

# Accelerating progress towards universal health coverage in South Asia in the era of COVID-19

How universal primary care can tackle the inseparable agendas of universal health coverage and health security

September 2021

COVID-19 represents the greatest global health threat in over a century and has propelled health to the forefront of political agendas. Yet across South Asia, countries have responded to the pandemic with variable levels of success. Those countries which have historically made most progress towards achieving universal health coverage (UHC) have undoubtedly benefited from stronger health systems and greater levels of financial risk protection in their pandemic response. This report looks at UHC through a COVID-19 lens, reflecting on some of the lessons learnt from the pandemic to date and providing some initial insights for South Asian countries to consider as they plan the next phase of their response to the coronavirus crisis and their long-term health strategies.

Rob Yates, Jessica Hamer, Nina van der Mark and Shaban Nganizi

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**Address:** UNICEF Regional Office for South Asia (ROSA)  
P.O. Box 5815, Lekhnath Marg, Kathmandu, Nepal  
Tel: +977-1-4417082 Email: [rosa@unicef.org](mailto:rosa@unicef.org)  
**Website:** [www.unicef.org/rosa/](http://www.unicef.org/rosa/)

**Design and layout:** Marta Rodríguez, Consultant

**Cover Photo:** ©UNICEF/UNI351555/Prasad Ngakhusi

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## ■ Acronyms

CMR – Child Mortality Rate

GDP – Gross Domestic Product

NCDs – Non-Communicable Diseases

OOPE- Out of Pocket Expenditure

PHC – Primary Health Care

PPE - Personal Protective Equipment

SAARC - South Asia Association for Regional Cooperation

SDGs – Sustainable Development Goals

UHC – Universal Health Coverage

UN HLM – UN High-Level Meeting

WHO – World Health Organization



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## Executive summary

Even in the midst of a global pandemic, countries can, and should, make progress towards universal health coverage (UHC), under which everyone accesses the quality health services they need without suffering financial hardship. Before COVID, UHC was driving the global health agenda – and it remains key during and beyond COVID. Achieving UHC is important, because it can deliver substantial benefits at a population level, not only improving health indicators, but also stimulating economic development, improving efficiency, reducing poverty and inequality, building social harmony, and maintaining political stability. At the UN High-Level Meeting in September 2019, all countries adopted a political declaration on UHC that saw them recommitting to achieving UHC by 2030. UHC is included in Sustainable Development Goal (SDG) 3, under target 3.8, and is often regarded as the key target for achieving the whole of SDG 3.

COVID-19 represents the greatest global health threat in over a century and has propelled health to the forefront of political agendas. But this crisis has also created opportunities for leaders to reform their health systems with the objective of achieving UHC. Looking at the countries that have made strong progress towards UHC, their health systems were often born out of disruptions, crises or disease outbreaks that exposed weaknesses in their health sector.

South Asia is an incredibly diverse region, with large variations in demographics, economic performance and health indicators. Although many factors outside the health sector – such as education, nutrition, poverty, gender equality and security – have an impact on health outcomes, access to effective health services plays an important role in maintaining and improving people's health status. Generally, countries with better coverage of health service tend to have better health outcomes. With the publication of the World Health Organization (WHO) and World Bank UHC Global Monitoring Reports in 2017 and 2019, South Asian countries can now track their performance in achieving UHC and compare their record against other countries. In the most recent UHC service coverage index, the average score for South Asia was 53, with all countries registering an improvement from 2017, with the exception of Nepal. Sri Lanka, the Maldives and Bhutan were the highest performers all scoring over 50, while India, Nepal, Pakistan and Afghanistan performed lower. While contexts differ widely, the UHC service coverage index is a good measure of the average coverage of essential health services in a country. Gaps in effective health coverage in the region are being driven by suboptimal quality and availability of key health service inputs and low levels of financial protection, associated with high levels of out-of-pocket expenditure (OOPE), both of which are closely associated with low levels of public health spending.

Around the world, UHC is achieved by governments increasing levels of public health financing and allocating these resources efficiently and equitably, with the specific objective of replacing inequitable out-of-pocket spending. As countries increase their public health spending, their levels of OOPPE tend to decrease. However, as well as increasing levels of public financing for health it is vital that these resources are spent efficiently and equitably, which involves prioritizing cost-effective primary health care (PHC) services over specialist inpatient hospital care. The UHC goals of financial protection, equitable access and quality services cannot be achieved without a focus on PHC components, such as scale-up of preventive and promotive services, community engagement and effective coverage of cost-effective essential services, as well as addressing the underlying determinants of health. PHC allows the health system to be more adaptive and responsive to local contexts and to the evolving needs of communities and individuals. It is a key way to address the main causes of poor health, because it focuses specifically on promotion, prevention and engaging people, families and communities. It is, therefore, a useful vehicle in the fight against novel pathogens and in preventing epidemics.

The COVID pandemic is a multi-year event. In the first half of 2021, more than a year since the first cases of COVID in the region, South Asia experienced a significant second wave of the pandemic, driven in part by the emergence of new, more transmissible variants. This has had a catastrophic impact in parts of the region, seeing health systems overwhelmed and shortages of key treatments such as medical oxygen.

Due to problems associated with data completeness and accuracy – which are not unique to South Asia – it is difficult to make robust comparisons between different country's approaches to the pandemic. However, it is

evident that responses and outcomes across the region and within countries have not been uniform. Looking at the outcomes of stronger performers suggests that tentative lessons can be drawn concerning the importance of universal health systems, response capacity, political commitment and the existence of a strong social contract. Countries that have responded relatively well to the pandemic so far, including Bhutan, the Maldives, and initially Sri Lanka, are all better performers on UHC indicators and have focused on early decisive action including the rapid scaling up of testing and surveillance capacity, building on existing health system foundations.

Preliminary evidence from South Asia indicates that UHC performance and, in particular, levels of public health spending and how resources are allocated are important factors in determining the effectiveness of a country's COVID-19 response. Where public financing has been low, the long-term underinvestment in health has left health systems ill-prepared to handle a crisis of this magnitude – resulting in the under-consumption of essential public and primary care services, especially by the poor. Evidence also suggests that a strong social contract, long-standing prioritization of health investment and a pre-existing primary care focused health system may facilitate a more robust response to COVID-19. This confirms a statement made by WHO's Director General, Dr Tedros, on 12 October 2020, that: "Universal health coverage, based on primary health care, is the foundation of health security, stability and sustainability" (WHO, 2020a).

Reflecting on how South Asian health systems have responded to the COVID-19 pandemic, this report highlights the following 10 key policy lessons concerning the need to integrate public health services within PHC-led, publicly financed UHC reforms.

### Key policy lessons

- Lesson 1:** Strengthen health security systems within broader UHC reforms.
- Lesson 2:** Prioritize closing primary health care gaps for UHC and health security.
- Lesson 3:** COVID-19 could provide a political window of opportunity to launch UHC reforms.
- Lesson 4:** Increase pooled public financing for health (to at least 2% of GDP) and replace private out-of-pocket spending.
- Lesson 5:** Improve quality of care through sustained health systems strengthening, particularly at the PHC level.
- Lesson 6:** Invest in strengthening human resources for health, especially community health workers and health providers at basic health care units.
- Lesson 7:** Be willing to invest more and target resources better for equity.
- Lesson 8:** Engage the private sector in tackling COVID-19 and UHC reforms.
- Lesson 9:** Strengthen governance and accountability systems PHC and UHC.
- Lesson 10:** Engage beyond health to strengthen critical drivers of UHC systems.



## Section 1. Introduction

All countries can make progress towards universal health coverage (UHC), wherever they are on their journey – even in the midst of a global health crisis. In the current COVID-19 pandemic, countries are having to balance responding effectively with trying to maintain and improve other essential health services. The priority investments that countries make now may have positive effects for their health system as a whole and reap broader socio-economic benefits through supporting healthier communities. There is the potential for the COVID crisis to catalyse extensive reforms, which could greatly accelerate progress towards UHC.

The COVID-19 pandemic has rekindled a debate initiated during previous public health crises on how to ensure that health systems are resilient enough to respond to shocks. Public health functions should be an integral part of primary health care (PHC)-focused health systems moving towards UHC. However, in reality, many countries have unbalanced health systems that focus too heavily on clinical services and levels above primary health care. Good health and wellbeing are not just determined by hospital services – they should start with the healthy behaviour of each person and every household in a community, with primary health care services delivered close to home and engaged communities.

COVID-19 represents the greatest global health threat in over a century and has propelled health protection and care to the forefront of political agendas. The

socio-economic impact of the crisis has also been immense. All over the world, country leaders are being scrutinized over their response to the pandemic, which may determine their political future. But this crisis has also created opportunities for leaders to become actively engaged in reform of their countries' health systems and sustainable health care financing with the objective of achieving the guiding principles of UHC. Historically, countries that made strong progress towards UHC have often had their health system reforms often born out of disruptions, crises or disease outbreaks that exposed weaknesses in the effectiveness their health care and public health systems.

This paper looks at UHC and PHC through a COVID-19 lens, reflecting on some of the lessons learnt from the pandemic to date and providing some initial insights for South Asian countries to consider as they plan the next phase of their response to the coronavirus crisis and their long-term health strategies.

Section 2 of this paper explains the basics of universal health coverage and looks at the progress made across the South Asia region. Section 3 examines primary health care, its linkages to UHC, and the need for the integration of the two concepts. Section 4 looks at the COVID-19 pandemic in the region, specifically at country responses and early lessons. Section 5 sets out some of the key lessons learnt to date.



## Section 2. What is universal health coverage and why does it matter?

### Universal health coverage defined

In simple terms, UHC means every person can access good quality health services without suffering financial hardship. WHO has also provided a more detailed definition:

**“Ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship. (WHO, 2020b)**

UHC is built on a foundation of equity and rights. Everyone must be covered, with services allocated according to people's needs and the health system financed according to people's ability to pay. In fulfilling these principles, it is essential that governments move towards UHC in a fair and equitable manner. This should mean giving greater priority to covering population groups with a higher need for services, such as the poor and vulnerable, over privileged groups who already have better access to health care.

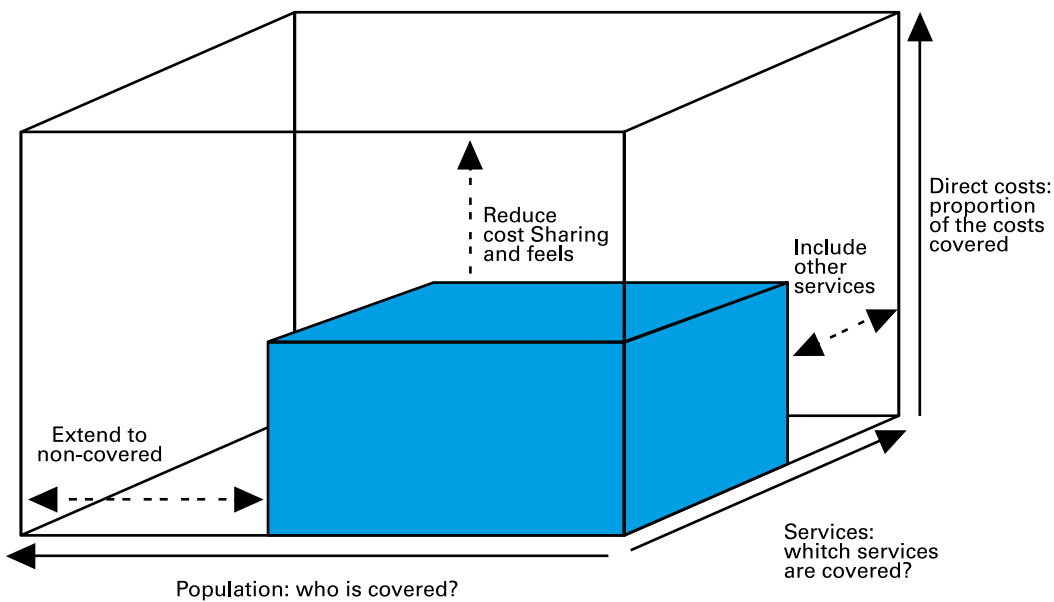
Although the context of UHC differs from country to country and there is no standard strategy for achieving it,

there are important common health system components that should be in place. These include (Beattie et al., 2016):

- An efficient, resilient health care delivery system
- Affordable care and a system of financing health care that does not impoverish users
- Access to essential medicines and medical technologies
- Health workers who are motivated, are sufficient in number and skills and are equitably distributed
- Functional and efficient administrative and governance arrangements

Achieving UHC requires advancing health services in three distinct ways. Firstly, the population covered should encompass all people in a country. Secondly, the range of services covered by UHC policies should expand as resources permit, including sufficient investment in essential public health functions. Services must also be accessible and of adequate quality to be effective. And, thirdly, the proportion of the financing required to deliver services should be drawn from pooled funds raised through compulsory prepayment mechanisms, including general taxation or compulsory social health insurance. Figure 1 illustrates how the expansion of all three dimensions will advance UHC in all directions (Beattie et al., 2016).

Figure 1. The three dimensions of universal health coverage



Source: World Health Report 2010 (WHO, 2010)

The benefits of UHC

Prior to COVID, UHC was driving the global health agenda. At the UN High-Level Meeting in September 2019, all countries adopted a political declaration on UHC that saw them recommitting to achieving UHC by 2030. UHC is included in SDG 3, under 3.8, and is often regarded as the key target for achieving the whole of SDG 3.

Achieving UHC is important, because it can deliver substantial benefits at a population level, not only improving health indicators, but also stimulating economic development, improving efficiency, reducing poverty and inequality, building social harmony and maintaining political stability. These benefits are summarized in Table 1.

Table 1: Benefits of UHC

Health benefits	A Lancet study of 153 countries showed broader health coverage tends to lead to better access to essential health care and improved population health, particularly for poorer segments of the population (Moreno-Serra & Smith, 2012). When truly universal, UHC improves outcomes fastest among the poorest and most marginalized, supporting equity and reducing or eliminating disparities within populations.
Health system benefits	Reaching all citizens with services requires a health system that has high geographic access, is staffed, equipped, and managed adequately, and is able to meet societal needs, especially for the most vulnerable. Including UHC as a policy goal can act as an incentive to sustain investments for health system strengthening, overcoming bottlenecks in supply chains, procurement, access to essential medicines and supplies, and improving the performance of the health workforce. A well-functioning, PHC focused health system is the foundation of UHC and health security (Beattie et al., 2016; WHO, 2013).

