Policy Brief:

COVID-19 and Universal Health Coverage

OCTOBER 2020

United Nations

Executive summary

In the space of nine months, COVID-19 has spread to more than 190 countries, with over 30 million cases reported. Over one million lives have been lost. The pandemic has laid bare long-ignored risks, including inadequate health systems, gaps in social protection and structural inequalities. It has also brought home the importance of basic public health, and strong health systems and emergency preparedness, as well as the resilience of a population in the face of a new virus or pandemic, lending ever greater urgency to the quest for universal health coverage (UHC).

Health is a fundamental human right, and universal health coverage is a critical tool for achieving health for all. Universal health coverage is defined as a situation where all individuals and communities receive the health services they need without undue financial hardship. However, at least half of the world's population still do not have full coverage of essential health services, and over 800 million people spend at least 10 per cent of their household budgets to pay for health.[1] It will be important to remove as much as possible financial barriers to accessing health services. This is challenging during an economic recession, but COVID-19 has shown that effective epidemic control benefits the economy. It has also exposed the down sides of financing health coverage primarily through wage-based contributions. In the context of a global economic crisis where unemployment increases, and where entitlement to services is linked to such contributions, access to health services is reduced at the time people need it the most.

What is universal health coverage?

Universal health coverage means that all individuals and communities receive the health services they need without undue financial hardship. The goal of universal health coverage is threefold:

- **Equity in access:** everyone who needs health services should get them, not only those who can pay for them
- **Sufficient quality:** health services should be good enough to improve the health of those receiving services
- **No undue financial risk:** The cost of using health services should not put people at risk of financial harm.

The idea of universal health coverage is based on the WHO constitution of 1948 declaring health a fundamental human right and on the Health for All agenda set by the Alma Ata Declaration in 1978. All United Nations Member States have reaffirmed their commitment to try to achieve universal health coverage by 2030, as part of the Sustainable Development Goals (A/RES/74/2, October 2019).

1 World Health Organization (WHO), "Universal health coverage (UHC)", 24 January 2019, available at www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

The world is now at a critical juncture of the COVID-19 pandemic. After some initial success in suppressing transmission, many countries are now experiencing a resurgence after easing of restrictions. With the flu season approaching in some part of the world, and with cases and hospitalizations increasing, many countries find themselves struggling to strike the right balance between protecting public health, protecting personal liberties and keeping their economies going.

With universal health coverage in place, countries could more effectively and efficiently address the three ways in which the COVID-19 crisis is directly and indirectly causing morbidity and mortality: the first is due to the virus itself, the second is due to the inability of health systems to provide ongoing essential health services, and the third is linked to its socioeconomic impact.

We have witnessed that the virus poses the greatest risk to those groups that were already in situations of greater vulnerability: those living in poverty, older people, those with pre-existing health conditions, women, children, migrants and those who have been forcibly displaced. In a matter of months, entire regions that were making progress on eradicating poverty and narrowing inequality have been set back years. Human development has gone backwards for the first time since we began to measure it in 1990.

There can no longer be any question about the links between public health and the broader resilience of economies and societies. COVID-19 has reinforced existing evidence that investments in health have long-term returns, while underinvestment has potential devastating large-scale global social and economic effects that could last for years. The pandemic is costing the global economy $375 billion a month and 500 million jobs since the crisis erupted. The focus needs to remain on addressing the root cause of the economic crisis — which is COVID-19. In this regard, ***WHO has provided comprehensive guidance*** on effective public health measures.

Safe and effective vaccines, diagnostics and therapeutics will also be vital for ending the pandemic and accelerating the global recovery. It has also become abundantly clear that it is in every country's national and economic self-interest to work together massively to expand access to tests and treatments, and to support a vaccine as a global public good — a "people's vaccine" available and affordable for everyone, everywhere. The Access to COVID-19 Tools Accelerator (ACT-Accelerator) with its COVAX Facility is the best global solution for getting us there.

Longer term, pandemic preparedness and response can be seen as a global public good with commensurate global and national-level investments. It requires a standardized outbreak alert system linked to concrete actions by national and local health authorities. As of now, only one third of countries have put in place the capacities for their public health emergency management systems as required under the *International Health Regulations* (2005).

