in government spending —might become unsustainable, and there is increasing talk of another debt crisis. Debt relief or cancellation would reduce this possibility, and if countries make different policy choices, they can modify this conclusion. The most important choice is to increase the share of health in general government expenditure. Working with debt owners and countries to use at least part of any debt cancellation for health will also allow public health spending to increase and get back on track toward UHC and health-related Sustainable Development Goals (SDGs).

Per capita OOP spending levels are likely to fall, probably reflecting lower household incomes and reduced coverage with needed non-COVID-19 health services. OOP spending is projected to fall in all income groups and in most countries. This can be attributed largely to the falls in GDP per capita and in private consumption expenditure linked to falling levels of employment and household incomes. The fall in OOP spending would normally be something to celebrate as an indicator that financial protection levels in health are improving, that is, that the incidence of financial catastrophe and impoverishment linked to OOP spending would be falling. Due to the pandemic, declining OOP spending may create the illusion of improvement in financial protection but in actuality show foregone care. This implies that the use of health services will also fall from a point where there was already considerable unmet need. This threatens progress toward UHC and the health gains of the immediate past.

Trends in development assistance for health are uncertain. If on-budget development assistance for health increases substantially as a result of COVID-19, as it did in the three countries that faced the Ebola outbreak in 2013, the adverse impact on government spending, including for health, could be smaller. Whether this is happening so far is not yet clear. There are some factors that might make this difficult. The first is that many more countries are affected by the current pandemic and the economic slowdown than during the Ebola outbreak. The second is that donor countries are all affected by the economic downturn: if they maintain, for example, the current share of development assistance in gross national income (GNI), development assistance will fall in 2020. Third, donors have been promising large sums to global common goods related to COVID-19 (e.g., vaccine and medicine development), and it is not yet clear if this will displace other development assistance arriving in countries.

Some caveats are necessary. We are assuming sustaining growth in levels of public spending on health is desirable given underfinancing of the sector among many low- and middle-income countries in the region. Nevertheless, how the money is used is just as important as how much is available. Higher levels of public spending will not improve outputs if they are absorbed ineffectively or absorbed by spending on things that might not necessarily contribute to

higher productivity in the sector (e.g., on a higher wage bill). And OOP spending levels may represent spending on unnecessary care, the cutting of which may be fine to cut. The focus in the paper is on what the COVID-19 economic contraction might mean for overall resource availability to the sector, but it is important to recognize that the magnitude of resources in health is not the only factor that is necessary to sustain improvements in UHC; furthermore, investments in other sector—education, agriculture, water and sanitation—are also important for health outputs and outcomes.

Given this backdrop, some of the following key recommendations will be critical to ensure sustainable and resilient health financing systems.

Prioritize Public Spending to Address the Pandemic: Countries, first and foremost, need to ensure prioritized public spending for containing the pandemic—including for medical supplies, testing, and surveillance—in addition to ensuring adequate health system capacity for hospitalization and intensive care. Initial estimates indicate that this has occurred to varying degrees across most countries with allocations averaging 0.3 percent of GDP spent on managing the immediate emergency health response to the pandemic (IMF 2020c). This could and should be financed from a variety of sources, including, if available, from emergency response funds, reserves, repurposing nonurgent financing, and using external financing as needed, combined with the removal of relevant duties and taxes as needed. Building resilience is also key. To best prepare for any second wave and future pandemics, countries should be monitoring and evaluating what has worked and what has not in health financing during the response phase and sharing this knowledge with policy makers domestically and internationally. Well-functioning public financial management (PFM) systems can also play an important role in strengthening resilience. Ensuring smooth and predictable flow of funds for emergency procurement, across different government agencies and levels of administration, is critical. In addition, flexibility in resource management—including, for example, allowing for provision of risk adjustments to wages for frontline health workers—should be considered. More generally, ensuring that available funds get to where they are needed rapidly, and can be used with more flexibility, during the response phase will also be important. Ensuring that enhanced spending and flexibility does not come with greater fraud will need to be a key consideration, prompting calls for removing PFM bottlenecks but also for "keeping the receipts" (IMF 2020d).

