Financial Protection in Health in the COVID-19 era

The baseline, what to expect, and how to respond

Financing Primary Health Care: Opportunities at the Boundaries

June 14-16, 2022
Interactions & Questions: Virtual Participants

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Side Event 1

Financial Protection in Health in the COVID-19 era

Ajay Tandon
Lead Economist, World Bank

Patrick Eozenou
Senior Economist, World Bank

Tamar Gabunia
First Deputy Minister Ministry of Internally Displaced People from the Occupied Territories, Labor, Health and Social Affairs, Georgia

Gabriela Flores
Senior Health Economist, World Health Organization

Amala de Silva
Senior Professor Dept. Economics, University of Colombo, Sri Lanka

Shabnum Sarfraz
Senior Development Professional Federal Planning Commission, Pakistan

June 14th / 08:00 – 09:30 EST
Financial Protection in Health in the COVID-19 era

The baseline, what to expect, and how to respond

Gabriela Flores (WHO), Patrick Eozenou (World Bank)
Financial hardship and financial barriers to access are key consequences of inadequate financial protection mechanisms.
Tracking financial hardship across the whole population: catastrophic and impoverishing health spending

**Data source:** HH surveys with "consumption aggregate" and OOP data ( > 900, representing > 80% of world population for new estimates in 2021 report).

- **CATastrophic OOP**
  Share of population with out-of-pocket medical spending (OOP) exceeds 40% of household budget.

- **IMPOVerishing OOP**
  Share of population pushed under (absolute and relative) poverty line by OOP.

- **Pushed further into poverty by OOP**
  Share of already poor population (absolute and relative) with any OOP.

- **New in 2021 report**

**Graphical representation:**
- Consumption expenditure
- Health out-of-pocket
- Total consumption
- Poverty line
- Cumulated % of population

- No financial hardship
- Spend more than 10% and not pushed into poverty
- Pushed into poverty
- Further pushed into poverty
The world was off-track to reduce financial hardship prior to the pandemic

• Incidence of catastrophic health spending increased continuously

• Incidence of impoverishing health spending decreased continuously
The world was off-track to reduce financial hardship prior to the pandemic

1.4 Billion incurred Financial Hardship (2017 baseline)

- 996 million people with catastrophic OOP (SDG 3.8.2)
- 505 million people with impoverishing OOP
- 435 million people pushed further into extreme poverty by OOP
- 70 million people pushed into extreme poverty by OOP

• over half a billion people were pushed or further pushed into extreme poverty by out-of-pocket health spending, even when small
Most people incurring financial hardship in 2017 lived in middle-income countries

Circle sizes proportional to the size of population facing financial hardship

1. The population facing catastrophic payments is concentrated in LMICs (43%) and UMICs (44%).

Reason: In LMICs and UMICs, population (39%, 34%) is much larger and incidence higher than elsewhere.

2. The population facing impoverishment into extreme poverty (pushed and further pushed) is concentrated in LICs (33%) and LMICs (52%).

Reason: Very high incidence in LICs, large population and high incidence in LMICs.

3. The population facing impoverishment into relative poverty (pushed and further pushed) is concentrated in UMICs (43%).

Reason: UMICs with large population and high incidence.
It is critical to reduce financial hardship on the path to UHC

Globally service coverage increased but catastrophic spending due to accessing health services worsened over the past two decades

Figure E5.1 Progress in service coverage (SDG indicator 3.8.1) and catastrophic health spending (SDG indicator 3.8.2, 10% threshold), 2000–2017

1. Income is a driver.
2. People with more money spend more.

Understanding the past matters because it helps us identify priorities going forward during this period. Would it be possible to reverse this course?
Available limited evidence points to an increase in both forgone care for financial reasons and financial hardship for those spending on health out-of-pocket.