Coming out of the COVID-19 pandemic will require a whole-of-government, whole-of-society and a global coordinated approach. The lessons learned call for universal health coverage that ensures equal access to quality health care without financial risks for everyone and that effectively protects societies from another health crisis with its devastating effects on lives and livelihoods. All United Nations Member States have agreed to try to achieve universal health coverage by 2030, as part of the Sustainable Development Goals and in keeping with the 2019 Political Declaration on Universal Health Coverage.

There are clear steps that can be taken in the context of the COVID-19 response and recovery measures to address the weaknesses that the pandemic has exposed and to invest in more resilient public health in the future. Ultimately, it is a political choice to ensure a pandemic of this scale and impact does not occur again.

RECOMMENDED ACTIONS

1. **URGENTLY CONTROL FURTHER TRANSMISSION OF COVID-19:**

- Continue to strengthen public health measures to reduce local COVID-19 transmission to zero
- Make universal provision for COVID-19 testing, isolating and contact tracing
- Ensure access to care for COVID-19 patients to reduce number of deaths.

2. **PROTECT DELIVERY OF OTHER ESSENTIAL HEALTH SERVICES.** To minimize morbidity and mortality, priority health services need to continue to be delivered during the acute phase of the COVID-19 pandemic.

3. **MASSIVELY EXPAND ACCESS TO NEW RAPID DIAGNOSTICS AND TREATMENTS AND ENSURE FUTURE COVID-19 VACCINES ARE A GLOBAL PUBLIC GOOD WITH EQUITABLE ACCESS FOR EVERYONE, EVERYWHERE:**

- Take a global approach to ensuring equitable access to new COVID-19 tools by fully funding the Access to COVID-19 Tools Accelerator (ACT-Accelerator)
- Urgently address the spread of misinformation and false rumours about vaccine safety.

4. **ACHIEVE UNIVERSAL HEALTH COVERAGE:**

- Invest in core health systems functions that are fundamental to protecting and promoting health and well-being, known as "common goods for health"
- Suspend user fees for COVID-19 and other essential health care.

5. **STRENGTHEN NATIONAL AND GLOBAL PANDEMIC PREPAREDNESS AND AIM FOR HEALTHY SOCIETIES FOR THE FUTURE.**

1. Impact of COVID-19 on health and pandemic response

Within just nine months, COVID-19 has spread to more than 190 countries. By the end of September 2020, the world had recorded over 30 million cases, and over 1 million people had lost their lives. COVID-19 is directly and indirectly causing morbidity and mortality in three ways: (1) due to the virus itself, (2) due to the inability of health systems to provide ongoing essential health services, (3) due to its socioeconomic impact.

1.1. THOSE MOST VULNERABLE TO COVID-19 AND NEED FOR A GLOBAL RESPONSE

Depending on the age structure of the population, about 5 to 15 per cent of COVID-19 patients will develop critical complications that require mechanical ventilation, and 15 to 20 per cent of patients will have severe symptoms that require oxygen therapy or other inpatient interventions.[2] Known risk factors for severe COVID-19 disease are being over 60 years of age, having hypertension, diabetes, cardiovascular disease, chronic respiratory disease or immunocompromising conditions. About one fifth of the world's population, 1.7 billion people, have at least one of these underlying conditions, whereas 350 million people (4 per cent of the global population) are at high risk of severe COVID-19.[3] The share of the population at increased risk is highest in countries with older populations, African countries with high HIV/AIDS prevalence, and small island nations with high diabetes prevalence.

COVID-19 often hits hardest those who can least afford it: the old, those with chronic disease, or those in poor living conditions. Older persons in long-term care facilities have high morbidity and mortality rates as well as high rates of staff absence due to COVID-19. In several European Union countries, deaths among residents have accounted for over half of all COVID-19-related deaths.[4] Persons living in confined living spaces, whether in crowded settlements, refugees, migrants, prisons, are also at high risk.

Healthcare workers are at high risk of COVID-19 infection because of more frequent contact with COVID-19 cases (see **box 1.1**). Frontline workers in essential occupations, such as in public transport, food production, law enforcement, also face greater exposure. A number of chronic conditions add to the susceptibility of COVID-19 infection and increase the adverse

2 WHO, "Operational considerations for case management of COVID-19 in health facility and community", 19 March 2020, available at https://apps.who.int/iris/bitstream/handle/10665/331492/WHO-2019-nCoV-HCF_operations-2020.1-eng.pdf?sequence=1&isAllowed=y.