<b>Economic benefits</b>	<p>UHC is a major driver of economic growth. In September 2015, 267 eminent economists from 44 countries signed the Economists' Declaration on Universal Health Coverage, which concluded that the economic returns on investing in UHC were more than ten times the cost.</p> <p>Health sectors are a major source of jobs (especially for women), and pharmaceutical and medical devices make a significant contribution to the industrial economy. Indirectly, well-functioning health systems affect the economy through the improved health of the working population and associated efficiency gains (Cylus et al., 2018).</p> <p>Additionally, influencing the health of those outside of the labour market, such as children, older people and those that are care-dependent, has effects on the economy, freeing up time for care givers and allowing for formal or informal contributions to those population groups (Cylus et al., 2018).</p> <p>In terms of preparing for health risks, the cost of inaction outweighs the cost of responding to health threats. For 67 low and middle-income countries it has been estimated that effective preparation against health threats would cost US \$13.8 billion per year, whereas the cost of responding to disasters totals more than US \$500 billion (Peters et al., 2019).</p>
<b>Political benefits</b>	<p>UHC requires strong political leadership and action by the state. Many politicians have found that extending health coverage is a popular policy and attracts support. It builds universalism and solidarity across social groups, acting as a force to unite rather than divide groups. Many leaders and political parties have won elections running on UHC platforms, including in the United Kingdom, Thailand, Ghana, Zambia, Brazil, South Korea and Nepal (WHO, 2013).</p>

The COVID-19 pandemic has affected nearly all countries in the world, severely affecting health systems and economies. It has brought the importance of resilient health systems to the fore and exposed weaknesses in countries that were ordinarily high performers (UHC2030, 2020b).

While countries grapple with the dual responsibility of responding to the pandemic and mitigating disruptions to other essential services, it is important to note that crucial investments in the health system during the pandemic could actually become a pathway to UHC. There is a historical precedent for this, as many countries that have made rapid progress towards UHC did so prompted by a major disruption of the status quo that broke the inertia in their previous health care reforms. Countries that have experienced such impetus include New Zealand (1938, following the Great Depression), France (1945), the United Kingdom (1948), Japan (1961, in the aftermath of World War II) and Thailand (2002, following the Asian Financial Crisis). Interestingly, one of the earlier triggers for Sri Lanka's universal free health reforms launched in 1951 was a series of devastating malaria epidemics in the 1930s and 40s. In many instances, these post-crisis UHC reforms involved rapid public investment in strong health systems based on primary health care (UHC2030, 2020a).

### Where are South Asian countries on the UHC journey

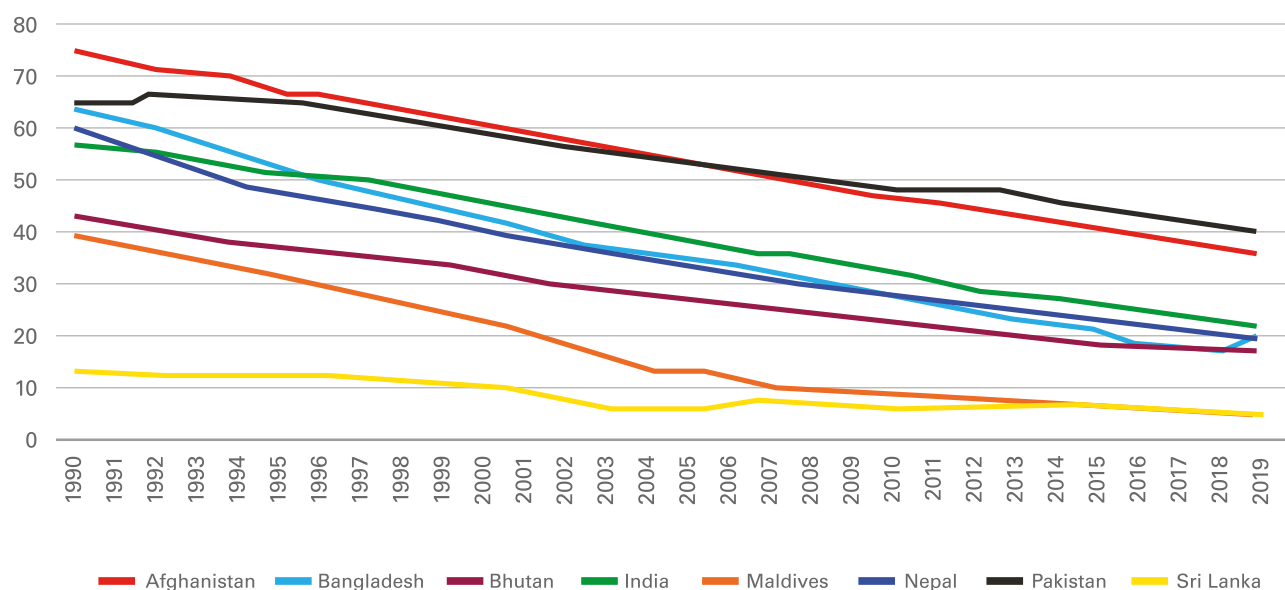
South Asia is an incredibly diverse region, with large disparities in demographics, economic performance, and health indicators within and between countries. Although each country has challenges that are particular to its specific situation, there are also common challenges across the region. These centre around health system functioning, such as the availability of essential medicines and supplies; the recruitment, training and retention of health workers; the need for efficient and equitable health financing; and the need to refocus health systems towards primary health care, including preventive services for non-communicable diseases (NCDs) and increased basic public health capacities (Kumar, 2019).

Whereas many factors outside the health sector – such as education, nutrition, poverty, gender equality and security – have an impact on health outcomes, equitable access to effective health services plays an important role in maintaining and improving people's health status. Therefore, tracking statistics on key health outcomes is a good way to start investigating levels of health coverage. The graphs below show how the different countries in South Asia have been performing in improving

important child health outcomes. Figure 2 shows that neonatal mortality rates are the highest in Pakistan and Afghanistan, whereas Sri Lanka and the Maldives have recorded the lowest neonatal mortality rates, with the latter having made particularly impressive progress since 1990.

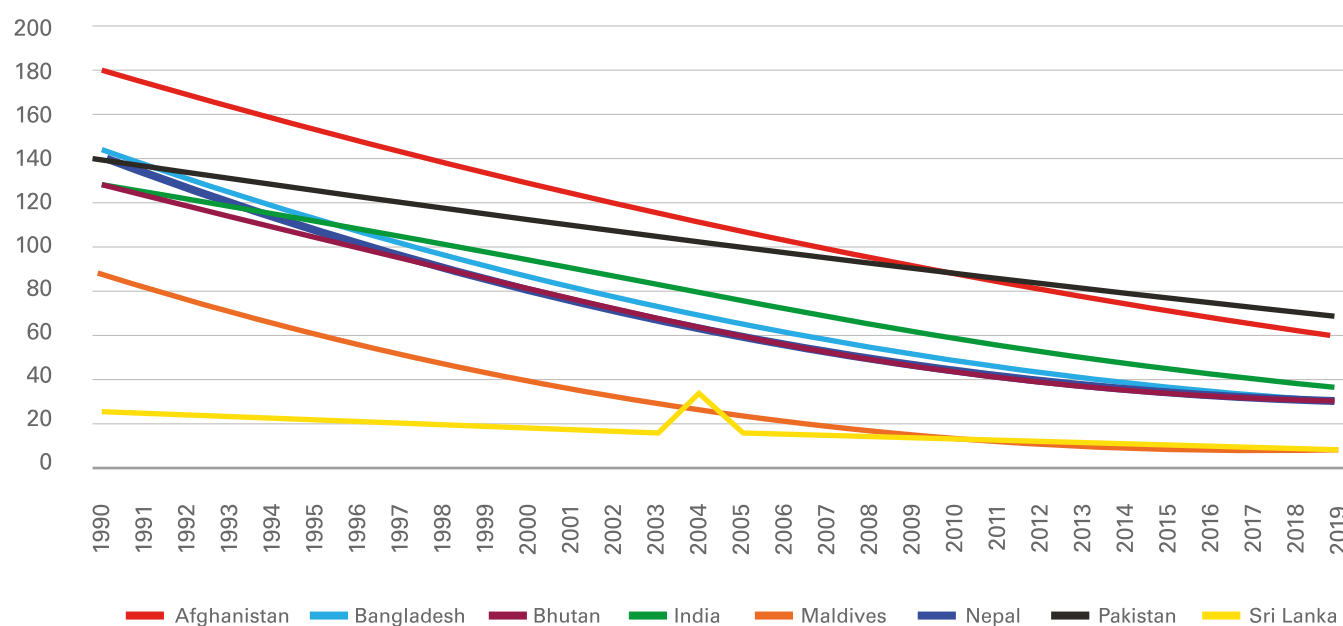
Child mortality rates (CMR) across the region tell a similar story, with the Maldives having made the most progress since 1990 in reaching a mortality rate comparable to Sri Lanka's.<sup>1</sup> Notably, in the last 10 years, Afghanistan has outperformed Pakistan, which now has the highest child mortality rate in the region (see Figure 3).

**Figure 2.** Neonatal mortality rates in South Asia (per 1,000 live births)



Source: United Nations Inter-agency Group for Child Mortality Estimation (IGME, 2020a)

**Figure 3.** Child mortality (under five) rates in South Asia (per 1,000 live births)



Source: United Nations Inter-agency Group for Child Mortality Estimation (IGME, 2020b)

[1] The peak in the CMR in Sri Lanka in 2004 was due to the high death rate associated with the Tsunami of December that year.



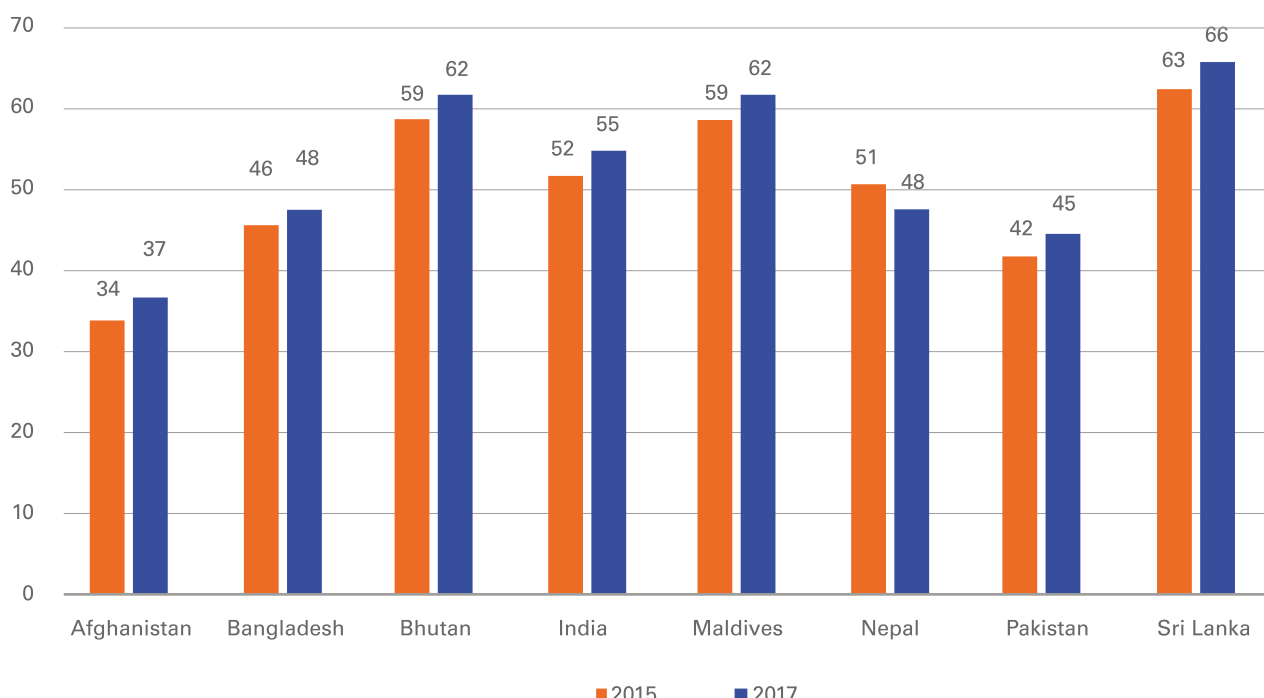
## Extending service coverage

Two of the main elements of UHC are the degree of coverage of effective health services and levels of financial protection. The rationale for tracking service coverage is that it is important to measure the uptake of key services (such as childhood immunizations and ante-natal visits), which have proven impact on health status. With the publication of the WHO and World Bank UHC Global Monitoring Reports in 2017 and 2019, South Asian countries can now track their performance towards achieving UHC and compare their progress

against that of other countries. In the most recent UHC service coverage index, the average score for South Asia was 53, with all countries registering an improvement from 2017, with the exception of Nepal (WHO & World Bank, 2020).

Figure 4 shows Sri Lanka, the Maldives and Bhutan as the highest performers all scoring over 50, while India, Nepal, Pakistan and Afghanistan are lower performers. Although contexts differ widely, the UHC service coverage index is a good measure of the average coverage of essential health services in a country.

**Figure 4.** Coverage of essential health services in South Asia: UHC index scores



Note: Essential health services are defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases, and service capacity and access, among the general and the most disadvantaged population. The indicator is an index reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage. The tracer indicators are as follows, organized by four components of service coverage: 1. Reproductive, maternal, newborn and child health; 2. Infectious diseases; 3. Non-communicable diseases; and 4. Service capacity and access.

