

Priorities for the Health Financing Response to COVID-19

by

the Health Financing Team at WHO's Headquarters and Regional Offices

31 March 2020

By now, every country in the world is affected by the COVID-19 pandemic. The need to act is urgent, but the response must be coherent. It will be of little help if the urgency of the moment leads to chaos in how countries and the global community respond. This requires distinguishing what needs to be done – actions in service delivery, financing, and governance – from the objectives to be achieved in terms of health security and universal health coverage (UHC). The choice is not between [health security and UHC](#). Investing in [core health systems-functions](#) is key to both, complemented by public policy actions beyond the health system.

At this moment, the planning, organization and reconfiguration of service delivery to meet immediate needs are the priority. Health financing measures can play a supportive role to facilitate a rapid, organized response to the pandemic. More specifically, the health financing response must support the scaling-up and delivery of the appropriate population-based and individual services in two important ways. These are the objectives for health financing in the current context, and should be pursued concurrently:

- **ENSURE SUFFICIENT FUNDING FOR COMMON GOODS FOR HEALTH**, i.e. population-based functions such as comprehensive surveillance (including laboratories), data and information systems, regulation, and communication and information campaigns. Funding these “[Common Goods for Health](#)” (CGH) helps ensure that the public health functions needed to be prepared for, and to respond to the crisis, are in place. In many countries, unfortunately, investment in [preparedness](#) was not sufficiently prioritized in recent years or in the weeks since the outbreak began. This problem can be redressed to strengthen systems to respond now to COVID-19, and to be better prepared for future challenges.
- **REMOVE FINANCIAL BARRIERS TO HEALTH SERVICES** to enable the timely diagnosis and treatment of COVID-19 for all who need them. It is essential that people understand and are enabled to act upon the advice of health authorities regarding when and where to seek care. Concerns about the affordability of health care for individuals and households should not be a factor in care-seeking decisions, particularly during a pandemic.

Key health financing actions to support these objectives are identified below.

1. **Increase public funding for the health system response**, including donor funds where these exist, to support both objectives. This will require actions on budgeting and public financial management (PFM) mechanisms to expand and re-prioritize [budgetary space](#) for the COVID19 response, as well as on processes to [coordinate, ensure complementarity, and align funds](#) (domestic and donor) for a comprehensive, government-wide response, cutting across health and finance authorities, national and sub-national levels of government, any other health service purchasing agencies (e.g. national/social health insurance agencies), and health care providers.
 - a) [Increase prioritization](#) for the health sector within the overall government budget, particularly as domestic public and donor funds are mobilized for the response. This may be reflected in the activation of exceptional spending processes in the first phase of the crisis, and subsequently formalized through supplementary budget laws.

- b) Reprogram funds rapidly to ensure [adequate, stable and sustained funding for CGH](#). Although more funding will not, in itself, secure adequate supplies, surveillance systems, contact tracing, water and sanitation, public health messaging, testing and laboratory capacities, directing adequate funding to these activities is critical. Constraints that impede the level or flow of funds should be removed as soon as possible.
 - c) Reprogram budgetary funds so that health services can cope with expected increases in demand and outreach services, incorporating needs for additional inputs and overtime pay for health workers, and facilitating access to testing and treatment for hard-to-reach populations.
 - d) Create a specific [budgetary program](#) for COVID-19 response in revised budgets to facilitate execution and expenditure tracking
 - e) Grant greater flexibility and spending authority for frontline service providers so that they can respond rapidly to shortages or stockouts of key supplies (e.g. soap, materials, medicines).
 - f) Ensure transparent reporting mechanisms on the use of these funds across all levels.
 - g) In countries receiving donor funds, engage funders in dialog to help fill gaps in national response plans and align with domestic PFM mechanisms.
- 2) **Adjust health financing policies to remove financial barriers to care**, making services free at the point of use. Co-payments (user fees) should be suspended as a complement to service delivery strategies designed to cope with the pandemic, including encouraging home care and tele-consultation where feasible.