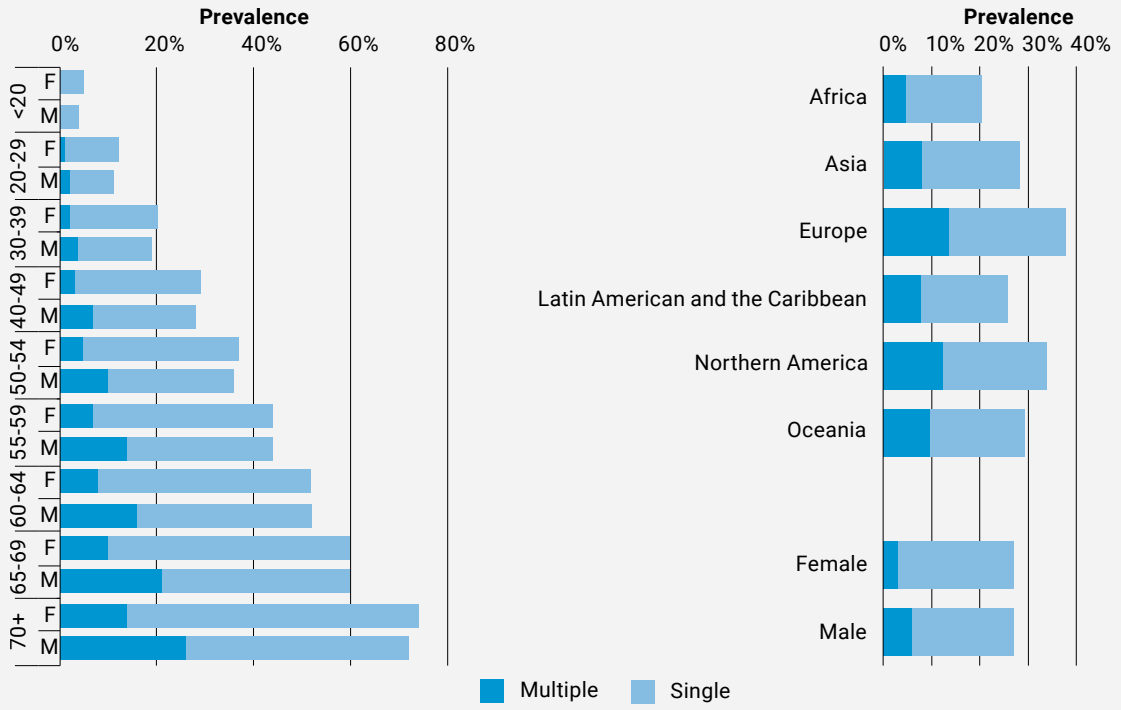
3 Andrew Clark and others, "Global, regional, and national estimates of the population at increased risk of severe COVID-19 due to underlying health conditions in 2020: a modelling study", *The Lancet*, 15 June 2020, available at www.thelancet.com/action/showPdf?pii=S2214-109X%2820%2930264-3.

4 European Centre for Disease Prevention and Control, "Epidemiology of COVID-19", 15 July 2020, available at www.ecdc.europa.eu/en/covid-19/latest-evidence/epidemiology.

consequences. For example, there are findings that HIV infection increased COVID-19 mortality in South Africa's Western Cape province 2.5-fold. Anxiety and depression appear to be common amongst people hospitalized for COVID-19, with one hospitalized cohort from Wuhan, China, indicating over 34 per cent of people experiencing symptoms of anxiety and 28 per cent experiencing symptoms of depression. This highlights the importance of mental health services being considered essential components of the national response to COVID-19, as outlined in the Policy Brief launched in May 2020 ***COVID-19 and the Need for Action on Mental Health***.

Women play a disproportionate role in responding to the pandemic, as healthcare workers, caregivers and community mobilizers. Globally, women make up 70 per cent of the health work force,[5] and in some countries, infections among female health workers are twice that of their male counterparts.[6] In the home, women do three times as much unpaid care work as men. When health systems are overloaded, a greater burden is placed on care in the home and that burden lands largely with women and girls.

FIGURE 1.1. PREVALENCE OF RISKS FACTORS FOR SEVERE DISEASE, BY AGE AND SEX AND BY REGION 2020



5 M. Boniol and others, "Gender Equity in the Health Workforce: Analysis of 104 Countries", Health Workforce Working Paper 1, WHO, 2019; for e.g the cases of Spain and the US where over 70 per cent of infected health-care workers were women, see UN-Women, "COVID-19: Emerging gender data and why it matters", 26 June 2020, available at https://data.unwomen.org/resources/covid-19-emerging-gender-data-and-why-it-matters.