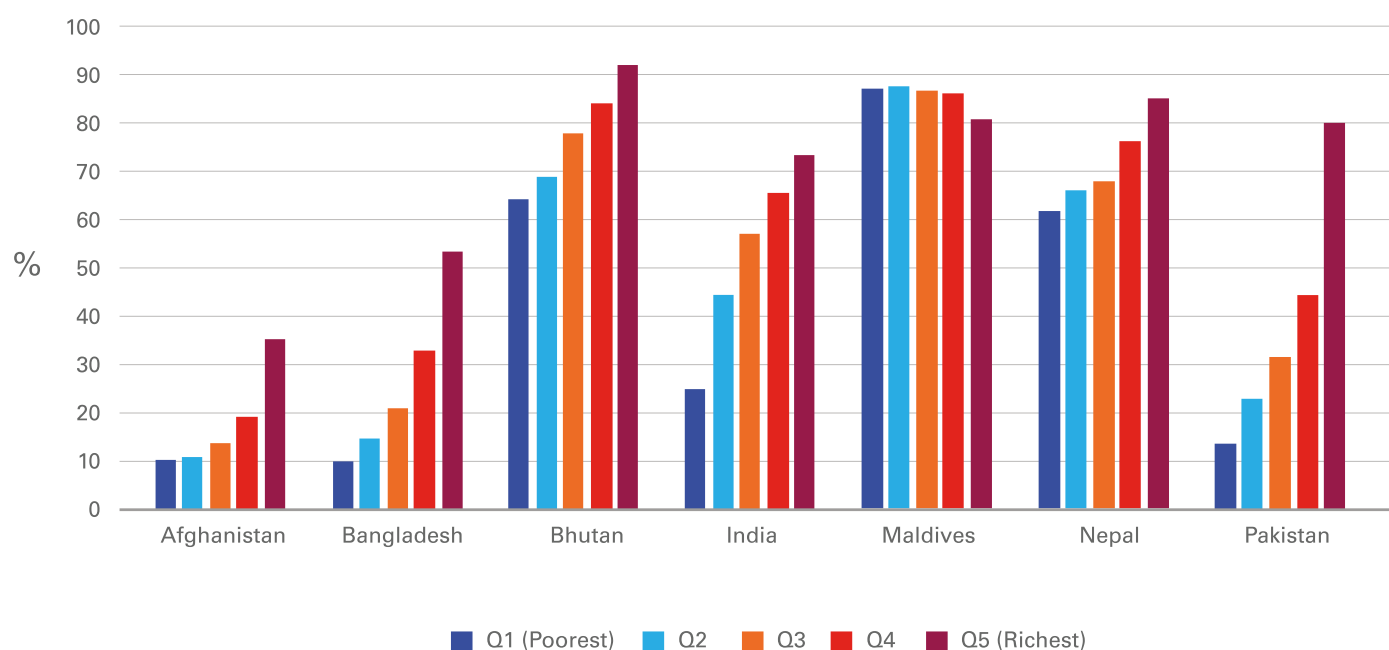
Many supply side and demand side factors impact on the uptake of essential health services including: geographical accessibility of services, availability of key inputs (including health workers, infrastructure, equipment, medicines and commodities), cultural and language barriers, migration status, administrative regulations and financial barriers, and, notably, whether or not service providers charge a fee at the point of care. In turn, many of these factors are driven by the level and allocation of public financing to the health sector in the countries concerned.

Between 2000 and 2017, the South Asia region achieved the largest overall reduction in maternal mortality, from 395 to 164 maternal deaths per 100,000 live births. But

access to essential health care services in South Asia is highly inequitable, driven by socio-economic inequities. Despite impressive overall achievements, maternal health services such as skilled birth attendance and antenatal visits still see significant differences based on wealth quintile and level of education (Scammell et al., 2016).

Figure 5 shows that antenatal services are generally skewed towards richer members of society, with the exception of the Maldives, where uptake of antenatal visits is more pro-poor. Wealth differences are most significant in Pakistan and Bangladesh, with Pakistan recording a 65.8 percentile difference between the highest and the lowest wealth groups and Bangladesh a 42.6 percentile difference.

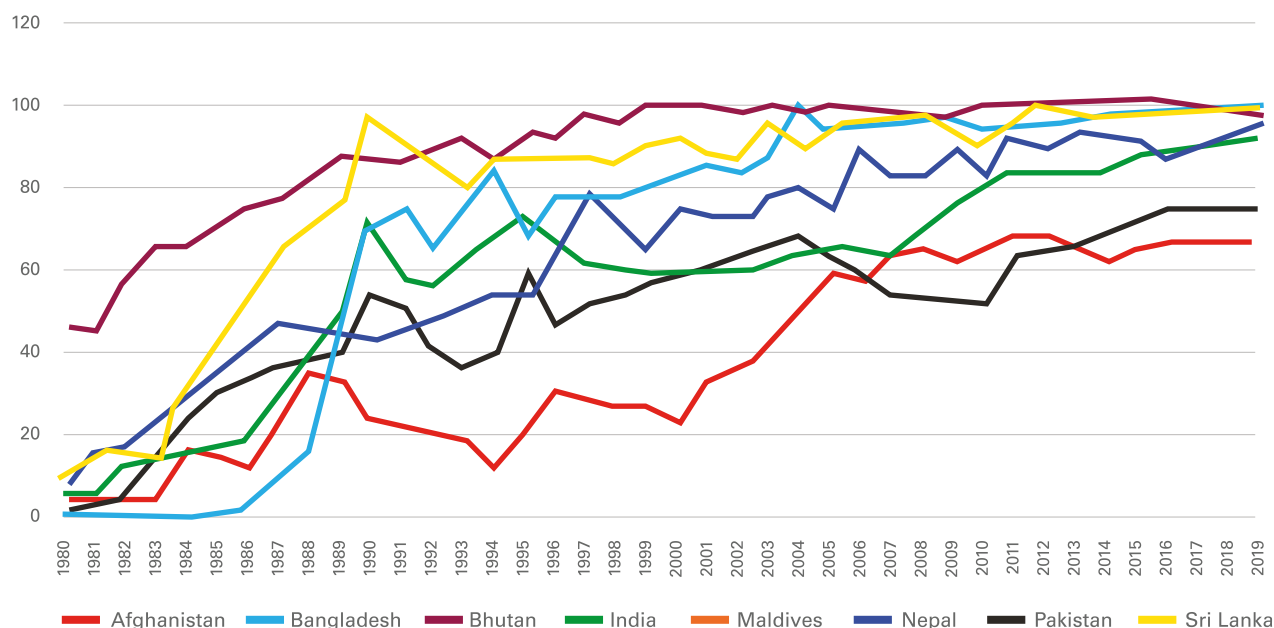
**Figure 5.** Percentage (%) of women receiving at least 4 antenatal visits in South Asia (by wealth quintile) two to three years before the survey, according to latest available complete data



Source based on: Global Health Observatory Data Repository (WHO, 2020f) which draws on Global Health Observatory Data Repository (source by country): Afghanistan (DHS, 2015), Bangladesh (DHS, 2011), Bhutan (MICS, 2010), India (DHS, 2015), Maldives (DHS, 2009), Nepal (DHS, 2016), Pakistan (DHS, 2012)

Immunization coverage varies widely across the region. India, Bhutan, Bangladesh, Nepal, the Maldives and Sri Lanka are reaching more than 90% of their child population (as measured by the uptake of diphtheria, tetanus, pertussis [DTP3]). However, 25%

of children in Pakistan and 34% in Afghanistan are still not covered (see Figure 6). In 2017, it was estimated that 2.9 million children in India and 1.3 million children in Pakistan were going without DTP3 immunisation (VanderEnde et al., 2018).

**Figure 6.** DTP3 immunization coverage estimates (Number of surviving infants receiving their third dose of DTP3).

Source: UNICEF Data: Immunization (UNICEF, 2021)

Even though the availability of some essential services has improved in some settings, health care quality remains a challenge for most South Asian countries. Moreover, regional and national average service coverage rates tend to mask sustained inequities between wealth quintiles. Health system factors that contribute to this include insufficient and inefficient spending on health, lack of essential health commodities and insufficient investment in primary health care services, including lack of a well-trained workforce in the public health care system of the required size.

Even in countries further advanced in the journey towards UHC, challenges remain. In Bhutan, for example, the health workforce stands at 0.5 doctors per 1,000 population (18.4/10,000 for all health workers) – well below WHO's recommended ratio for human resources for health (Ministry of Health, 2020). Sri Lanka has been celebrated for achieving 'good health at low cost' (Balabanova et al., 2013) and continues to report impressive health indicators for the region, due to its predominantly tax-financed public health system. However, although Sri Lanka has a well-developed preventive health sector, its primary curative sector is under-resourced. Most primary care facilities experience shortages in essential medicines and supplies (Kumar, 2019).

A common and fast emerging challenge across South Asia is the shifting burden of disease towards NCDs, while communicable diseases remain highly prevalent – a situation exacerbated by the COVID-19 pandemic. This is leading to a double, or even triple, burden of disease. Already in 2004, nearly half of the adult disease burden in South Asia was attributable to NCDs (Ghaffar et al., 2004).

### Extending financial protection

There is significant variation in how health systems are financed and organized across the region. For example, whereas India and Pakistan's health systems are highly devolved to the state/provincial level and are primarily privately financed, Sri Lanka and Bhutan's systems are more centralized and publicly financed.

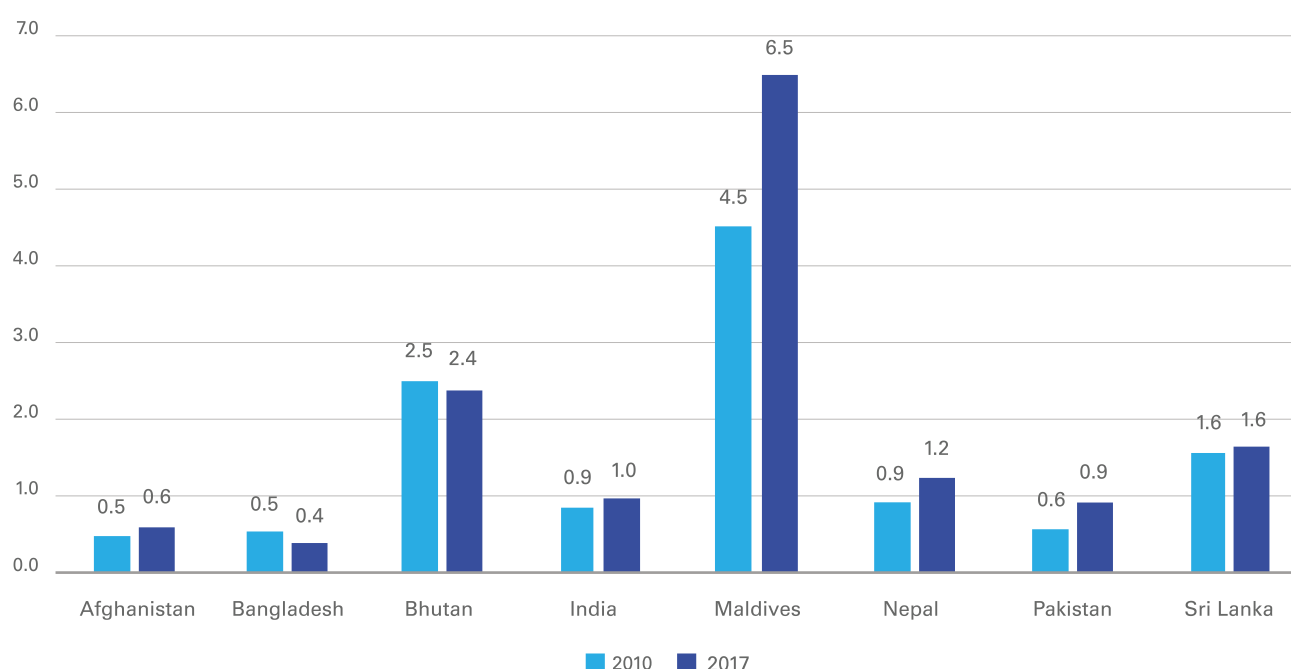
In contexts like Bangladesh, India and Pakistan, low public financing has led to an overreliance on private providers for primary care, without sufficient governance and regulation of costs and quality in place (Sengupta et al., 2018). In India, more than 78% of care is provided by the private sector, which is focused on tertiary and curative care (Van Weel et al., 2016). With low public investment and a lack of financial protection, these services tend to be financed by inequitable out-of-pocket expenditure (OOPE) and leave unprotected the most marginalized members of society.

Gaps in effective health coverage in the region are being driven by suboptimal quality and availability of key health service inputs<sup>2</sup> and low levels of financial protection associated with high levels of OOPe, both of which are closely associated with low levels of public health spending. As Dr Gro Harlem Brundtland, former Director General of WHO, noted at the High Level Meeting on UHC in September 2019, “If there is one lesson the world has learnt, it is that you can only reach UHC through PUBLIC financing” (The Elders, 2019). Despite the vital

importance of public financing to UHC, public health expenditure in South Asia is under-prioritized.

Since 1995, public health expenditure has not increased much in the region, with most countries spending below 2% of their GDP on health, according to Global Health Observatory data (WHO, 2019a). Between 2010 and 2017, the only country with a significant increase in health expenditure was the Maldives, which, as noted above, also recorded the best improvements in health coverage (see Figure 7).

**Figure 7.** Public health expenditure as % of GDP in South Asia



Source: Global Health Expenditure Database (WHO, n.d.)

Not surprisingly, low levels of public spending tend to be linked to poor quality of health services and poor health outcomes for people. An inadequate level of public health provision pushes people to seek private health care providers of variable quality, driving up their out-of-pocket spending. Increased public health expenditure is correlated with a decreased death rate, reduction in infant mortality and other positive health outcomes. Meanwhile, high levels of OOPe are associated with decreased utilization, financial hardship for households and reduced population coverage (Gupta & Chowdhury, 2014).

Regardless of the way health systems are organized, ensuring financial risk protection against health care

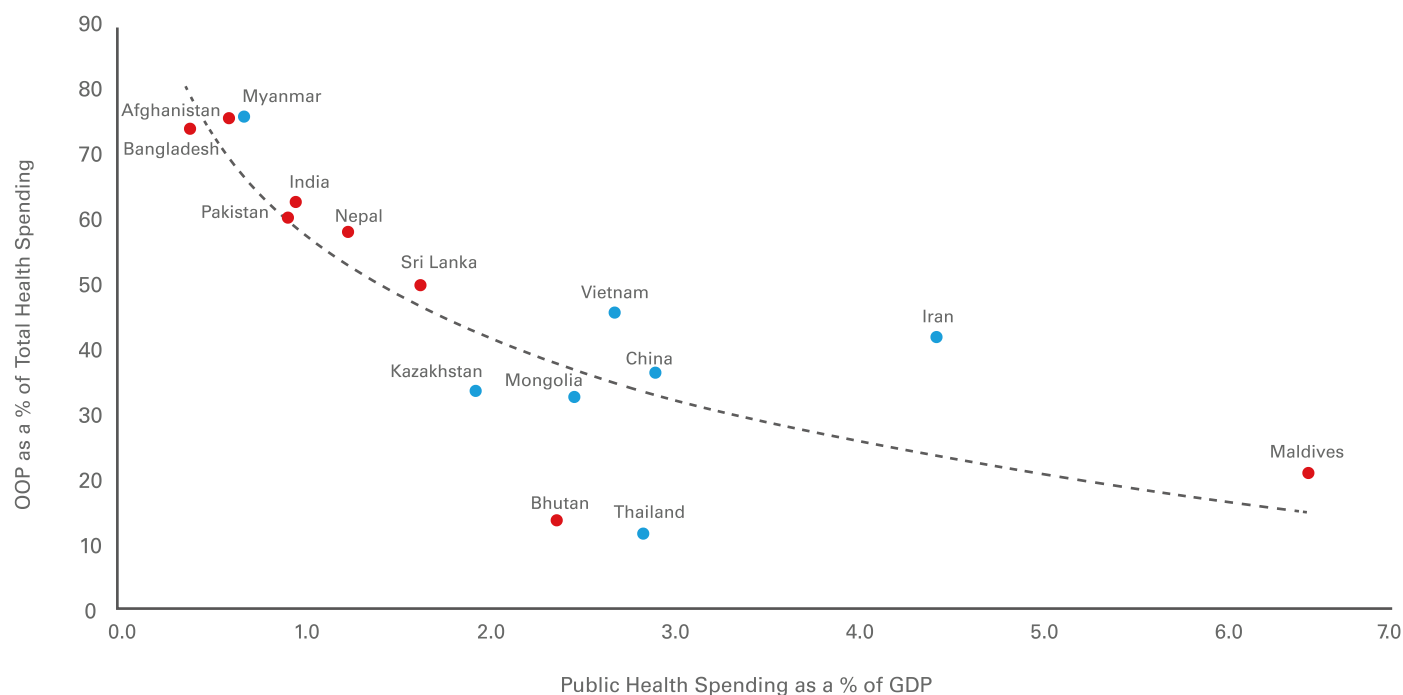
costs is a critical element in achieving UHC. Financial risk protection helps ensure equitable and affordable access to care, irrespective of socio-economic status. This stimulates demand for essential services, especially by the poor and vulnerable, and reduces levels of health-related impoverishment. Across the world, this is achieved by governments increasing levels of public health financing and allocating these resources efficiently and equitably, with the specific objective of replacing levels of inequitable out-of-pocket spending. This is shown in the following graph, where one can see that as countries increase their public health spending, their levels of OOPe tend to decrease (see Figure 8).