Trends in catastrophic health spending (SDG indicator 3.8.2, 10% threshold), 2020

1. Very few surveys conducted in 2020, only partially covered the pandemic period;

2. Important to track forgone care;
OOPs for new type of services and products emerged during the pandemic, representing an additional source of financial hardship.
Potential pathways for the impact of COVID-19 on financial protection

- COVID-19 Pandemic
- Public health and social measures
- Massive supply and demand shock
- Increase in unemployment and informality
- Lower GDP
- Increased poverty

- Supply of Health Services
- Demand for Health Services
- Other Health Determinants
- Household income
- Domestic Government Revenues
- External Financing
- Social Health Insurance Contributions
- Private Insurance Contributions

- Utilization
- Foregone care
- Lower/higher out-of-pocket payment
- Decreased capacity to pay
- Deeper poverty

Impact on financial protection

a: Containment efforts, expanded COVID-related care; crowding-out of non-COVID supply; higher price of medicines
b: COVID-related increase in utilization; fear and lockdown-related decline in utilization; increased rate of self-medication
c: Reduction in air pollution and road traffic accidents, improved hygiene, face masks; mental health, self-medication
COVID-19 Also Had Massive Economic Impact on GDP…

Much worse, more widespread than previous crises

Mixed prospects for recovery remain, even with positive growth, economic output will take longer to revert to pre-crisis levels

Variable economic impact across countries: overwhelming majority saw a contraction in 2020; even the few that did not contract did see an economic slowdown
The Economic and Health Impacts of the COVID-19 Pandemic are Leading to a Significant Worsening of Financial Protection

Global Extreme Poverty, 2015-2021

Households reporting affordability as the main reason for not accessing healthcare when needed, 2021

% of those unable to access care

Public spending on health is expected to face constraints in the years to come

**a) Change in aggregate government revenues, 2017–2023**

**b) Change in aggregate government expenditure, 2017–2023**

Source: Authors calculations using data from IMF (2021) (2).
Public spending on health is expected to face constraints in the years to come
c) Deficit and debt levels have increased globally
Targeted public spending and policies to ensure access to essential services and financial protection during the pandemic

- Dramatically exacerbated fiscal constraints
- Smart, targeted policies to ensure access to essential services and financial protection for those most in need
  - Exempt poor and near-poor from OOP spending, extend coverage for the elderly
  - Expand and deepen social protection
  - Cash transfers to the poor
- Funding primarily from domestic resources
  - International assistance highly critical for low- and middle-income countries
## Concluding points

<table>
<thead>
<tr>
<th>COVID-19 not just a health ‘shock’, it has also adversely impacted economic activity, poverty rates have risen, unemployment is up, remittances are down; vaccines also economic stimulus intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public revenues declined but public expenditures increased to finance emergency response/vaccines, and public debt has risen; tightening of fiscal space will likely continue for several years</td>
</tr>
<tr>
<td>The impact of COVID-19 on financial protection will be driven by health sector financing, supply and demand side factors, as well as by broader social protection coverage and poverty dynamics</td>
</tr>
<tr>
<td>Assessing the actual net impact of this shock on financial protection will require actual household expenditure survey data post COVID and setting up more agile, nimble and responsive data collection instruments</td>
</tr>
</tbody>
</table>
Improving Financial Protection in Health in Pakistan

The Covid pandemic, economic crisis, and beyond

Dr Shabnum Sarfraz
Planning Commission, Government of Pakistan
PUBLIC IS CONTRIBUTING THE MOST TO THE CURRENT HEALTH EXPENDITURE

- Local NGOs: 5.9%
- Official Donor Agencies: 0.6%
- Federal & Provincial Government: 29.7%
- Military health expenditure: 51.7%
- District & Tehsil Government: 3.1%
- Social Security: 6.0%
- Autonomous Bodies: 0.3%
- Out of Pocket Expenses: 1.0%
Widening gap between current and development public sector expenditure

HEALTH EXPENDITURE AS % OF GDP STAGGERING

GOVERNMENT EXPENDITURE NOT INCREASING IN PROPORTION TO TOTAL INCREASE
PAKISTAN FARING LOW REGIONALLY

REGIONAL HEALTH FINANCING PERFORMANCE (2019)

Recommended Current Health Expenditure as % of GDP = 5%

- General government health expenditure (GGHE-D) as percentage of current health expenditure (CHE) (%)
- Out of Pocket expenditure (Health) per capita (US$)
- Health Expenditure per Capita (US$)
- Total Health Expenditure as % of GDP
National and Provincial Health Expenditures (2017-18)