6 UN-Women, "COVID-19 And Women's Leadership: From An Effective Response to Building Back Better", Policy Brief no. 18, 2020, available at www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-covid-19-and-womens-leadership-en.pdf?la=en&vs=409.

Women's role and burden in the pandemic are not reflected at the decision-making table. As of 1 January 2020, three quarters of the world's parliamentary seats are held by men. Only 25 per cent of the world's health ministers are women, and women hold just 25 per cent of senior roles in health institutions. Meanwhile, 72 per cent of executives of global health organizations are men.[7] Women's roles need to be extended beyond the frontlines to participating in the design, implementation and monitoring of national COVID-19 responses. Evidence shows where women are Heads of State and Government, the response to COVID-19 has been perceived as particularly effective.[8]

Noting that most of the frontline workers are women, support to such workers should take women's needs in to account. Such measures may include offering flexible working arrangements, free transportation, extra payments and services, also recognizing women's increased burden of unpaid care work during the pandemic.

BOX 1.1. INCLUSION OF REFUGEES

Refugees, internally displaced persons and stateless persons in vulnerable situations are particularly exposed to the health impact of COVID-19. The risks are compounded in fragile, conflict-affected and humanitarian settings, in which large numbers of refugees and internally displaced persons live in overcrowded or unsanitary conditions where COVID-19 can easily spread. More than 85 per cent of refugees are hosted in low to middle-income countries. The Global Compact on Refugees calls for the international community to ensure that refugees and their host communities are not left behind in a country's progress towards the Sustainable Development Goals, including by supporting refugee inclusion in national health systems.[9] The Secretary-General's Policy Brief on ***COVID-19 and People on the Move*** further called for their inclusion in national COVID-19 response plans, protection of their human rights, and recognition of their enormous potential to contribute to solutions.

7 UN-Women, "COVID-19 And Women's Leadership", see for e.g. Denmark, Ethiopia, Finland, Germany, Iceland, New Zealand, and Slovakia.

8 UN-Women, "Rapid gender assessment of the situation and needs of women in the context of COVID-19 in Ukraine", 2020, available at https://www2.unwomen.org/-/media/field%20office%20eca/attachments/publications/2020/06/rapid%20gender%20assessment_engmin.pdf?la=en&vs=3646.

9 United Nations High Commissioner for Refugees, "Global Compact on Refugees", available at www.unhcr.org/the-global-compact-on-refugees.html.

BOX 1.2. EXAMPLES OF GOOD PRACTICE

IN ADDRESSING THE HEALTH IMPACT OF COVID-19 ON REFUGEES AND IDPS

- In Ghana and Turkey, refugees are fully included in national health systems on par with nationals.
- In Rwanda, urban refugees in Kigali have been included in the national social health insurance scheme.
- In Mauritania, with the support of the World Bank, a transition is underway to build the capacity of the national system to fully include refugees.
- In Peru, temporary health coverage has been approved for refugees and migrants suspected of or testing positive for COVID-19.

States need both financial and technical support in order to implement fully inclusive public healthcare policies. By adopting such policies, refugee-hosting countries may be able to access humanitarian and development funding and the possibility to plan for multi-year projects.

IN ADDRESSING THE SOCIO-ECONOMIC FALLOUT OF COVID-19 ON THOSE WHO HAVE BEEN FORCIBLY DISPLACED

- Peru, Chile and Argentina recently began allowing foreign-trained refugee doctors, nurses and others with medical training to work during the COVID-19 response. In Ireland, the Medical Council has announced it would allow refugees and asylum-seekers with medical training to provide medical support by taking up roles, including as healthcare assistants.
- Humanitarian actors in Burkina Faso, Chad, Guinea and Liberia continue to pay teacher incentives during the closure of schools for refugee teachers to ensure continuity of income.
- The South African Government confirmed that 30 per cent of financial support for small convenience shop owners can go to foreign-owned businesses, including those owned by refugees.