[2] Notably, human resources, medicines and commodities.

Figures 8 and 9 show public financing replacing OOPe across the region and the percentage of OOPe still prevalent, as a percentage of current health expenditure. Afghanistan, Pakistan, Bangladesh, India

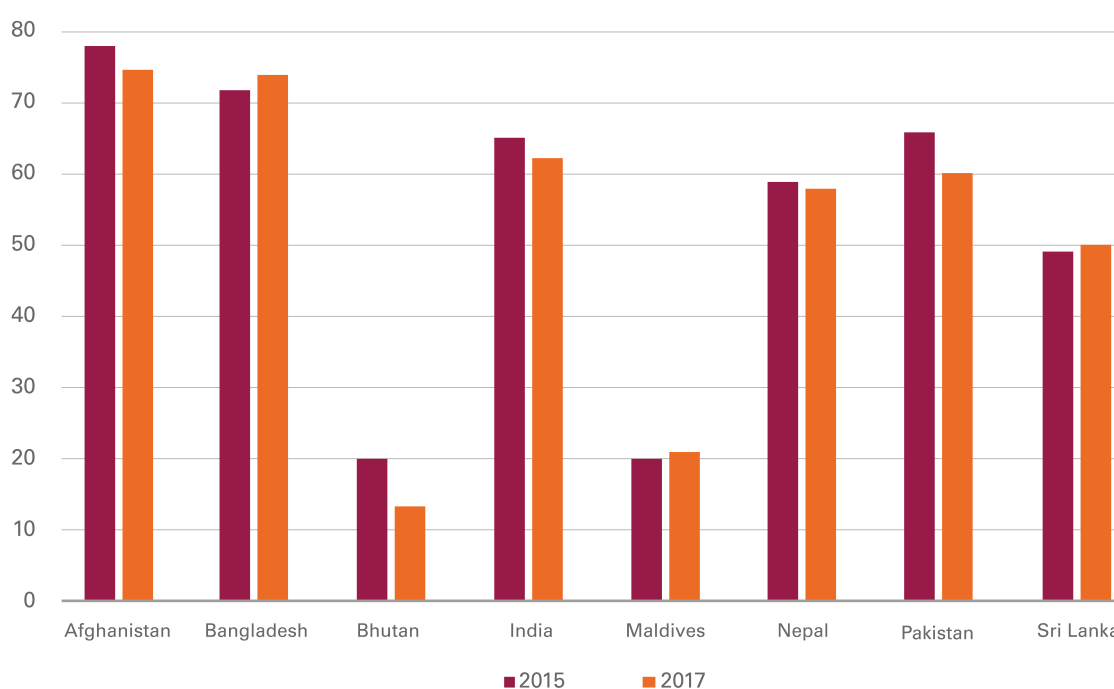
have the highest levels of OOPe in the region – all exceeding 60% of total health expenditure – three times the maximum level recommended by WHO.

**Figure 8.** Public financing replacing out-of-pocket spending in South Asia and comparative countries



Source: Global Health Expenditure database (WHO, n.d.)

**Figure 9 :** Out-of-pocket expenditure as a percentage of current health expenditure

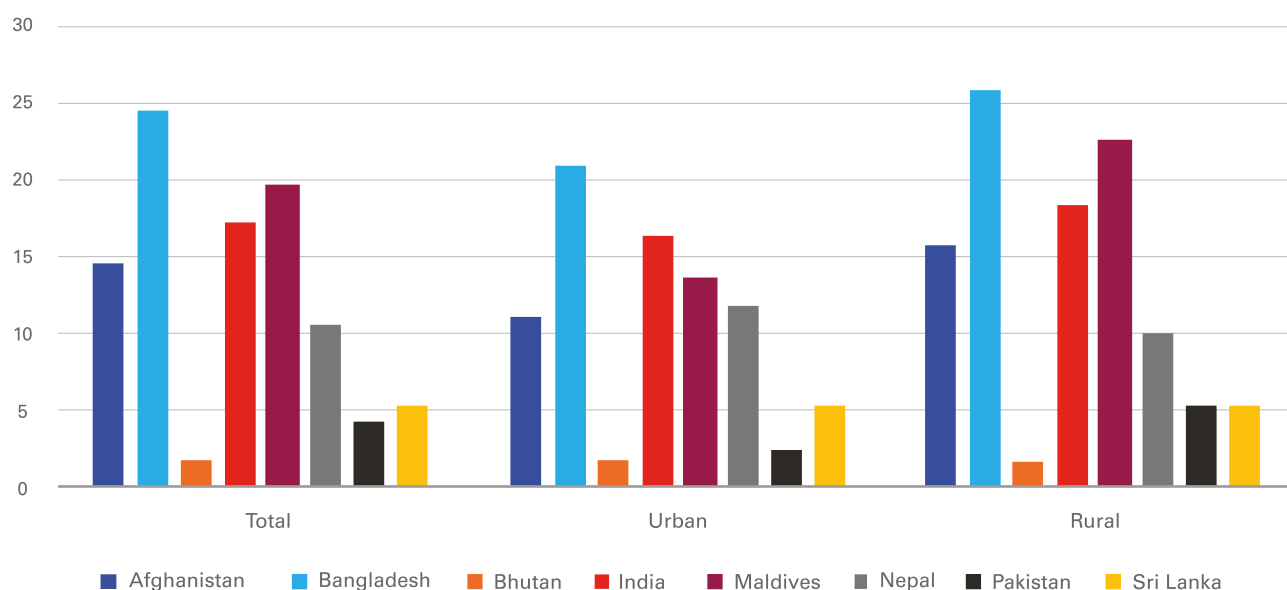


Source: Global Health Expenditure Database (WHO, n.d.)

Looking at one of the specific UHC indicators for financial protection – incidence of catastrophic health spending<sup>3</sup> (defined as more than 10% of total household expenditure) – again one can see a mixed picture across the South Asia region. In total, in 2015, it was estimated that 301 million households (17.2%)

suffered catastrophic health expenditure (WHO, 2019a). Figure 10 shows a more detailed picture of catastrophic expenditure per country in South Asia, indicating that around a quarter of households in Bangladesh experienced catastrophic health expenditure in 2016.

**Figure 10.** Catastrophic OOPE (greater than 10% of household expenditure or income) in South Asia



Source: Global Health Observatory Database (WHO, 2019a); drawn from latest data available for each country (Afghanistan: 2013, Bangladesh: 2016, Bhutan: 2017, India: 2011, Maldives: 2009, Nepal: 2014, Pakistan: 2015, Sri Lanka: 2016)

Private spending on medicines is one of the main drivers of OOPE across South Asia, especially in Bangladesh, Nepal, India, Bhutan, the Maldives and Pakistan (Datta et al., 2019; Wang et al., 2018). This is a major concern, as disease burdens are changing and more people will be affected by chronic NCDs in the future, requiring ongoing medication.

Over recent decades, Sri Lanka has performed relatively well in the region in sustaining a universal entitlement to free publicly-financed services and has a well-established primary health care system dating back to 1951 (Kumar, 2019). However, as the burden of NCDs has been increasing and incomes rising, there has been a trend for households to prefer private providers, because of perceived better amenities and quality, illustrated by the rise in OOPE in the country (Kumara & Samararatunge, 2016). To avoid this leading to a two-tier health system, quality improvements in the public health care sector will be vital to ensure people in higher socio-economic strata continue to pay taxes to finance Sri Lanka's free

health care policy. Nepal is another country in the region where stagnating levels of public spending has led to more people shifting to private providers, mostly using regressive out-of-pocket spending. This has contributed to 10.7% of households incurring catastrophic health expenses in 2014 (WHO & World Bank, 2020).

In an effort to improve financial protection, especially for the poor, in recent years there have been many attempts to launch specific targeted health financing initiatives for vulnerable populations. This has included using public funds to contract private providers to provide free health care services in disadvantaged areas using different models in Bangladesh, Afghanistan, India and Pakistan (Zaidi et al., 2017). There have also been frequent attempts to launch state-funded or subsidized insurance schemes for the poor, but these have tended to perform relatively poorly, suffering common problems associated with determining the eligibility of beneficiaries, a benefit package focused on inpatient hospital care, a lack of reimbursements for transport and other additional costs,

[3] Catastrophic health spending is an SDG 3.8.2 indicator of financial protection used to monitor progress towards UHC at global, regional and national levels. It is defined as out-of-pocket payments that exceed a predefined percentage or threshold of a household's ability to pay for health care.



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and poor integration with provincial health care initiatives (Zaidi et al., 2017). These models of targeted health insurance schemes for people below the poverty line have been common in India, Pakistan and Bangladesh, but, to date, these schemes have not proved effective in significantly improving access to services or financial protection.

This picture of stagnant levels of public health spending and chronically high levels of out-of-pocket spending in the largest countries in the region does

not augur well for progress towards UHC in South Asia and undermines countries socio-economic development. While some countries and states had been heralded as providing 'good health at low cost' (Balabanova et al., 2013), these successes were mostly in terms of providing access to maternal and child health services and infectious diseases. However, facing a growing burden of non-communicable diseases, and now a global pandemic, these resources will not be sufficient to sustain or improve population health outcomes.



## Section 3. What is primary health care and why is it fundamental to achieving universal health care?

### Primary health care defined

In October 2018, 2000 delegates from more than 120 countries renewed their commitment to comprehensive primary health care for all with the Astana Declaration, which redefined PHC as:

- a. whole-of-society approach to health that aims to ensure the highest possible level of health and well-being and their equitable distribution, by focusing on people's needs and preferences (as individuals, families, and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment. (WHO & UNICEF, 2018)

The Astana Declaration also defined three components of PHC throughout a person's life course, including public health services for population health, systematically addressing the broader determinants of health (which requires policy action across all sectors) and empowering people and communities to optimize and advocate for their health and wellbeing (WHO & UNICEF, 2018).

PHC allows health systems to be more adaptive, responsive, and resilient. It is a key way to address the main causes of poor health as it focuses specifically on promotion, prevention, and engaging people, families and communities. It is, therefore, a useful vehicle to address

novel pathogens and prevent epidemics of infectious diseases (WHO & UNICEF, 2018). This is particularly the case in low-income contexts, where community engagement is a key strategy and where nationwide lockdowns and isolation strategies are not always feasible.

Figure 11. Components of primary health care



Source: A Vision for Primary Health Care in the 21st Century (WHO & UNICEF, 2018)

As an approach, PHC specifically includes population-based services such as disease prevention, emergency preparedness, surveillance and response. In PHC focused systems, public health functions can be delivered through (sub)national programmes or primary care services, as long as public health functions are integrated with primary care in a coherent way. Better alignment of public health and primary care is

associated with better health literacy, health outcomes and improvements in health behaviour (WHO & UNICEF, 2018). PHC and UHC are intrinsically linked, as shown in Table 2. UHC's goals of financial protection, equitable access and quality services cannot be achieved without a focus on PHC components, such as community engagement, cost-effective essential services and addressing the underlying determinants of health.

**Table 2. How PHC supports the achievement of UHC**

Components of PHC	Financial protection/ reducing household expenditure on health	Quality services, medicines and vaccines	Equitable access
<b>Primary care and essential public health functions</b>	Population-level services prevent ill-health and promote well-being > reduced individual care > reduced expenditure  Expenditure in primary care has been shown to be cost-effective compared with delivering those same services through referral care.	Health systems based on high-performing primary care that is first-contact, continuous, comprehensive, coordinated and people-centred have improved health outcomes	PHC's emphasis on community-based services is an important way to ensure access, even in rural, remote and disadvantaged populations
<b>Multi-sectoral policy and action</b>	Addressing underlying determinants prevents ill-health and promotes well-being > reduced individual care > reduced expenditure	Reduces burden of disease in the population, thereby freeing resources for improving the quality and safety of health care delivery.	Addressing underlying determinants can increase appropriate access to services by reducing barriers (e.g., environmental, educational) to access.
<b>Empowered people and communities</b>	Advocacy for expanding financial protection; involvement in design of financing systems improves acceptability and increases buy-in, which is critical for scaling interventions.	Advocacy for expanding access; involvement as co-developers of services > increased cultural sensitivity and patient satisfaction > more appropriate use and improved health literacy > better outcomes > improved self-care capacity	Advocacy for not leaving anyone behind; role as informal caregivers