Prioritize Health in Government Budgets, Including via Debt Relief: Ensuring health gets sufficient priority in budget discussions is critical now, given the need to spend on the COVID-19 response while maintaining other essential health services. Financing needs will be massive for vaccination drives (once an effective vaccine becomes available), both in terms of procurement costs and incremental delivery costs. It is also important during the recovery phase when governments frequently prioritize supporting employment and economic growth rather than social spending. The new normal in health will be somewhat different to the pre-COVID-19 normal, with higher health spending requirements, including for enhanced pandemic preparedness. This is because prudent health policy will require governments to maintain stocks of COVID-19–related medicines, equipment, and hospital beds, even if they remain unused. They will also have to address the pent-up demand that has built up during the response phase because some health interventions had to be deferred, on top of maintaining other essential health services such as routine childhood immunization, maternal and child health services, and prevention and treatment of communicable diseases. Even heavily indebted countries will need to spend more for the COVID-19 response, and there are fears that the world could face another debt crisis. Early debt relief is one solution, as a form of provision of development assistance to countries most in need. Supporting that at least some of the forgiven debt can be used to fund health is a valuable role for external partners, even if they are not debt owners.

Sustain and Expand Coverage, Delinking Prepayment from Entitlement in SHI Programs: Sustain and enlarge coverage. Several countries have made COVID-19–related services universally accessible, effectively expanding coverage to people previously lacking it. Governments should sustain this coverage expansion and build on it for other essential services. And, while doing this, delinking prepayment from entitlement in SHI programs. Previous crises have been triggers for reforms related to expansion of coverage, especially for the poor. This reform could, similarly, be one that removes the connection between whether or not one prepays into the scheme versus whether or not one gets covered. Impoverishment and unemployment will make it difficult to administratively and financially manage schemes that do not do so, given the scale of changes in economic status that are ongoing as a result of the pandemic.

Mobilize Adequate Domestic Revenues, Including via Health Taxes: Even before the pandemic, general government revenues were relatively low in many low- and middle-income countries. Tax revenue collection rates are especially low, often far below the 15 percent of GDP benchmark that has recently been identified as necessary for sustainable growth and development across countries (Gaspar, Jaramillo, and Wingender 2016). Shortfalls in revenue collection are due to challenges in collection of both "direct" taxes (e.g., taxes on income and profits) as well as "indirect" taxes (e.g., taxes on consumption of goods and services), the former being especially difficult to overcome. Improving tax revenue collection will require the efficient design and implementation of value-added taxes, improving property taxation, and increasing the base for taxing income from firms and individuals (IMF 2020e). It is also an opportune time for countries to consider significantly ramping up health taxes—taxes on goods and services that have harmful health effects such as on tobacco, alcohol, sugar-sweetened beverages, and carbon emissions—and to remove subsidies on fossil fuels. Given declining outputs and government revenues resulting from the pandemic, health taxes can help plug some of the shortfalls and are far less likely to face political opposition in light of the tightening fiscal environment. Given the nature of excise duties, health taxes may be easier to collect than broader consumption taxes. Soft earmarks of revenues raised thus targeted toward pro-poor health programs could help offset some concerns related to the potential regressivity of some such measures. Recent analysis shows that if one takes into account the externality of increased health costs, the net effect of these taxes is not regressive and likely to be pro-poor when linked to progressive health policies such as UHC expansion to the poor (Fuchs Tarlovsky et al. 2019).

Improve Value for Money in Health and Enhance Pro-Poor Targeting. Take the opportunity to improve value for money in health. Inefficiencies abound in health and seizing the opportunity to get more efficient during the crisis can have long-lasting benefits. Some countries have already taken steps during the crisis, including increasing the use of telemedicine and the digital economy. Reducing fragmentation of fund flows and also parallel administrative arrangements to improve efficiency of public spending on health would be important reform areas. Given the large projected increase in the number of people living in extreme poverty, ensuring that these people obtain the health services they need, without further financial hardship, is critical. Appropriate targeting is required as is the capacity to monitor the targeting; primary health care services must be bolstered and scarce public resource use optimized.