Governments around the world have expanded their control measures to reduce the spread of COVID-19. The measures have included school and workplace closing, cancelling public events, restrictions on gathering size, reducing public transport, stay-at-home requirements and restrictions on internal movement and international travel.[10] Such measures have been effective in reversing the rising numbers of COVID-19 cases and deaths. For instance, countries that went into lockdown early experienced fewer deaths in subsequent weeks. Also, the cumulative per-capita mortality rate from COVID-19 has plateaued at different levels in different countries. Some people at particularly high risk, such as those of older ages, may need further shielding from potential exposure to COVID-19 infection. Others, such as nonviolent prisoners living in confined spaces, have been released on a case-by-case base.

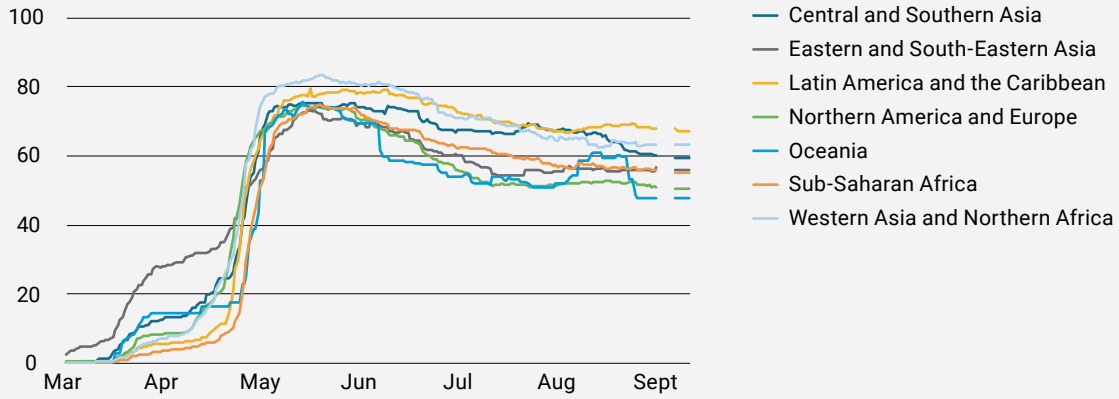
10 Blavatnik School of Government, University of Oxford, "US Government Response", 14 September 2020, available at www.bsg.ox.ac.uk/research/research-projects/coronavirus-government-response-tracker.

Treatment and care decisions need to be based on medical need and not on discriminatory factors such as ethnicity, nationality, religion, sex, age, disability or political affiliation. It is essential that patients with similar health problems or symptoms receive equal treatment and care.

Patients and their caregivers need to be involved in decision-making to the greatest extent possible, explaining options and limitations in treatment. It is important that treatment and care does not increase peoples' financial hardship, which is a core principal of universal health coverage.

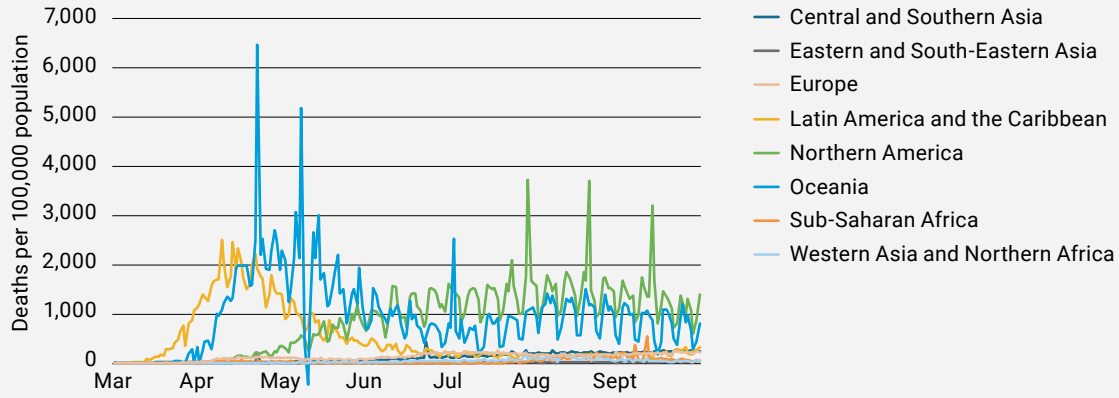
FIGURE 1.2. IMPLEMENTATION OF CONTAINMENT AND PUBLIC HEALTH INTERVENTIONS BY REGION, 2020

Index runs from 0 to 100 and signifies the strength of public health response by region.



Source: World Health Organization.