**FEDERAL AND PROVINCIAL HEALTH EXPENDITURE BY SOURCE**

<table>
<thead>
<tr>
<th>Source</th>
<th>Federal Government</th>
<th>Provincial Government</th>
<th>District/ Tehsil Governments</th>
<th>Autonomous Bodies</th>
<th>Employer Funds</th>
<th>Out of Pocket Expenses</th>
<th>Official Donor Agencies</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Baluchistan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20%</td>
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<tr>
<td>KPK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>40%</td>
</tr>
<tr>
<td>Sindh</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>Punjab</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

**PER CAPITA GOVERNMENT HEALTH SPENDING**

<table>
<thead>
<tr>
<th>Province</th>
<th>Health Budget 2020-21 in PKR Billion</th>
<th>2021 Population in Million projected using Census 2017</th>
<th>Health Budget in Actual PKR Per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azad Jammu and Kashmir*</td>
<td>11</td>
<td>4.89</td>
<td>2719</td>
</tr>
<tr>
<td>Gilgit Baltistan*</td>
<td>3.42</td>
<td>1.98</td>
<td>1727</td>
</tr>
<tr>
<td>Baluchistan*</td>
<td>31.4</td>
<td>14.09</td>
<td>2361</td>
</tr>
<tr>
<td>Khyber Pakhtunkhwa*</td>
<td>106</td>
<td>39.81</td>
<td>2802</td>
</tr>
<tr>
<td>Punjab*</td>
<td>293</td>
<td>119.69</td>
<td>2539</td>
</tr>
<tr>
<td>Sindh</td>
<td>156.4</td>
<td>52.67</td>
<td>3095</td>
</tr>
</tbody>
</table>
GAP TO CLOSE TO MEET SDG2030 COMMITMENTS

SDG 3 - Key Indicators 2019 and 2030 Targets

- Penta3 Immunization coverage
- Skilled Birth Attendance
- Maternal Mortality Ratio
- Tuberculosis effective treatment
- Under 5 Mortality Rate
- Universal Health Coverage Index
- Family Planning demand satisfied with modern method
- Essential Health Workforce Density
- Total Health Expenditure as % of GDP
- Hospital Beds Density