In conclusion, to reduce the likelihood of a scenario in which public spending on health could decline or remain stagnant as a result of the economic contagion from COVID-19, and with the caveat that protecting levels of financing will not be effective if resources are not used properly to begin with, ministries of health will need to pay careful attention to planning and budgeting—demonstrating where waste can be reduced and efficiency enhanced—and prioritize within their outlays interventions that are the most cost-effective and equitable. At the same time, ministries of finance should improve the adequacy and predictability of outlays for the sector, taking a multiyear programming perspective in doing so, while considering augmenting resources by increasing the scope and breadth of pro-health taxes and proactively seeking out debt relief opportunities, especially if these can be tied to efforts to reprioritize health within overall government budgets where necessary.[24] Whereas there is the perception that the health sector has been flooded with new resources to manage the pandemic, it remains unclear to what extent these have been additional and not a result of reprogramming of outlays from other areas within health. If this additionality did happen, it was ad hoc and of an emergency nature drawing on contingencies and targeted resource mobilization efforts and may not be sustained. To the extent COVID-19 presents an opportunity, it is one for removing any doubts that health and the economy are inextricably linked, nudging both ministries of health and finance to reevaluate their priorities, accountabilities, and performance to sustain improvements in population health, including for ensuring pandemic preparedness, *and* economic performance.

24. For more on reprioritization challenges, see Tandon et al. (2014).

REFERENCES

Bhutta, Z. A., F. A. Bawany, A. Feroze, A. Rizvi, S. J. Thapa, and M. Patel. 2009. "Effects of the Crises on Child Nutrition and Health in East Asia and the Pacific." *Global Social Policy* 9: 119–43.

Brinkman, H. J., S. de Pee, I. Sanogo, L. Subran, and M. W. Bloem. 2010. "High Food Prices and the Global Financial Crisis Have Reduced Access to Nutritious Food and Worsened Nutritional Status and Health." *Journal of Nutrition. Supplement: The Impact of Climate Change, the Economic Crisis, and the Increase in Food Prices on Malnutrition* 10: 153–61S.

Fan, V. Y., and W. D. Savedoff. 2014. "The Health Financing Transition: A Conceptual Framework and Empirical Evidence." *Social Science and Medicine* 105: 112–21.

Fuchs Tarlovsky, A., P. V. Marquez, S. Dutta, and M. F. Gonzalez Icaza. 2019. "Is Tobacco Taxation Regressive? Evidence on Public Health, Domestic Resource Mobilization, and Equity Improvements." WBG Global Tobacco Control Program. Washington, DC: World Bank Group.

Gaspar, V., L. Jaramillo, and P. Wingender. 2016. "Tax Capacity and Growth: Is there a Tipping Point?" IMF Working Paper no. WP/16/234. Washington, DC: International Monetary Fund.

Hale, T., N. Angrist, E. Cameron-Blake, L. Hallas, B. Kira, S. Majumdar, A. Petherick, T. Phillips, H. Tatlow, and S. Webster. 2020. "Oxford COVID-19 Government Response Tracker." Oxford, UK: Oxford University, Blavatnik School of Government.

Hopkins, S. 2006. "Economic Stability and Health Status: Evidence from East Asia before and after the 1990s Economic Crisis". *Health Policy* 75: 347–57.

Hou, X., R. F. Lunes, O. K. Smith, E. V. Velenyi, and A. S. Yazbeck. 2013. "Learning from Economic Downturns: How to Better Assess, Track, and Mitigate the Impact on the Health Sector." Washington, D.C: World Bank Group.

IMF (International Monetary Fund). 2020a. "A Crisis Like No Other, An Uncertain Recovery." *World Economic Outlook* Update (June). Washington, DC: IMF.

_____. 2020b. "Policy Responses to COVID-19." https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19.

_____. 2020c. "The Great Lockdown." *World Economic Outlook* (April). Washington, DC: IMF.

_____. 2020d. "Keeping the Receipts: Transparency, Accountability, and Legitimacy in Emergency Responses." Special Series on Fiscal Policies to Respond to COVID-19. Washington, DC: IMF.

_____. 2020e. Fiscal Monitor (April). Washington, DC: IMF.

IHME (Institute for Health Metrics and Evaluation). 2020. *Development Assistance for Health Database, 1990–2019*. Seattle: IHME.

Kutzin, J., W. Yip, and C. Cashin. 2016. "Alternative Financing Strategies for Universal Health Coverage." In *Handbook of Global Health Economics and Public Policy,* vol. 1, *The Economics of Health and Health Systems*, ed. R. M. Scheffler, 267–309. Singapore: World Scientific Publishing.

Kwon, S., Y. Jung, A. Islam, B. Pande, and L. Yao. 2010. "The Impact of the Global Recession on the Health of the People in Asia" in *Poverty and Sustainable Development in Asia: Impacts and Responses to the Global Economic Crisis*, ed. A. Bauer and M. Thant. Mandaluyong City: Asian Development Bank.