FIGURE 1.3. TREND IN COVID-19 CASES AND DEATHS BY SDG REGION, 2020



Source: World Health Organization.

1.2. IMPACT ON OTHER HEALTH SERVICES

The additional patient load caused by COVID-19 threatens the ability of health systems to provide other essential health services. On a local scale this may mean the cancellation of elective surgeries and other non-urgent procedures, but may also lead to wider effects owing to the restriction of travel, interruption of supply chains and redeployment of staff.[11] The indirect effects can sometimes outweigh the direct impact of the COVID-19 outbreak itself. Already, we have seen disruptions in 90 per cent of countries. As with COVID-19, those who miss out on essential health services are likely to be from poor, disadvantaged groups with poorer access to services.

On a global scale, the effects may seriously impair or reverse progress towards the Sustainable Development Goals (SDGs). For example, coverage reductions of 9.8 to 18.5 per cent of reproductive, maternal and child health interventions, such as immunization, and a wasting increase of 10 per cent, could lead to more than 250,000 additional child deaths and 12,000 maternal deaths over 6 months in 118 countries.[12] Furthermore, 47 million women may not be able to access modern contraceptives, 7 million unintended pregnancies may occur and 31 million additional cases of gender-based violence can be expected to occur if lockdowns continue for at least six months in 114 low- and middle-income countries.[13] A suspension of planned insecticide-treated nets distributions in 2020, and reduced access to effective anti-malarial treatment could lead to an estimated 769,000 malaria deaths by the end of 2020.[14] A global reduction of 25 per cent in expected tuberculosis detection for 3 months could increase tuberculosis deaths by 13 per cent, bringing us back to the levels of tuberculosis mortality that we had 5 years ago.[15] A six-month disruption of antiretroviral therapy could lead to more than 500,000 extra deaths from AIDS-related illnesses in sub-Saharan Africa in 2020–2021: in 2018, an estimated 470,000 people died of AIDS-related deaths in the region.[16]

COVID-19 can negatively affect outcomes in people with noncommunicable diseases through delays in diagnosis of noncommunicable diseases, such as cancers and heart disease among others, resulting in more advanced stages of disease. Delays in seeking care for heart attack, stroke and cancer have been reported in some countries.[17]

To minimize morbidity and mortality, countries need to identify essential health services that will be prioritized for continuation during the acute phase of the COVID-19 pandemic. High-priority categories are listed in box 1.3.[18]

11 WHO, "Maintaining essential health services: operational guidance for the COVID-19 context", 1 June 2020, available at www.who.int/publications/i/item/WHO-2019-nCoV-essential-health-services-2020.1.

12 Timothy Roberton and others, "Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study", *The Lancet: Global Health*, vol. 8, No. 7, 1 July 2020, available at www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30229-1/fulltext.

13 United Nations Population Fund, "Coronavirus Disease (COVID-19) Pandemic", June 2020, available at www.unfpa.org/sites/default/files/resource-pdf/UNFPA_Global_Response_Plan_Revised_June_2020_.pdf.

14 WHO, "The potential impact of health service disruptions on the burden of malaria", 23 April 2020, available at www.who.int/publications/i/item/the-potential-impact-of-health-service-disruptions-on-the-burden-of-malaria.

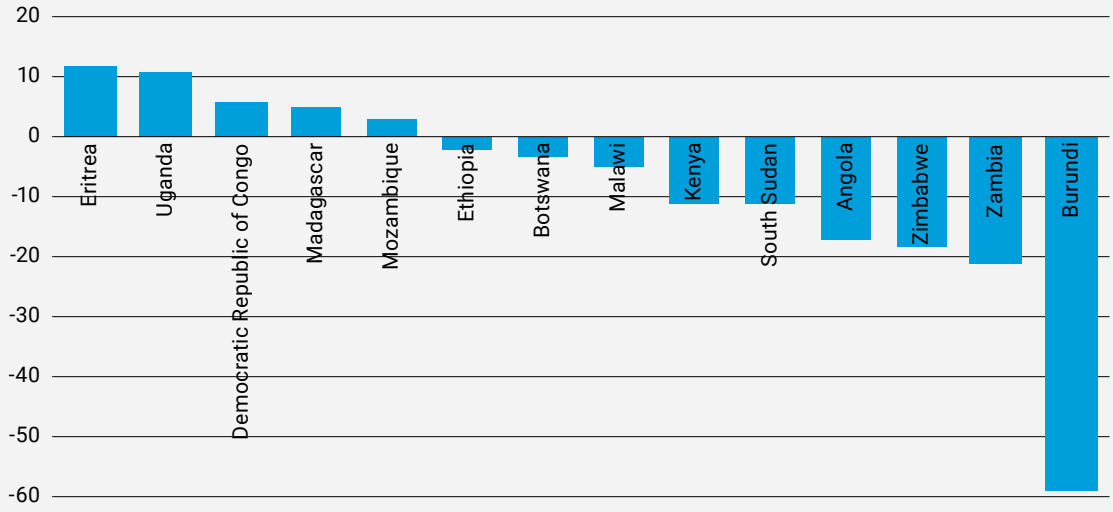
15 WHO, "Tuberculosis and COVID-19", Information Note, 12 May 2020, available at www.who.int/docs/default-source/documents/tuberculosis/infonote-tb-covid-19.pdf?sfvrsn=b5985459_18.