This measure is not meant to encourage everyone to come to health facilities, but rather to remove financial considerations as a factor in someone's decision to seek care because the evidence is overwhelming that [fees](#) at the point of use do not selectively deter "unnecessary" care but reduce use of all services, particularly for poorer persons. If people believe or are unsure whether or not they will have to pay, they may delay or forego [seeking care](#), making the pandemic harder to control and putting entire societies at risk. Therefore, persons needing treatment or in quarantine and isolation should not be asked to pay for services, including treatment of co-morbidities, because the expectation of payment, even for non-COVID-19 services, can inhibit people from obtaining necessary care.

A mere declaration of free services is not enough, however, especially in those countries where [informal payment](#) (e.g. for medical supplies or to health workers) for ostensibly free services has been [people's lived reality](#) or where people face high transport costs or other barriers to access.

- a) [Suspend all co-payments \(user fees\)](#) for all patients, regardless of their insurance, citizenship, or residence status, for services in health facilities, home-based care, and for services during quarantine or isolation. Clearly communicate this simple message to the population.
- b) Compensate health facilities for the loss of co-payment income as part of the overall public funding measures described above, to enable providers to cope with increased demand. As part of the measures to increase public funding (per actions (e) and (f) above), give greater authority to facility managers to use these funds, balancing this increased flexibility with transparent reporting requirements. Consider supplements for additional health worker incentives.
- c) Develop or simplify protocols that allow private providers to be integrated and contracted, including related payment methods, rates, and information reporting requirements.
- d) [Advance payments](#) to public and private providers to cope with anticipated increases in demand. This can be done by front-loading budgets or capitation payments, or by "pre-

funding” payments that would otherwise come through retrospective reimbursement of claims.

- e) Adapt payment models and pricing to reinforce changes in the location and delivery mode for services during the response, including for home-based care, tele-consultation and other forms of e-health.
- f) Consider [multi-purpose cash transfers](#) to households, including those who may not be reached by conventional mechanisms, such as refugees, internally displaced persons, migrants, and homeless people, using [digital platforms](#) where feasible. Cash transfers may be particularly important in poorer regions of a country and in [fragile and conflict-affected](#) contexts, including possibly specific settings such as [refugee camps](#), to enable people to stay home as needed while obtaining food and other necessities and alleviating indirect costs of seeking care, including transport costs and foregone earnings from lost labour time; they should not, however, be used as a justification for keeping in place user fees for health services. Implementing cash transfers is likely to involve [targeted social assistance](#), in collaboration with the relevant ministerial authority for this (e.g. social protection ministry or agency).

As with the rest of the health system, health financing arrangements need to adapt to and support the current context quickly. Most of all, financing mechanisms need to be simplified, streamlined, and accompanied by clear communication to the population regarding entitlements and the desired patterns of care seeking. The actions outlined here provide a roadmap as services are reconfigured and scaled-up and will provide a [strong foundation](#) for health financing arrangements that are better prepared to support health security and UHC in the future.

This product reflects a collective effort by the World Health Organization’s Health Financing Team at Headquarters and the Regional Offices for Africa, the Americas, Eastern Mediterranean, Europe, South-East Asia and Western Pacific. Specific contributors to the report were Joseph Kutzin, Susan Sparkes, Agnès Soucat, Hélène Barroy, Matthew Jowett, Camilo Cid, Peter Cowley, Jonathan Cylus, Valeria de Oliveira Cruz, Fahdi Dkhimi, Alexandra Earle, Tamás Evetovits, Xu Ke, Awad Mataria, Inke Mathauer, Bruno Meessen, Diane Muhongerwa, Juliet Nabyonga, Claudia Pescetto, Tomas Roubal, Sarah Thomson, Tsolmongerel Tsilaajav, Prosper Tumusiime, and Hui Wang.