McIntyre, D., and F. Meheus. 2014. "Fiscal Space for Domestic Funding of Health and Other Social Services." London: Chatham House.

Mcintyre, D., F. Meheus, and J. A. Røttingen. 2017. "What Level of Domestic Government Health Expenditure Should We Aspire to for Universal Health Coverage?" *Health Economics, Policy and Law* 12: 125–37.

OECD (Organisation for Economic Co-operation and Development). 2020. *Revenue Statistics in Asian and Pacific Economies, 2020*. Paris: OECD Publishing.

Roser, M., H. Ritchie, E. Ortiz-Ospina, and J. Hasell. 2020. "Coronavirus Pandemic (COVID-19)." https://ourworldindata.org/coronavirus.

Tandon, A., L. Fleisher, R. Li, and W. A. Yap. 2014. "Reprioritizing Public Spending on Health: Pushing an Elephant Up the Stairs?" HNP Discussion Paper. Washington, DC: World Bank Group.

Tandon, A., J. Cain, C. Kurowski, and I. Postolovska. 2018. "Intertemporal Dynamics of Public Financing for Universal Health Coverage: Accounting for Fiscal Space Across Countries." HNP Discussion Paper. Washington, DC: World Bank Group.

Tandon, A., J. Cain, C. Kurowski, A. Dozol, and I. Postolovska. 2020. "From Slippery Slopes to Steep Hills: Contrasting Landscapes of Economic Growth and Public Spending for Health." *Social Science and Medicine* 259: 113171.

Thomson, S., J. Figueras, T. Evetovits, M. Jowett, P. Mladovsky, J. Cylus, M. Karanikolos, and H. Kluge. 2015. "Economic Crisis, Health Systems and Health in Europe. Impact and Implications for Policy." European Observatory on Health Systems and Policies Series. Geneva: World Health Organization.

World Bank. 2020a. "Pandemic, Recession: The Global Economy in Crisis." Global Economic Prospects. Washington, DC: World Bank.

_____. 2020b. "Projected Poverty Impacts of COVID-19 (Coronavirus)." Brief (June 8). https://www.worldbank.org/en/topic/poverty/brief/projected-poverty-impacts-of-COVID-19.

_____. 2020c. "Debt Service Suspension and COVID-19." Factsheet (May 11). https://www.worldbank.org/en/news/factsheet/2020/05/11/debt-relief-and-covid-19-coronavirus.

WHO (World Health Organization). 2010. "Health Systems Financing, the Role to Universal Health Coverage." World Health Report. Geneva: WHO.

_____. 2019. "Primary Health Care on the Road to Universal Health Coverage." Global Monitoring Report. Geneva: WHO.

_____. 2020. Government Health Expenditure Database. https://apps.who.int/nha/database.

Yang, B., N. Prescott, and E. Bae. 2001. "The Impact of Economic Crisis on Health-Care Consumption in Korea." *Health Policy and Planning* 16 (4): 372–85.

COVID-19's impact has gone far beyond its direct effect on morbidity and mortality. Tentative projections indicate that, in the absence of reprioritization, growth in public spending for health could decline across most low- and middle-income countries in the region, including becoming negative in some cases, risking reversal of gains made toward expanding universal health coverage in recent years. To reduce the likelihood of such a scenario, and with the caveat that protecting levels of financing will not be effective if resources are not used properly to begin with, ministries of health will need to pay careful attention to planning and budgeting—demonstrating where waste can be reduced and efficiency enhanced—and prioritize within their outlays interventions that are the most cost-effective and equitable. To the extent COVID-19 presents an opportunity, it is one for removing any doubts that health and the economy are inextricably linked, nudging both ministries of health and finance to reevaluate their priorities, accountabilities, and performance to sustain improvements in both population health, including for ensuring pandemic preparedness, and economic performance.

ABOUT THIS SERIES:

This series is produced by the Health, Nutrition, and Population Global Practice of the World Bank. The papers in this series aim to provide a vehicle for publishing preliminary results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual author/s whose name appears on the paper. Enquiries about the series and submissions should be made directly to the Editor Martin Lutalo (mlutalo@ worldbank.org) or HNP Advisory Service (askhnp@worldbank.org, tel 202 473-2256).

For more information, see also www.worldbank.org/hnppublications.

1818 H Street, NW
Washington, DC USA 20433

Telephone: 202 473 1000
Facsimile: 202 477 6391
Internet: www.worldbank.org
E-mail: feedback@worldbank.org