16 A. Hogan and others "Spiral: Report 19: The Potential Impact of the COVID-19 Epidemic on HIV, TB and Malaria in Low- and Middle-Income Countries", 30 April 2020, available at https://spiral.imperial.ac.uk:8443/handle/10044/1/78670.

17 Marion M. Mafham and others, "COVID-19 pandemic and admission rates for and management of acute coronary syndromes in England", *The Lancet*, vol. 396, No. 10248, 8 August 2020, available at https://doi.org/10.1016/S0140-6736(20)31356-8.

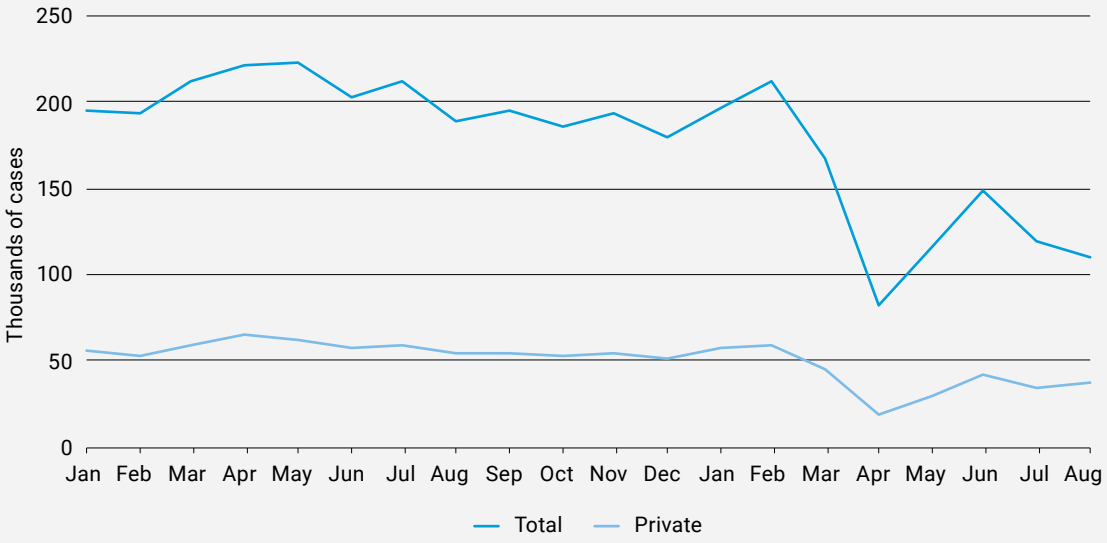
18 WHO, "Maintaining essential health services".

FIGURE 1.4. PERCENTAGE CHANGE IN DELIVERIES BORNE IN PUBLIC HEALTH FACILITIES IN EAST AND SOUTHERN AFRICA, 2020 VERSUS 2019



Source: Regional multi-agency (UNFPA, UNAIDS, UNICEF and WHO) 2gether 4 SRHR Programme.

FIGURE 1.5. FALL IN TUBERCULOSIS CASES ATTENDING HEALTH FACILITIES IN INDIA, 2019–2020



The national lockdown started on week 12, partial lifts were initiated on week 16 in some states. Data extracted from the public web-site of the national real-time tuberculosis surveillance system.