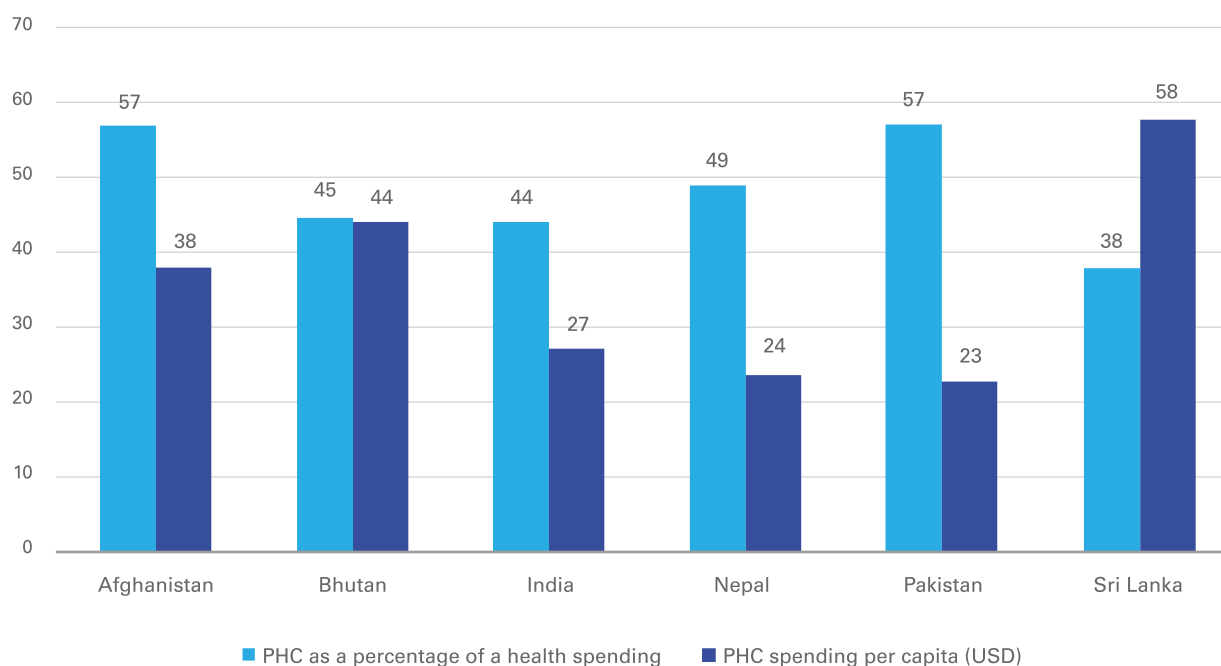
Source: A Vision for Primary Health Care in the 21st Century (WHO & UNICEF, 2018)

### Where are countries in South Asia on the PHC journey

Looking at the Astana triangle, countries in South Asia have made efforts in all three areas: multisectoral policies and action, primary care and public health functions, and empowered people and communities. However, an honest assessment of recent performance indicates that many South Asia countries are not adopting PHC-led UHC strategies. This is demonstrated by low public expenditure on health, an emphasis on hospital and specialist care rather than community-based services, chronically high OOPe, and poor integration of PHC in

UHC advocacy, training, and engagement with patients and communities (Van Weel et al., 2016).

In South Asian countries PHC related spending constitutes a relatively high share of total (government and private) health spending. However, the bulk of this funding is associated with households' purchasing medicines over the counter in the private sector, with governments providing very little funding for primary care medicines. Likewise, governments tend not to prioritize preventive services, and often external aid funds the majority of categorical programmes for prevention.

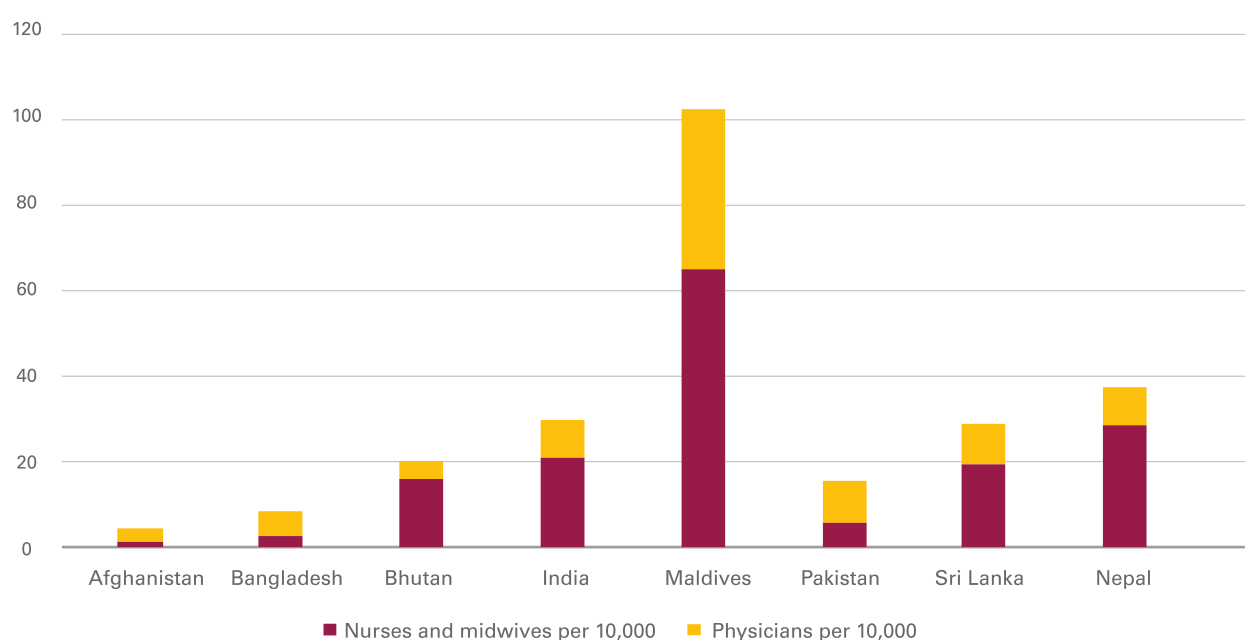
**Figure 12.** PHC spending as a % of health spending and per capita

Note: No data available for Bangladesh and Maldives

Source: Global Spending on Health – A World in Transition (WHO, 2019b)

As shown earlier, the availability of quality health service inputs is a major factor in determining whether or not services are utilized and how service coverage is realized in practice. One of the main determinants of quality service delivery is the availability of well-trained, motivated health workers. WHO recommends 23 doctors, nurses, and midwives per 10,000 population as a minimum threshold to provide basic coverage (WHO, 2020c). In South Asia, with the exception of the Maldives (see Figure 13), there are currently clear shortfalls in the

number of health workers, compared to what is needed to cover the population. Furthermore, there tends to be a skewed distribution of health workers towards urban areas and the private sector, where out-of-pocket financing for their services represents a significant barrier to the poor. For example, in India, 80% of health workers are located in urban areas, where only a quarter of the population live, and, in Nepal, more than half of patients access private care for acute and chronic illnesses (Sengupta et al., 2018).

**Figure 13.** Health workers in South Asia (per 10,000 population)

Note: Notes: Data is for 2017, except for Physicians in Afghanistan, for which it is for 2016. Figures for 2018 are available for some countries, but have not been used to allow greater comparability. Health workers include doctors, nurses and midwives (not including community health workers).

Source: Global Health Observatory Database (WHO, 2021c)



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More positively, and in accordance with PHC and UHC principles, community health workers (CHWs) represent a substantial proportion of the total health workforce in South Asia. According to recent figures, CHWs comprise nearly half of the total workforce in Pakistan (43%) and India (46%) (Aye et al., 2018). However, the majority of this workforce is unpaid, are not formally integrated into the health system, the scope of the work delegated to them is ever increasing and the support systems for their functionality are weak and chronically under-funded.

There are several common primary health care challenges across South Asia. Firstly, UHC reforms have not tended to include a strong focus on primary health

care systems nor prioritize investments for PHC level service delivery and community engagement. Integrating and prioritizing primary health care will be crucial for achieving UHC in the region. Secondly, integrating public health functions within primary health care will be crucial for future resilience to infectious disease outbreaks. Thirdly, engagement beyond the health sector is needed to address the social determinants of health. In South Asia, overcrowded living conditions, poor sanitation, air pollution, and other social factors all contribute to people's vulnerability to infectious and other diseases. Fourthly, investing in primary health care infrastructure, as well as a well-trained workforce, and ensuring geographical access in urban and rural areas will be vital.

### Box 1: Community health workers in South Asia

The South Asia region has a long history of using community health workers as a way to complement the more traditional health workforce. CHWs have shorter training and are part of the communities in which they work. While they are supported by the health system, they are not necessarily formally part of it (Aye et al., 2018). Developed primarily during the MDGs era, CHW supported programmes usually focus on family planning, health promotion and education, immunization, and maternal and child health care. Post-Astana PHC reforms need to take into account the wide range of vertically managed interventions to design integrated community health programmes that actively deliver efficient and effective team-based service delivery at the community level within primary health care platforms.

India, Nepal, and Pakistan all have large-scale, nationwide and government led CHW programmes, employing informal sector workers at remuneration rates below the minimum wage. Even though CHW programmes have made a great contribution to improving population health outcomes, fair pay and social assistance mechanisms should be put in place to support CHW activities. In comparison Bangladesh's CHW model is dominated by its strong non-governmental organization (NGO) sector (Aye et al., 2018).

Kerala state in southern India is an example of where community engagement has been successful in improving population health outcomes. Kerala has had a longstanding focus on public health and primary health care, health infrastructure, community participation and female education programmes. Health prioritization was done in collaboration with communities, which improved utilization rates (PHCPI, 2018). Even though many South Asian countries have had a rich tradition of community development initiatives through community health workers they are yet to establish comprehensive effective primary care systems.



## Section 4. Universal health coverage and COVID-19 in South Asian countries

### Situation analysis of COVID-19 response in South Asia

As in the rest of the world, the COVID-19 pandemic is having a profound impact on health, economic and social indicators in all South Asian countries. It is challenging to make robust comparisons between different countries while the pandemic is still evolving, and when data quality is variable across the region. Despite low scores on pandemic preparedness across the region, in 2020 mortality rates appeared to be lower in South Asia than in other regions at the beginning of the pandemic (Giridhara et al., 2021). Possible explanations for this include the region's relatively young population, comparatively late arrival of the pandemic allowing for learning from other countries, and early intervention and early lockdowns (Giridhara et al., 2021). Challenges with the timely reporting of deaths may have also led to the possible underestimation of the scale of the pandemic (Giridhara et al., 2021).

However, the situation changed significantly in 2021, with case numbers and deaths rising across the

region, particularly affecting India, Bangladesh, Nepal and Pakistan. While this is in part linked to the rise of new, more transmissible coronavirus variants, factors such as population behaviour, political leadership and challenges around global vaccine procurement have also shaped the pandemic's most recent phase.

Most South Asian governments are dealing with a triple challenge in their response to COVID-19: a lack of public resources for health and social welfare including the health care workforce, constraints on their disease surveillance and epidemic response capacity, and poor health system resilience. Countries that have responded relatively well to the pandemic so far, including Bhutan, the Maldives and initially Sri Lanka, are better performers on UHC indicators and appear to have taken decisive action early, including the rapid scaling up of testing and surveillance capacity, building on existing health system foundations. All three of these countries have recorded less than 3,000 deaths from COVID-19, with Bhutan registering 1 fatality at the time of writing (WHO, n.d.).

**Table 3: COVID-19 epidemiology statistics for South Asia (2021)**

	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Number of confirmed cases (as of June 24th)	107,957	866,877	1,970	30,028,709	72,466	627,854	951,865	246,109
Cases per million people (as of June 24th)	2,773	5,264	2,550	21,760	133,818	21,548	4,309	11,488
Case fatality rate (as of June 22nd)	4.06%	1.59%	0.05%	1.30%	0.29%	1.41%	2.32%	1.11%
Population density	60/km <sup>2</sup>	1,265/km <sup>2</sup>	20/km <sup>2</sup>	464/km <sup>2</sup>	1,802/km <sup>2</sup>	203/km <sup>2</sup>	287/km <sup>2</sup>	341/km <sup>2</sup>
Median age	18.4	27.6	28.1	28.4	29.9	24.6	22.8	34
Daily COVID-19 tests administered per 1,000 people (As of June 22nd unless indicated)	No data	0.14 (June 21st)	7.49 (May 27th)	1.31	8.41 (June 17th)	0.29 (June 17th)	0.19	0.85 (June 21st)
Proportion of COVID-19 tests that are positive (As of June 21st unless indicated)	No data	16.19%	0.40% (May 27th)	3.20%	5.70% (June 17th)	24.30% (June 17th)	2.30%	12.40%

Note: Data based on reported figures only, actual figures may differ.

Source: Indicator selection based on South Asia Regional Economic Focus (World Bank, 2020a); population figures based on the 2020 estimates from UN midyear projections (UN DESA, 2019); confirmed cases and deaths (Johns Hopkins; Dong et al., 2021); testing figures (Ritchie et al., 2021)

### Response capacity: Testing, contact tracing and data quality

Testing, isolating cases and contact tracing are critical tools for understanding and tackling the COVID-19 pandemic, managing the care of infected individuals, and restricting cost-intensive measures such as lockdowns and travel bans. These vital public health functions also facilitate the efficient allocation of resources and medical personnel.

In South Asia, testing and tracing has been challenged in most countries by the limited availability of tests and

reagents, as well as qualified personnel. As Table 3 shows, daily testing figures are still low, while positivity rates are high across the region.

Poor financial access is also suppressing demand for testing and treatment, with the cost of these services deterring many millions of people from accessing them across the region. At points in the pandemic, restricting access by imposing user fees has been a deliberate policy, for example, in Bangladesh where fees were introduced for COVID-19 tests at the end of June 2020 “to avoid unnecessary testing” (Reza Shovon, 2020). This practice has been condemned by public health experts.

Death registration, data quality and data use are also issues in tracking and tackling the pandemic. South Asian countries are committed to improving vital registration, but progress has been slow, particularly in the region's larger countries. In terms of death registration completeness, only India, the Maldives and Sri Lanka have data available on completeness of death registration, of which India reported 10% completion (2011), Sri Lanka 81.9% (2006) and the Maldives 91% (2015) (World Bank, 2020b). The latter two countries both have a relatively well-functioning public health care system and surveillance capacity and, as has been identified, are also recognized as good UHC performers in the region.