Monitoring Health for SDGs, PDHS 2017-18, PSLM 2019-20, NHA 2017-18 NNS, NTP-MIS, PES 2019
### PROVINCIAL PERFORMANCE ON SDGS (2019)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Punjab</th>
<th>Sindh</th>
<th>KP (FATA)</th>
<th>Balochistan</th>
<th>GB</th>
<th>AJK</th>
<th>Pak</th>
<th>Bangladesh</th>
<th>Iran</th>
<th>India</th>
<th>Sri Lanka</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mortality Ratio*</td>
<td>157</td>
<td>224</td>
<td>165</td>
<td>298</td>
<td>157</td>
<td>104</td>
<td>186</td>
<td>176</td>
<td>25</td>
<td>174</td>
<td>30</td>
</tr>
<tr>
<td>Skilled Birth Attendance*</td>
<td>71.3</td>
<td>74.8</td>
<td>67.4 (52.1)</td>
<td>38.2</td>
<td>64.4</td>
<td>64.1</td>
<td>69.3</td>
<td>69.8 (50.5)</td>
<td>50.5</td>
<td>81.4</td>
<td>99</td>
</tr>
<tr>
<td>Under 5 Mortality Rate*</td>
<td>85</td>
<td>77</td>
<td>64 (33)</td>
<td>78</td>
<td>76</td>
<td>53</td>
<td>74</td>
<td>37</td>
<td>15</td>
<td>47</td>
<td>9</td>
</tr>
<tr>
<td>Neonatal Mortality Rate*</td>
<td>51</td>
<td>38</td>
<td>42</td>
<td>34</td>
<td>47</td>
<td>30</td>
<td>42</td>
<td>19.06</td>
<td>8.58</td>
<td>21.66</td>
<td>4.27</td>
</tr>
<tr>
<td>FP demand satisfied with modern methods*</td>
<td>50.3</td>
<td>50.2</td>
<td>45.1 (35.3)</td>
<td>33.8</td>
<td>46.4</td>
<td>38.5</td>
<td>48.6</td>
<td>70.3</td>
<td>68.5</td>
<td>61.7</td>
<td>74.3</td>
</tr>
<tr>
<td>Universal Health Coverage Index</td>
<td>48.03</td>
<td>47.95</td>
<td>45.87</td>
<td>35.41</td>
<td>44.6</td>
<td>47.7</td>
<td>47.2</td>
<td>46</td>
<td>65</td>
<td>56</td>
<td>62</td>
</tr>
<tr>
<td>Essential Health Workforce Density</td>
<td>1.45</td>
<td>2.02</td>
<td>1.2</td>
<td>0.63</td>
<td>0.46</td>
<td>0.51</td>
<td>1.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penta3 Immunization coverage*</td>
<td>89</td>
<td>59.2</td>
<td>64.9 (42.6)</td>
<td>37.3</td>
<td>61.1</td>
<td>84.3</td>
<td>75.4</td>
<td>94</td>
<td>98</td>
<td>87</td>
<td>99</td>
</tr>
<tr>
<td>Tuberculosis effective treatment</td>
<td>59.5</td>
<td>54.4</td>
<td>54.9</td>
<td>30.7</td>
<td>62.8</td>
<td>43.7</td>
<td>54.9/93</td>
<td>94</td>
<td>86</td>
<td>82</td>
<td>85</td>
</tr>
<tr>
<td>Hospital Beds Density per 1000</td>
<td>2.89</td>
<td>7.7</td>
<td>6.5</td>
<td>5.94</td>
<td>0.82</td>
<td>3.77</td>
<td>5.21</td>
<td>7.9</td>
<td>15.6</td>
<td>5.3</td>
<td>41.5</td>
</tr>
<tr>
<td>Stunting*</td>
<td>36.4</td>
<td>45.5</td>
<td>40 (48.3)</td>
<td>46.6</td>
<td>46.6</td>
<td>39.3</td>
<td>40.2</td>
<td>28</td>
<td>6.8</td>
<td>34.7</td>
<td>17.3</td>
</tr>
<tr>
<td>Wasting*</td>
<td>15.3</td>
<td>23.3</td>
<td>15 (23.1)</td>
<td>18.9</td>
<td>9.4</td>
<td>16.1</td>
<td>17.7</td>
<td>9.8</td>
<td>4</td>
<td>20.8</td>
<td>15.1</td>
</tr>
<tr>
<td>Government Health Spending (US$)</td>
<td>16.56</td>
<td>20.1</td>
<td>18.2</td>
<td>15.4</td>
<td>4.5</td>
<td>17.7</td>
<td>9.91</td>
<td>5.79</td>
<td>197.5</td>
<td>15.1</td>
<td>65.92</td>
</tr>
</tbody>
</table>

Source: PDHS, PMMS, PSLM, NNS, NTP-MIS
SBP's Timely & Innovative Measures Helped Save Jobs and Supported Industry

- Introduced Refinance Facility new industrial investments (TERF) & hospitals
- Introduced a Rozgar scheme to prevent layoff by financing wages & salaries of employees
- Provided relief for loan restructuring to borrowers to combat economic disruptions
- Introduced principal loan extension program to ease cash constraints of borrowers
- SBP reduced the policy rate by 625 bps in a short span of time

Billion rupees & % of GDP FY2019-20

- 470, 1.1% - Interest rate benefit
- 254, 0.6% - Loan rescheduling
- 657, 1.6% - Loan deferment
- 238, 0.6% - Rozgar scheme
- 454, 1.1% - Total

Source: SBP Governor’s Presentation

Impact of policy interventions* by the SBP during GFC and Covid
as % of GDP

GFC 2008
- CRR, 0.9
- Interest Rate, 0.6

COVID-19
- TERF & support for hospitals, 1.1
- Rozgar scheme, 0.6
- Loan rescheduling, 0.6
- Loan deferment, 1.6
- Interest rate, 1.1

5

Source: SBP Governor’s Presentation
## Government Sector Footprint

<table>
<thead>
<tr>
<th>Sector</th>
<th>GoP Share in Sector (%)</th>
<th>Sector Share in GDP (%)</th>
<th>GoP Share in Economy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>43.1</td>
<td>19.3</td>
<td>8.3</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>11.9</td>
<td>12.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Mining &amp; Quarrying</td>
<td>79.6</td>
<td>2.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Construction</td>
<td>75.0</td>
<td>2.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Transport &amp; Communication</td>
<td>73.4</td>
<td>12.3</td>
<td>9.0</td>
</tr>
<tr>
<td>Electricity Oil &amp; Gas</td>
<td>77.6</td>
<td>1.8</td>
<td>1.4</td>
</tr>
<tr>
<td>Wholesale &amp; Retail</td>
<td>7.9</td>
<td>18.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Health &amp; Education</td>
<td>49.3</td>
<td>6.5</td>
<td>3.2</td>
</tr>
<tr>
<td>Finance &amp; Insurance</td>
<td>45.5</td>
<td>3.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Other Services</td>
<td>60.0</td>
<td>20.8</td>
<td>12.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100 (%)</strong></td>
<td><strong>42.8 (%)</strong></td>
<td></td>
</tr>
</tbody>
</table>

Authors' Calculations – Based on estimates from Framework from Economic Growth (2011) and Haque, N. & Ullah, Raja. (2020)
Improving Financial Protection in Health in Sri Lanka

The Covid pandemic, economic crisis, and beyond

Prof. Amala de Silva
Sri Lanka had high OOPE & unmet needs despite free healthcare

- Sri Lanka – free healthcare since 1951 and a PHC system from the 1930s that preceded Alma Ata
- Limited fiscal space – averaging around 2% of total healthcare of 4%
- Problem stems from low taxation, high public debt, restricting government allocations to the health sector.
- Private healthcare expenditure is around 50% of total health expenditure with around 85% of private expenditure being out of pocket. In 2017 catastrophic health expenditure 5.3%

- While the majority of OOPE is borne by the higher income deciles, even the poor bear OOPE even in the context of free healthcare - Why?
  - Lack of NCD care at PHC level
  - Long waiting lists for surgery
  - Only morning NCD clinics so high opportunity cost of utilization, pushes poor to private sector, and then poor continuity of care due to affordability issues
  - Unmet need – delays in NCD screening and poor NCD control even post diagnosis
Impact of Covid-19 on financial protection

- Barriers in accessing free healthcare
- Substitution of private healthcare
- Unmet need and pent up demand
- Higher household healthcare expenditure, Catastrophic health expenditure, and health impoverishment

- Major Macroeconomic impacts affected health and the healthcare financial burden. In Sri Lanka the economic crisis was emerging and was only made marginally worsened by covid, but massive impact on tourism sector.

- Sri Lanka benefitted from external assistance particularly on vaccines: Controlled spread, and had a positive impact on financial protection through allowing economic activities to return to normal faster
Impact of economic crisis on financial protection

- Economic crisis, particularly depreciation of the dollar has increased drug prices.
- State sector facing drug shortages
- May result in Middle Class switching to state sector, that which will challenge access of poor further
- Rise in drug expenditure likely to result in greater health impoverishment and catastrophic health expenditure.
- Higher unemployment, low economic growth and hyper inflation are likely to contribute to the worsening of health and increasing the burden of healthcare expenditure.
Can Financial protection in Sri Lanka be improved?

**A Reform in Provision** - planned in 2018, pre-covid – but now crucial post covid and with the economic crisis

Shift to the Cluster Healthcare System - PHC encompassing NCD
NCD care is costly and long term, and NCDs often affect productivity and earnings so households affected by NCDs are more likely to face catastrophic health expenditure and impoverishment (WHO-SEARO 2008 Alawwa study).

Cluster Reform, a PHC focused on NCDs could become the corner stone in achieving ‘real UHC’.

From a health financing perspective, reduce OOPE of the poor
From an economic perspective enhance productivity and human capital, and contribute to growth;

**At institutional level improving efficiency and ensuring essential services to**

**Systematic Health financing reforms**
THANK YOU