### Social contract and engaging communities

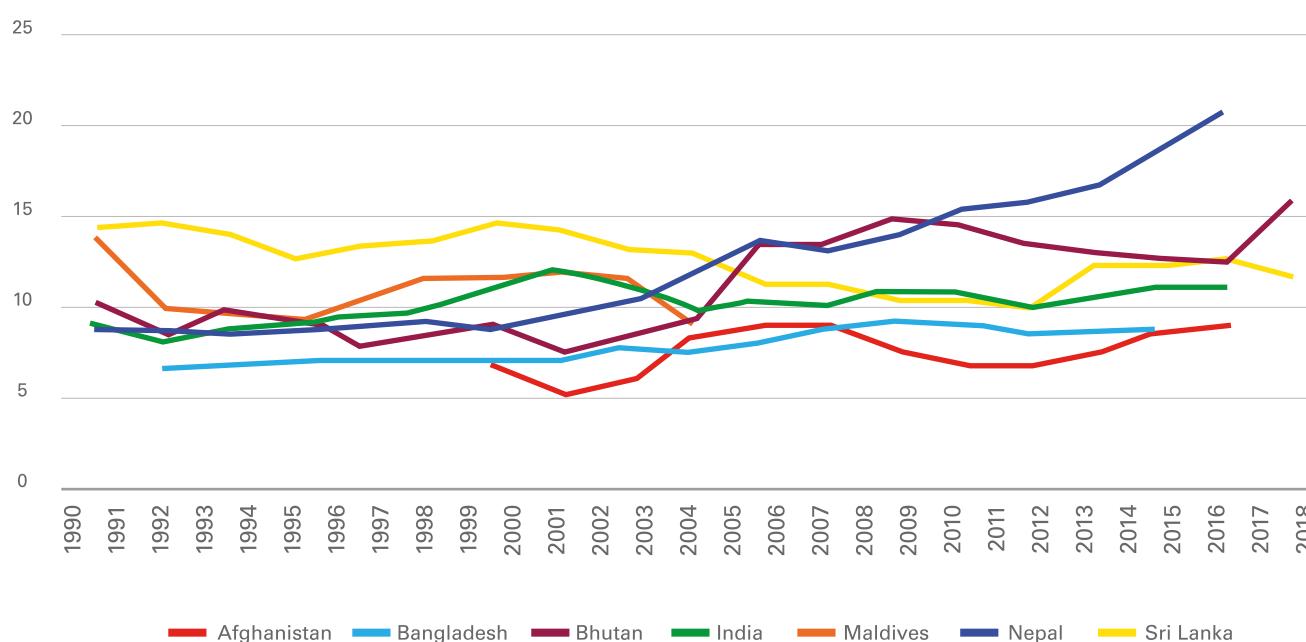
The strength of the social contract is important for the health security of a country. When trust in institutions is low and social protection mechanisms are lacking, crucial elements of an infectious disease response – such as getting tested, adhering to social distancing measures and presenting at a treatment facility – are likely to be impacted, as people are not adequately protected against financial hardships and negative impacts on their food security or employment status.

Latest available figures from the International Labour Organization (ILO) show that informality in South Asia is at least 80%, with 90% of workers in India in the informal sector (contributing half of GDP) and more than 85% in Bangladesh. Even outside the agriculture

sector, 72% of jobs in Pakistan are in the informal sector (Markhof, 2020). In addition to low public health spending, social protection spending is also very low across most countries in the region. Hundreds of millions in the informal sector experience barriers to accessing social protection mechanisms, including health insurance, because where these measures are available, they are often restricted to people living below the official poverty line. This overlooks the 'missing middle', made up of those who fall just outside those categories (Markhof, 2020).

Informal workers are more likely to live in informal settlements and slums, which have living conditions conducive to the spread of COVID-19. Infectious diseases are intimately linked with the social determinants of health and the extent and effectiveness of social protection schemes in the region. Many migrants work in the informal sector and face additional challenges accessing health services. These include barriers to registration for state support, exclusionary policies, cost of services, and discrimination while high levels of mobility can also hinder sustained care (Adhikary et al., 2020; The Rockefeller Foundation, n.d.; Santalahti et al., 2020). In South Asia, the impacts of previous and ongoing epidemics of infectious diseases, such as tuberculosis, are clearly linked to the direct consequences of poverty, including poor nutrition levels and food insecurity, overcrowded living conditions, poor hygiene and sanitation, as well as with a lack of access to health care (Bishwajit et al., 2014).

Figure 14 : Tax ratio as a % of GDP in South Asia



Note: No data available for Pakistan.

Source: International Monetary Fund, Government Finance Statistics Yearbook and data files, and World Bank and OECD GDP estimates (cited in World Bank, 2020c). <https://creativecommons.org/licenses/by/4.0/>

This situation is in stark contrast to that in nearby countries such as Thailand and Vietnam, where stronger social contracts have evolved that involve populations paying higher levels of taxation, but, in return, all people are entitled to use free or heavily subsidized public health services. In Vietnam, for example, public financing for health grew from 1.5% of GDP in 2003 to 2.7% in 2017, which, given the country's rapid economic growth, has significantly scaled up resources for health. This provided Vietnam with a strong base and it has dealt effectively with the COVID-19 pandemic to date, seeing comparatively low levels of cases and deaths (WHO, n.d.).

### History of prioritizing health and social welfare

Preliminary evidence from South Asia also indicates that UHC performance and, in particular, levels of public health spending and how resources are allocated are important factors in determining the effectiveness of a country's COVID-19 response. Where public financing has been low, the long-term underinvestment in health has left health systems ill-prepared to handle a crisis of this magnitude, resulting in the under-consumption of essential public and primary care services, especially by the poor (Guo et al., 2019).

Public health preparedness is not a question of sporadic investments when vulnerabilities emerge. A failure to sufficiently invest in public health leaves health systems unable to scale up the detection and treatment capacity needed to address large-scale outbreaks in a timely manner. The prevention of disease requires an approach that not only includes a sound health system, but also tackles the conditions in which people live, work and play – the social determinants of health. This includes reducing levels of inequalities, given the clear links between low incomes and high rates of chronic health conditions, as well as low utilization of health care (Bishwajit et al., 2014).

Although more evidence is needed, it appears that those countries in South Asia that have been comparatively successful in curtailing the pandemic are those with strong health systems and high response capacity, as well as effective community engagement and relief packages for vulnerable population groups. As in the rest of the world, it remains to be seen how other economic and social protection measures taken throughout the pandemic will impact on health and other development indicators in South Asian countries in the long-term.

### Individual country responses

Governments in South Asia responded swiftly to the initial crisis, implementing social distancing measures, providing relief packages, and allowing delayed payment of rent and utilities, as well as debt servicing. Most countries started implementing stricter measures in early March 2020 and escalated them at the end of that month with a focus on reducing domestic contagion, rather than addressing issues related to restricting international transmission (World Bank, 2020a).

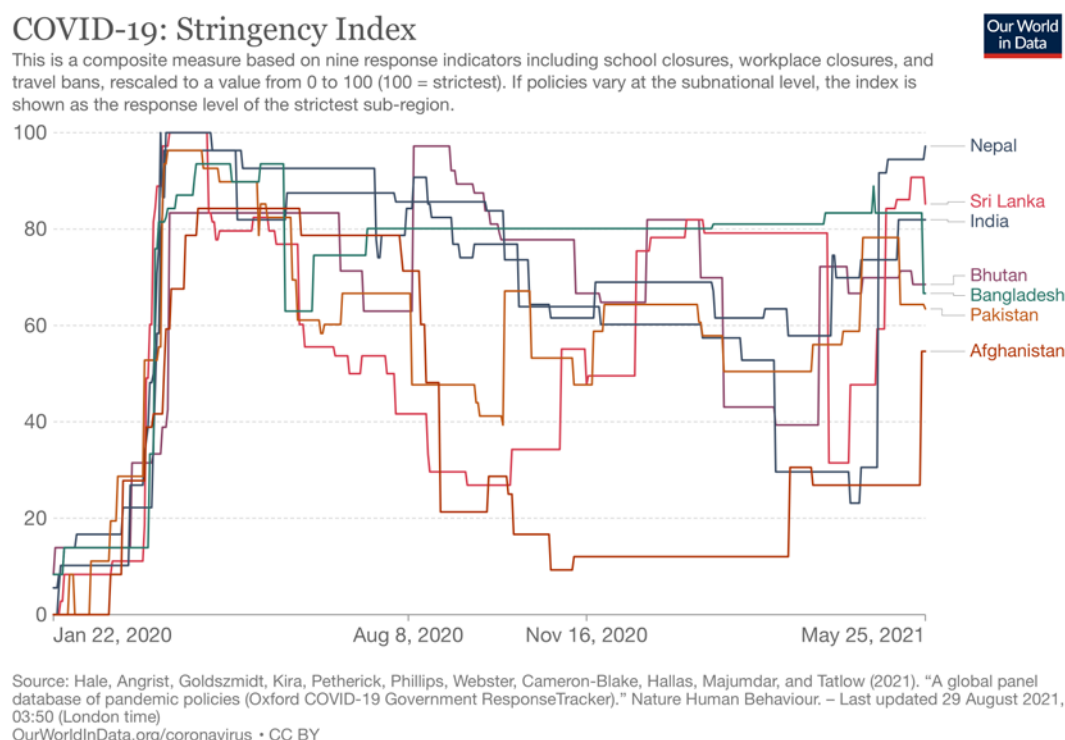
Categorizing the response in each country is challenging. According to available data from the government stringency index, South Asian countries – excluding the Maldives – score relatively high on policy measures introduced to date, such as the closure of schools and workplaces and travel bans. However, restrictions and testing rates have been variable across countries throughout the pandemic. In April 2021, Bangladesh instigated a national lockdown – which has since been extended- and in May Pakistan implemented a shutdown to avoid a surge in cases during Eid-Al-Fitr (Aljazeera, 2021a; Aljazeera, 2021c).

**Figure 15** : Compilation of early policy measures against COVID-19

Country	Airport screening initiated	Quarantine initiation	Lockdown initiation	Duration of lockdown
Afghanistan	25 January 2020		28 March 2020	-
Bangladesh	22 January 2020	9 March 2020	26 March 2020	50 days
Bhutan	6 March 2020	16 March 2020	24 March 2020	21 days
India	31 January 2020	26 January 2020	25 March 2020	75 days
Maldives	26 January 2020	10 March 2020	16 April 2020	-
Nepal	End of February 2020	Mid-February 2020	19 March 2020	-
Pakistan	24 January 2020	28 March 2020	No national lockdown	-
Sri Lanka	27 January 2020	13 March 2020	18 March 2020	52 days

This table shows the timeline of when various interventions were adopted in each country as a measure to reduce to reduce the number of people contracting COVID-19 nationally and internationally.

Source: Pandemic Preparedness and Response to COVID 19 in South Asian Countries (Babu et al., 2020).  
<https://creativecommons.org/licenses/by-nc-nd/4.0/>

**Figure 16** : Compilation of early policy measures against COVID-19. Source: [World Bank South Asia Economic Focus \(2020\)](#).

## Afghanistan

Afghanistan has 107,957 confirmed cases of COVID-19 with more than 4,000 deaths at the time of writing (WHO, n.d.). The pandemic has significantly impacted on the country's fragile health system and population, following decades of insecurity and a chronically weak economy. Despite WHO's reporting of COVID-19 related deaths in Afghanistan, the absence of a national death register together with limited public health resources and a hesitancy in the population against testing, confirmed cases and deaths are likely to be inaccurate and under-reported (Cousins, 2020). Less than 0.5% of the population have been fully vaccinated against COVID-19 to date (Dong et al., 2020). In May 2021, public health officials reported that the country was entering a 'critical state' in its third wave of the pandemic, amid the potential spread of variant B.1.617.2 (Middle East Monitor, 2021).

## Bangladesh

Bangladesh has had significant challenges in dealing with the COVID-19 pandemic. At the time of writing, WHO reported over 860,000 confirmed cases of COVID-19 alongside more than 13,000 deaths (WHO, n.d.). In an attempt to reduce transmission, the government imposed intermittent national lockdowns from March

2020, with the latest implemented in response to a surge in cases in April 2021 (Aljazeera, 2021a). As with other countries in the region, recent growth in cases has been linked to coronavirus variants (Mallapaty, 2021). It has been estimated that COVID-19 induced an increase in the poverty rate to 44% after the first wave, with impacts of further lockdowns as yet unknown. This poverty increase had been particularly evident in urban areas, which have experienced reduced access to markets and usual sources of income, as well as marginalized sections of the community with multiple pre-existing vulnerabilities (UNSDG, 2020a). Bangladesh had fully vaccinated 2.6% of the population by late June 2021, although supplies of vaccines have been affected by a pause in vaccine exports by India (Dong et al., 2020; Reuters, 2021b).

## Bhutan

Bhutan recorded only one death related to COVID-19 between March 2020 and June 2021, and cases have been similarly low, standing at 1,970 to date (WHO, n.d.). The government's response to the pandemic included a National Preparedness and Response Plan (NPRP), which enhanced the health sector's capacity for surveillance, early detection, prevention and recovery, as well as the provision of direct income support to individuals affected by the pandemic (UNSDG, 2020b). Bhutan also established an Economic Contingency Plan setting out



actions to support economic recovery in key sectors such as construction, tourism and agriculture (UNSDG, 2020b). Bhutan's success in tackling the pandemic has been attributed to factors such as effective political leadership; the quick implementation of public health measures including lockdowns, quarantines, and a large-scale test and trace system; financial support for people needing to self-isolate; previous investment in pandemic preparedness; a strong community-based primary health care system; and a high level of solidarity among the population (Drexler, 2021).

## India

In early May 2021, India reported the highest number of daily cases of COVID-19 in the world accounting for almost 50% of new global cases (WHO India, 2021). At the time of writing, India has also reported the third highest number of deaths worldwide (WHO, n.d.). New variants of coronavirus are linked to the high level of disease burden, including the B.1.617 variant, which was first identified in the country (Vaidyanathan, 2021). Both cases and deaths are likely to be significantly under-reported (Dyer, 2021). High infection rates were further impacted by the COVID-19 vaccination roll-out and vaccine shortages. A decision by the central government to allow private hospitals and state governments to purchase vaccines directly from manufacturers, and to open up vaccination to all adults, resulted in a free-for-all rush on vaccine supply (BBC, 2021b). The policy has subsequently been reversed, with central government now assuming control over the majority of vaccine

supplies and distributing these for free (Reuters, 2021a). India's fragmented health care system hindered the effectiveness of the public health measures that were implemented to contain the virus during the first wave, notably travel restrictions and a national lockdown in March-May 2020 (Venkata-Subramani & Roman, 2020). Subsequent state or city-level lockdowns have been implemented, although the central government has been criticized for complacency and allowing large gatherings including election rallies in early 2021 (Bhuyan, 2021). India's underfunded health care infrastructure has faced collapse in parts of the country, while spiralling direct costs for COVID-19 treatment in private hospitals have been reported (Bhuyan, 2021; Thiagarajan, 2021).

## Maldives

To address the COVID-19 outbreak in 2020, the Government of the Maldives placed several restrictions on tourism-related travel into the country with a travel ban on those travelling from China in place as early as February 2020 (Ministry of Economic Development, Republic of the Maldives, and UNDP, 2020). Lockdown measures were lifted and tourism restarted in July 2020 (WHO Maldives, 2020). The pandemic has highlighted the vulnerabilities of its tourism-led economic model, particularly for the nation's growing migrant population (UN Maldives, 2020). As of May 2021, 469,381 vaccine doses had been administered in the country, and 30.4% of the population fully vaccinated although the rate of vaccination slowed during May (Dong et al., 2020).

A significant surge in infections in April-June 2021 – despite the high rate of vaccination – saw further travel restrictions imposed and a curfew introduced to curb the spread of the virus (Aljazeera, 2021b). The number of deaths remain low to date, however (WHO, n.d.).

## Nepal

The first case of COVID-19 in Nepal was recorded in January 2020, but by March 2020 Nepal had no active cases (Kansakar et al., 2021; WHO, n.d.). The government implemented robust measures to contain the disease in the first months of the pandemic, including closing international borders from March to June 2020, implementing a nationwide lockdown, expanding laboratory capacity, and establishing quarantine facilities, although these suffered from overcrowding (Kansakar et al., 2021). In addition, the government introduced free treatment for COVID-19. Subsequent lockdowns were implemented in response to rising cases (Kansakar et al., 2021). In April, May and June 2021, Nepal saw a surge in cases linked to more transmissible variants, and had more COVID cases relative to population size than India at certain points (Mallapaty, 2021). At times, the health system has been overwhelmed by high demand (The Guardian, 2021). There has been a vaccination drive across Nepal since January 2021, with 2.5% of the population fully vaccinated at the time of writing (June 2021) (Dong et al., 2020). However, with a pause in exports of the AstraZeneca vaccine by India, continued roll-out of this vaccination is uncertain (Kansakar et al., 2021). China has also supplied more than a million vaccinations to Nepal (Kathmandu Post, 2021).

## Pakistan

At the time of writing, Pakistan had over 950,000 confirmed cases of COVID-19 and more than 22,000 deaths attributed to the virus (WHO, n.d.). Despite a National Action Plan for Preparedness and Response to COVID-19 in Pakistan in place since February 2020, and comparatively effective suppression of the first wave between July and October of that year, the nation struggled to control the spread of the virus later in 2020 and into 2021 (Waris et al., 2020; WHO, n.d.). By April 2021, Pakistan had reported a peak of more than 6,000 daily cases, reaching a level of infection last seen in June 2020 (WHO, n.d.). To date, just 1.4% of the population is fully vaccinated to protect against COVID, with Pakistan struggling to procure doses for its large population, among global supply challenges, as well as facing vaccine hesitancy in recent months (Dong et al., 2020; Deutsche Welle, 2021). To tackle the pandemic the Government of Pakistan has imposed numerous lockdowns and other restrictions; strengthened local production of personal protective equipment (PPE), ventilators and other critical

health system inputs; established a central reporting system to track COVID-19 data; and provided additional cash support through existing social protection schemes (Bhutta et al., 2021). Pakistan has been commended for using existing networks of community health workers to carry out contact tracing and surveillance functions (WHO, 2020e). However, Pakistan re-entered lockdown in May 2021 to deal with the growth in cases (Aljazeera, 2021c).

## Sri Lanka

Despite a swift reaction from the Sri Lankan government to the COVID-19 outbreak in March 2020, infections in the country rose towards the end of 2020 and by mid-May 2021 were rising at the highest rate seen in Sri Lanka to date (WHO, n.d.). Measures introduced at the outset of the pandemic included a ban on air travel as well as an island-wide lockdown from mid-March to mid-April 2020, while localized lockdowns were introduced in October 2020 in the populous Western, Central and North Western provinces (World Bank, 2021b). Further lockdown measures were introduced in May 2021 (BBC, 2021a). In March 2021, Sri Lanka received its first batch of COVID-19 vaccines from the COVAX facility, with COVAX committing to provide 8.4 million vaccine doses to cover 20% of the Sri Lankan population in 2021 (WHO, 2021a). While Sri Lanka was recognized globally for its initial success in suppressing the virus, by May 2021 pressure on hospitals was mounting amid a surge in cases linked to more transmissible variants (Amaratunga, 2020; Mallapaty, 2021).

## Regional impact of COVID-19

### Health and education impacts

Beyond the immediate health impact of people becoming infected with COVID-19, there are major concerns about other vital health services being disrupted by the pandemic. This is particularly important for South Asia, where the disruption of essential services, such as routine immunization, is a major risk factor for indirect deaths due to the pandemic (UNICEF, 2020). The first wave in South Asia may have contributed to the deaths of an estimated 228,000 children and 11,000 mothers due to drastic cuts in essential public health services, affecting availability and accessibility (UNICEF et al., 2021). In April 2020, Bangladesh reported a 49% reduction in the number of children receiving routine vaccinations compared to the previous month, and 55% less than in February 2020 (UNICEF, 2020). Bangladesh restored immunization coverage to pre-COVID-19 levels in June 2020, but it is unclear how the third wave will

impact on the country's ability to maintain a high level of coverage (WHO, UNICEF & GAVI, 2021). In the Sindh region of Pakistan, the drop in routine immunization coverage was as high as 52.5%, when comparing data from September 2019 to July 2020 (Chandir et al., 2020).

Most countries in South Asia have a critical lack of health care professionals, infrastructure and commodities, meaning that those now tackling the pandemic are facing a huge workload with a limited supply of beds, medicines, commodities and equipment, including PPE. Furthermore, in some countries, health workers have experienced attacks and harassment by patients and families – there have been reports of attacks in Pakistan, Afghanistan and India (Ganapathy, 2020a; Hadid, 2020; South Asia Monitor, 2020). The infections of health workers is also a major concern.

The pandemic is also severely disrupting children's education across the region. Pandemic control measures in South Asia have forced an estimated 420 million children out of school. This is expected to exacerbate inequalities between rich and poor households and rural and urban populations in the future (UNICEF et al., 2021).

### Economic impacts

Economic growth in South Asia has been strongly affected by the pandemic, with the World Bank showing a regional 5.4% decline in GDP in 2020 (World Bank, 2021b). In addition, economic impacts in the region include lower trade volumes, lower revenue collection, and higher recurrent spending, which all contribute to macroeconomic instability (Rasul et al., 2021). Economic factors restricting growth

include a marked reduction in tourism, disruption in supply chains, lowering demand for garments, loss of international capital and disrupted remittances (World Bank, 2020a). India is the biggest recipient of remittances in the region, and the world, receiving an estimated US \$83.1 billion in remittances in 2019 (The Economic Times, 2020).

Domestically, lockdowns have had a negative impact on the economy, causing significant loss of earnings and jobs. Given the high percentage of the population working in the informal sector without social safety nets, it is inevitable that poverty levels will rise and fewer children will complete their education; it is, therefore, likely that child labour will increase (UNICEF, 2020). These consequences will be particularly felt by informal workers in sectors such as wholesale and retail suppliers, manufacturing and agricultural industries, all of which have been heavily impacted by the pandemic (Shaikh, 2020b; Rasul et al., 2021). In India, varying degrees of lockdowns across the country and its devastating second wave are challenging the country's prospects for strong economic recovery, with the World Bank predicting a 10% growth rate in the 2021–2022 fiscal year (World Bank, 2021b).

The ILO estimates around 80 million full time jobs were lost in South Asia in 2020, and predicts a further loss of 7 million to 30 million full time jobs in an optimistic to pessimistic scenario (ILO, 2021). The majority of workers in South Asia work in the informal sector, which has been particularly hard hit. Informal workers tend to have worse health outcomes and often lack access to social security benefits and other social protection measures, such as direct cash transfers. This has a compounding



effect on food and livelihood security, household income and health outcomes. For these reasons, the COVID-19 pandemic cannot solely be seen as a health problem – it signals the need for a whole-of-society approach to tackle the knock-on effects on the economy and society at large, and shows the interconnectedness of health with other development indicators (Rasul et al., 2021).

### Food security

Lockdown policies implemented across South Asia are having profound effects on food supply chains. Supply side effects include disrupted workforce and farm inputs, postponed or cancelled capital investments in the agricultural sector, export restrictions, and the impact of the second wave (Falkendal et al., 2021). The pandemic has affected household food consumption through reduced mobility because of lockdown restrictions, as well as job losses, reduced working hours and diminished household incomes. Even before the pandemic, the nutrition status of children in the region was poor, with an estimated 7.7 million children under 5 suffering from severe wasting and over 56 million being stunted (UNICEF et al., 2021). The closure of schools has disrupted school meal and nutrition programmes.

### Climate security

The South Asia region is particularly prone to climate disasters. On top of the global pandemic, India and Bangladesh were hit by Amphan, a powerful cyclone, in May 2020, and by Nisarga in June, with associated flooding in west India. Although there is no clear-cut evidence yet of disaster-related disruptions to social distancing and forced displacement increasing numbers of infections, in Bangladesh and India it is reasonable to assume this has played a part – not in the least because much of the infrastructure for evacuation, such as community buildings, shelters and schools, have also been used as quarantine facilities. To reduce the risk of infection associated with evacuation, local authorities have adopted measures such as allowing shelters to be half full to ensure social distancing (Asia-Pacific Disaster Resilience Network, 2020).

### Regional cooperation and external investment

In terms of regional cooperation, India's Prime Minister Modi organized a video-conference with the South Asian Association for Regional Cooperation (SAARC) on the COVID-19 pandemic on 15 March 2020. The mid-March high level meeting of this group was the first gathering of leaders on this scale since 2014 and launched a COVID-19 emergency fund with an initial allocation of US \$10 million and voluntary contributions by SAARC countries

totalling US \$8 million (Adhikari, 2020). However, since then, there has been limited disbursement of the fund. In December 2020, a news outlet reported Indian rupees (INR) 6.12 crore (US \$845,000) was provided to Nepal, 3.64 crore (US \$500,000) to Bangladesh, 1.69 crore (US \$233,000) to Bhutan, 1.55 crore (US \$213,000) to Sri Lanka, 60.14 lakh (US \$83,000) to the Maldives, and 29.3 lakh (US \$40,436) to Afghanistan. No money was disbursed to Pakistan (Mishra, 2020).

Further positive developments from this meeting included increased collaboration between governments, the sharing of best practices, a SAARC disaster management centre, a COVID-19 website, and shipments of medical equipment to countries in the region (Fruman & Kaul, 2020). Countries are also looking to strengthen regional cooperation in the tourism sector, especially as, according to World Bank estimates, the sector has lost around 10 million jobs and US \$52 billion in revenue due to COVID-19, which has disproportionately impacted on women, young people and indigenous people (Schafer, 2020).

As the pandemic has progressed, regional cooperation has unfortunately reduced. India's initial offer of vaccines to regional allies, including Bhutan, Nepal, Maldives, and Bangladesh, has been affected by a pause in vaccine exports from India, which are not expected to resume until October 2021 (Chatterjee, Mahmood & Marcussen, 2021). This has left a number of countries in the region scrambling to secure alternative vaccine supplies, including for vital second doses for those people already-vaccinated (Reuters, 2021b).

### An evolving situation

With a new wave of COVID-19 infections hitting the South Asian region, it is not yet clear how factors explaining lower rates of infection at the start of the pandemic in South Asia currently apply. Countries in the region with stronger health systems, such as Sri Lanka and the Maldives have now also grappled with high increases of new COVID-19 infections, although death rates remain lower than in other South Asian nations (WHO, n.d.). It is also important to note that better health coverage has enabled these countries to build on their sustained record of higher public health spending, financial protection for households, health system strengthening and prioritization of health to rapidly scale up public health capacities, such as surveillance and monitoring, and to strengthen treatment services and social protection measures throughout the pandemic. The combination of a strong social contract, long-standing prioritization of health investment, and a pre-existing, primary care-focused health system embedded in communities has undoubtedly brought benefits to the



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pandemic response, particularly during the first wave.

Migrant workers and migration have been consistent factors influencing infection rates in South Asian countries. The status of migrant workers in South Asian countries demonstrates one of the ways in which social determinants of health are intrinsically linked with infectious disease control and health outcomes. Vulnerable populations such as migrant workers are more likely to become infected, as they have lower access to health services and experience poorer housing and working conditions, often including a lack of basic sanitation. Lockdown policies have affected more than a hundred million migrant workers in the region, who

had to go back to their villages when their jobs in urban centres were no longer viable in 2020 (Shaikh, 2020b), with many more affected in 2021. Food insecurity is one of the main drivers of this type of migration. To address these underlying determinants, countries are implementing short-term measures such as social protection schemes, bailouts and cash transfers. However, longer, more sustained investments are needed across a range of sectors, in line with the SDGs, including achieving truly equitable PHC-driven UHC and reducing inequalities across society.



## Section 5. Ten lessons for universal health coverage and health security in South Asia

As the Director General of WHO has argued, health security and UHC are “two-sides of the same coin” (UHC2030, 2020) – they are inseparable and should be addressed simultaneously. Unfortunately, the COVID-19 crisis has shown that in many countries around the world, including in South Asia, these agendas are not well-integrated, which has led to alarming coverage gaps, especially involving vital public health services. Reflecting on how South Asian health systems have responded to the COVID-19 pandemic, this report highlights the following 10 key lessons:

### **Lesson 1: Strengthen health security systems within broader UHC reforms.**

COVID-19 is showing the value of publicly-financed UHC, but is highlighting the relative neglect of public health and primary care in the health systems of many countries in South Asia. Several countries have tended to prioritize insuring people against inpatient hospital care over primary and public health. Learning from the pandemic, UHC reforms should ensure coverage of a full continuum of health services, including health promotion, prevention and treatment. In particular, public health services, notably surveillance and emergency preparedness, should be part and parcel of a primary health care system, recognizing that investments in prevention are the best foundation for both UHC and improving health security.

Immediate priorities for South Asian countries should include substantial additional investment in public health functions such as surveillance, information systems, risk communication campaigns, laboratories and primary health care capacities. Such investments made in response to the COVID-19 pandemic would have positive effects for the larger health system as well – greater use of telehealth services and digital technology in Sri Lanka, Rajasthan (India) and Bangladesh are prime examples of this. Specific policies and investments to address workforce shortages and key skills gaps will also be essential to improve preparedness as well as future resilience.

### **Lesson 2: Prioritize closing primary health care gaps for UHC and health security.**

The COVID-19 pandemic has reinforced the importance of a strong health system based on universal publicly-financed primary health care as the foundation for an effective response to tackling infectious diseases and the first step towards achieving UHC. Investing in universal primary care represents the most effective, efficient and equitable strategy to improving health security, expanding health coverage and delivering tangible results quickly. This was emphasised by WHO Director General Dr Tedros on 12 October 2020 when he said: “Universal health coverage, based on primary health care, is the foundation of health security, stability and sustainability” (CGTN, 2020).

A greater focus on the role of community engagement and strengthening primary care services is essential for identifying cases, isolating people appropriately and tracing their contacts during disease outbreaks. This has been shown to be an effective way to contain COVID-19 within South Asia (notably in Sri Lanka initially and Bhutan) and other Asian countries (e.g., Thailand and Vietnam). As an immediate priority, countries will also need to resume and scale up essential PHC services, which have been badly disrupted by the pandemic, especially concerning maternal and child health services.

Prioritizing achieving greater population coverage with a basic package of services focused on primary care, rather than building additional tertiary hospitals, would have a stronger impact on collective health security, as it addresses a higher proportion of the population, including those who are at greater risk of infection due to their socio-economic status, work, or place of residence (Fruman & Kaul, 2020). Furthermore, evidence from around the world has shown that countries that prioritize reaching full population coverage (with a more modest benefit package) outperform those that target higher benefit packages for select groups. This is often associated with more people (especially in the middle classes) having a stake in maintaining and improving the universal public system. Achieving and sustaining a universal PHC system will require investing in the three components of PHC identified in the Astana Declaration (Figure 11), which also represent the three foundational elements of a robust health security system.

### **Lesson 3: COVID-19 could provide a political window of opportunity to launch UHC reforms.**

The COVID-19 pandemic is a globally disruptive event and across the world people are turning to their governments, especially their heads of state, to resolve the crisis and protect their health, livelihoods and future well-being. Choices made during the pandemic, including social protection measures, economic stimulus packages and investing in infrastructure, will likely determine the course of political leadership in South Asian countries. How leaders perform and respond to the pandemic is likely to define their political careers – and this presents a tremendous opportunity for them to write themselves into the history books as great leaders, rescuing their people from a crisis (Yates, 2020).

With this being primarily a health-related crisis, one obvious area where leaders should look to act decisively is in reforming their health systems and, in particular, extending effective health coverage to all of their people. Interestingly, there is a long history of political leaders

launching UHC reforms as a practical way to rebuild their nations after a crisis. This includes the UK, Japan and France after World War II and Thailand after the Asian Financial crisis at the turn of the century.

Furthermore, there are specific examples of South Asian governments launching UHC-related reforms after periods of national crisis, including Nepal's new democratic government abolishing health care user fees in 2008 and Sri Lanka launching universal free public health services in response to devastating malaria epidemics in the 1930s and 40s (Cothran, 2016; WHO, 2013). This new crisis may be an opportunity for other political leaders in South Asia to launch UHC reforms in their countries. This would be an excellent way to build back better from COVID-19, and investments made during the pandemic would have positive knock on effects for the larger health system, as well as stimulating economic growth.

### **Lesson 4: Increase pooled public financing for health to at least 2% of GDP and replace private out of pocket spending.**

Public financing is the key to achieving UHC and health security, as this is the only way to ensure that healthy wealthy people subsidize vital services for the sick and the poor (The Elders, 2016). Committing more public financing to the health system is of paramount importance for building resilience, strengthening PHC, and ensuring everyone accesses the health services they need, including public health services. It is also vital for ensuring that services are utilized equitably (WHO, 2013). Evidence from this research shows that countries in South Asia with higher levels of public health spending and that are closer to UHC performed better in tackling COVID-19 (notably the Maldives, Bhutan and initially Sri Lanka). Whereas other larger countries that spend only around 1% of their GDP on their public health systems are exhibiting lower levels of health coverage, higher financial hardship due to out-of-pocket payments, and their health systems are struggling to cope with the COVID-19 pandemic. All countries in South Asia need to increase their public spending on health to at least 2% of GDP, and this is particularly urgent in India, Pakistan and Bangladesh, which should aim to double levels of funding for health from compulsory public mechanisms, notably general taxation (UN, 2019). This will be necessary to strengthen COVID-19 related services and reduce disruptions to essential health services as the pandemic evolves.

Immediate priorities for additional public financing include vital public health functions such as surveillance, data and

information systems, and communication and information campaigns, as well as the rapid scaling up of testing, surveillance and investment in primary care infrastructure for the pandemic response. Sufficient public financing must also be in place (including aid financing) to ensure that test-kits, vaccines and therapeutics are available to all people who need them and can be rolled-out equitably. These short-term measures could also catalyse more substantial, longer-term health financing reforms, which would see a greater share of GDP allocated to health and necessitate broader supply and demand side reforms, including:

- Improving the allocative efficiency of health resources – especially towards cost-effective primary care services
- Increasing revenue for health from innovative public sources, including taxes on commodities harmful to health – notably tobacco, alcohol and sugar
- Extending effective health coverage to all members of society and, most importantly, to people working in the informal sector, who tend to be left behind in large-scale insurance schemes, and people living below the poverty line
- Improving health system absorptive capacity, including by building additional infrastructure, strengthening supply chains and addressing human resource gaps

South Asia's largest countries have some of the highest levels of out-of-pocket spending on health in the world, which, as well as reducing access to services, is plunging

tens of millions of people into poverty every year. To improve access to vital services during the pandemic, WHO is recommending that countries should, at least temporarily, remove all user fees for everyone for all publicly-financed health services (Kutzin, 2020). This would be an appropriate policy response for all countries in South Asia.

However, removing user fees would not be sufficient without additional financing to replace lost revenue and meet increased demand for services. This will require replacing private out-of-pocket spending with more efficient and equitable pooled public financing.

Worryingly, before the pandemic, South Asia was predicted to have the highest growth in prepaid private spending on health (through private insurance), and the lowest projections for pooled public health spending per capita by 2040 (Dieleman et al., 2018). This is concerning because evidence from around the world shows that one cannot reach UHC relying on private voluntary insurance. However, there are many lessons from the wider Asia-Pacific region of pooled public health financing systems making great advances towards UHC using general taxation and compulsory social health insurance. Ensuring increased investment in health and social welfare services that cover a larger proportion of the population over the long term can also be a key driver for improving tax collection and, therefore, be beneficial to countries wanting to increase their government revenue (Markhof, 2020).



### Lesson 5: Improve quality of care through sustained health systems strengthening.

Quality primary care for all is the foundation of UHC. Countries aiming to achieve progress towards UHC, and mitigate the impact of COVID-19, should start by investing in primary health care focused on building basic capacities, including: trained and motivated health workers with adequate access to PPE and equipment, reliable access to medicines and health commodities, easily accessible and appropriate health infrastructure, effective information systems, and improved management and governance systems. Some immediate measures that countries can take to strengthen health systems and improve the quality of services during the pandemic include:

- Investing in basic public health capacities – notably in surveillance, testing and contact tracing
- Increasing health worker training in pandemic preparedness and protection – including mobilizing community health workers
- Building demand for services and trust in the health system through widespread risk communication campaigns and community engagement

COVID-19 may also prove to be an opportunity to scale up digital health solutions piloted during the pandemic. South Asian governments have been using digital technology extensively in tackling COVID-19, including social media, online dashboards, direct benefit transfers and virtual doctors (Kumar et al., 2020). For example, Rajasthan, the third largest state in India, used a WhatsApp chatbot and automated voice calls for follow up and spreading information (PHCPI, 2020a). Sri Lanka's Ministry of Health also developed a web-based Digital Health Information Software (DHIS2) package that captures information on high-risk passengers entering the country from at-risk countries to improve COVID-19 surveillance (PHCPI, 2020b). Given geographic challenges to access and limited health workforces, digital health solutions (including telemedicine), when combined with approaches to bridge digital divides, could be a valuable tool for expanding quality health care across the region.

### Lesson 6: Invest in strengthening human resources for health, especially community health workers.

One of the main determinants of an effective and efficient health system is the availability of motivated, trained and well-managed health workers. Users of health services often cite health worker attitudes as one of their most important quality indicators. Unfortunately, many studies in the South Asia region have highlighted shortcomings in human resources, including insufficient numbers of nurses, midwives, doctors and other key personnel; poor training; inefficient and inequitable

distribution of health workers; a lack of supportive supervision; poor remuneration and other benefits; opaque promotion opportunities; and weak management. Much of this underinvestment in human resources is a consequence of the lack of public financing for health.

Furthermore, with many countries prioritizing the allocation of scarce public resources towards curative hospital services, there are acute shortages of health workers in primary health care in both rural and urban settings. This results in people bypassing primary care facilities to access more costly hospital services or buying medicines over the counter in the private sector.

Therefore, achieving universal coverage of primary care services (Lesson 2) will require a substantial investment in human resources at this level, to recruit more health workers and improve their pay, conditions and supervision. One proven cost-effective way to scale up the human resources for PHC services is by recruiting, training and remunerating community health workers, who should be fully integrated into the formal health workforce. Community health worker salaries should be publicly financed. Furthermore, in order to improve the availability of health workers in publicly-financed primary care units, governments can enter into contractual arrangements with private practitioners, employing them on a sessional basis. This model is being employed by the Delhi State Government in India, which has seen millions of people use 'Mohalla' or neighbourhood clinics, which are staffed by publicly-financed private doctors. This model is now being rolled out in nine other states in India.

### Lesson 7: Be willing to pay more and invest better for equity

UHC, by definition, is meant to provide effective health coverage for everyone and also ensure that vital health services are allocated according to need. However, marginalized and disadvantaged groups typically have less access to quality health services (Samman, 2020). To ensure a more equitable uptake of services, governments need to go further than introducing universal entitlements to services and provide additional resources and measures to reach disadvantaged groups. This should involve targeted policies to address the specific health needs of women, children, adolescents, the elderly, LGBTQIA+ populations, poor people, remote rural populations, refugees and migrants, the elderly, people living with disabilities and people from disadvantaged ethnic groups.

In addition to improving equity in health service access, it will also be necessary to address equity issues concerning the social and economic determinants of health, as shown in Lesson 10. Early lessons from the COVID-19 pandemic show that one population group that

has tended to be relatively neglected in South Asia – and indeed across the world – and for which greater effort is needed to improve health coverage, is migrants. Therefore, to close coverage gaps and improve health security for everyone, governments should implement specific policies that address the health and social welfare of migrant workers, who have been hardest hit by lockdown policies. As an immediate priority, this should involve ensuring that there are no financial barriers to accessing COVID-19 testing and treatment for these population groups.

The connection between COVID-19 and urban areas with higher population densities is well known (Hamidi et al., 2020). Countries in the region should, therefore, invest in information systems to track the impact of COVID-19 on specific population groups, measuring rates of testing, cases and health outcomes with a view to informing evidence-based policies to reduce inequalities in health outcomes and other development indicators.

#### **Lesson 8: Engage the private sector in tackling COVID-19 and UHC reforms.**

The private sector plays a large role in the health care systems in South Asia and, in many countries, is where the majority of people access their health care, particularly when it comes to curative outpatient services. As this is likely to remain the situation in the foreseeable future, it will be essential during the COVID-19 crisis and beyond for governments to engage constructively with private health providers to improve equitable access to their services and the quality of services provided. This may involve contracting with private health facilities using public funds to allow access to services for free at the point of delivery to populations previously excluded because of user charges. There have been examples of this approach being employed, in particular involving the use of private labs for COVID-19 testing.

The private sector will also play a pivotal role in manufacturing essential inputs to tackle COVID-19 and accelerate progress towards UHC. For example, Bangladesh's garment industry has been employed to manufacture PPE and other health commodities (Ovi, 2020). The region's extensive pharmaceutical sector has also played a crucial role in researching and manufacturing vaccines, medicines and test kits. Media stories of excessive charging by some private providers, the sale of fake vaccination certificates in Bangladesh, and pushing the burden of paying for vaccines onto

citizens in India (Kaur & Kapil, 2021) indicates that governments will also need to strengthen the regulation of private health organizations to financially protect consumers and monitor private sector practices.

#### **Lesson 9: Strengthen governance and accountability systems.**

It will be essential to establish effective accountability systems that enable communities to monitor progress in tackling the pandemic and towards UHC objectives, and to hold health service providers and governments accountable for sub-standard performance. Civil society organizations will have an important role in establishing and engaging in these systems.

The COVID-19 pandemic is both an opportunity and a threat to UHC progress. Public health has never been higher on the political agenda, but it is vital that politicians are accountable to their populations and fulfil their expectations for better quality health services. Transparency in priority setting and, in the allocation and management of resources will be vital for building trust among members of the public. In meeting international commitments to health security and UHC, it will also be important for governments to invest in data systems and participate in global processes to review progress in achieving SDG targets relating to health outcomes, UHC, health systems and preparedness.

#### **Lesson 10: Engage beyond health to strengthen critical drivers of UHC systems**

Responding to the COVID-19 crisis has shown governments worldwide the importance of addressing the social determinants of health, as well as strengthening health systems to improve health outcomes. Specifically, adverse outcomes associated with: high levels of non-communicable diseases (linked to poor diet and physical inactivity), air pollution, over-crowding, poor housing and sanitation, as well as poverty, inequality and marginalized populations (especially migrants), have illustrated the importance of policies and investments that go beyond the health sector. Going forward, governments in South Asia should adopt a more holistic and multi-disciplinary strategy to improving health by taking a "Health in All" approach to guide policies in other sectors (WHO & Finland Ministry of Social Affairs and Health, 2014).

# Conclusion



The fact that tackling COVID-19 has become the top priority of leaders in South Asia and around the world has propelled health and health systems to the top of the political agenda. This presents a tremendous opportunity for countries to reform their health systems with a view to overcoming the pandemic, improving preparedness and accelerating progress towards UHC ahead of future pandemics. Countries can achieve this by accelerating primary health care reforms and building on innovations implemented during the pandemic, investing in basic public health capacities through a PHC approach, and transforming the health workforce through sustained and increased investment in the health system.

Some South Asian countries entered the pandemic with significant gaps in health coverage, especially in relation to public health infrastructure and access to basic services. The root cause of these shortfalls is the chronically low level of public spending on health. The COVID-19 pandemic has exacerbated existing weaknesses in health and social care systems in the region, but this presents an opportunity to invest in an inclusive, sustainable recovery that will build back resilience in health care systems.

This will necessitate increasing public spending on health systems in the region to at least 2% of GDP and investing additional resources in ensuring universal access to a package of health services focused on cost-effective primary care services provided free at the point of delivery. This should be accompanied by measures to strengthen health systems, especially in the areas of improving the availability and quality of human resources for health, medicines and health commodities, health infrastructure, and information and governance systems.

This should be combined with a 'Health in All Policies' approach to improve health through interventions in other sectors, such as building and expanding social safety net programmes, including cash transfers. Such an approach to building healthy societies, which has been emphasized in WHO's global programme of work, will not only help strengthen health security and improve health outcomes, but also help countries make faster progress towards all the SDGs.

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# Accelerating progress towards universal health coverage in South Asia in the era of COVID-19

How universal primary care can tackle the  
inseparable agendas of universal health coverage  
and health security



## **For further information**

UNICEF Regional Office for South Asia (ROSA)  
P.O. Box 5815, Lekhnath Marg, Kathmandu, Nepal  
Tel: +977-1-4417082  
Email: [rosa@unicef.org](mailto:rosa@unicef.org)  
Website: [www.unicef.org/rosa/](http://www.unicef.org/rosa/)