Source: https://reports.nikshay.in/Reports/TBNotification

BOX 1.3. SERVICES TO BE PRIORITIZED DURING COVID-19 PANDEMIC

- Management of emergency health conditions and common acute presentations that require time-sensitive interventions, including care for women survivors of violence
- Prevention and treatment services for communicable diseases, including immunizations
- Services related to sexual and reproductive health, including during pregnancy and childbirth
- Core services for vulnerable populations, such as infants and older adults
- Provision of medications, supplies and support from health care workers for the ongoing management of chronic diseases, including mental health conditions and
- Auxiliary services, such as basic diagnostic imaging, laboratory and blood bank services.

As the COVID-19 case-load decreases, many services that were suspended will need to be restored rapidly. Decisions about modifications to service delivery must be informed by accurate and timely data on the delivery of a core set of essential services. Reports should highlight any changes in the readiness of health facility and community delivery systems, including interrupted preventive programmes, such as for missed vaccinations, as well as severe exacerbations of non-communicable diseases or advanced infections. Service restoration is likely to occur in the context of a "new normal", with ongoing risks of COVID-19 transmission and recurrence of local clusters or community transmission. Contingency planning for the possible resuspension of services is necessary and may include resupplying of equipment and medicines and training personnel.

1.3. SOCIO-ECONOMIC IMPACT

Various measures used to limit the spread of COVID-19, and ease the strain on health care systems, have reduced travel, consumption and investment, as well as restricted labour supply and production, causing huge socio-economic impacts, especially for the most vulnerable.[19] These impacts and measures to mitigate them have been laid out in great depth in the previous policy briefs. The IMF and the World Bank are supporting the Debt Service Suspension Initiative in which borrowers can use freed-up resources to increase social, health, or economic spending. This is critical for universal health coverage in particular, as progress requires public funding.[20, 21, 22]

19 World Bank, *Global Economic Prospects 2020*, "Chapter 1: Global Outlook, Pandemic, Recession: The Global Economy in Crisis", June 2020, available at https://openknowledge.worldbank.org/bitstream/handle/10986/33748/211553-Ch01.pdf.

20 WHO, "Policy Brief No 1 Raising revenues for health in support of UHC: strategic issues for policy makers", 10 November 2015, available at www.who.int/publications/i/item/raising-revenues-for-health-in-support-of-uhc-strategic-issues-for-policy-makers.

21 Ajay Tandon and others, "From slippery slopes to steep hills: Contrasting landscapes of economic growth and public spending for health", *Social Science and Medicine*, vol. 259, August 2020, available at www.sciencedirect.com/science/article/pii/S0277953620303907?dgcid=rss_sd_all.

22 Joseph Kutzin, Winnie Yip and Cheryl Cashin, "Alternative Financing Strategies for Universal Health Coverage", *World Scientific Handbook of Global Health Economics and Public Policy*, 2016, available at www.worldscientific.com/doi/abs/10.1142/9789813140493_0005.

Despite these fiscal stimulus interventions, advanced economies are expected to experience a 7 per cent drop in output, while emerging market and developing economies will mark their first output contraction in more than 50 years. The pandemic is costing the global economy $375 billion a month and 500 million jobs since the beginning of the crisis. It will be vital to address the root cause of the economic crisis — which is the COVID-19 disease — by prioritizing health investments now. The financial costs for a comprehensive public health response to the pandemic will be small compared with those of a prolonged global recession. Health financing policies need to prioritize public financing for health and remove financial barriers to accessing services.[23]

The global recession is projected to lead to the first rise in global extreme poverty since 1998. It is estimated that COVID-19 could push an additional 70 to 100 million people into extreme poverty in 2020, effectively wiping out progress made since 2017. The consequences for human health are potentially serious, with each health-related SDG target likely to go backwards. Those most influenced by a poverty indicator will likely be most affected (e.g. tuberculosis will be less likely to be treated, skilled delivery rates reduced).

A large share of the new extreme poor will be concentrated in countries that are already struggling with high poverty rates and numbers of poor. Almost half of the projected new poor will be in South Asia, and more than a third in Sub-Saharan Africa. The increase in world poverty threatens the ability of the most vulnerable to access health services.

The incidence of catastrophic health expenditure increased continuously between 2000 and 2015, and its incidence may increase further due to the COVID-19 pandemic.[24]

1.4. MASSIVELY EXPAND ACCESS TO NEW RAPID DIAGNOSTICS AND TREATMENTS AND ENSURE FUTURE COVID-19 VACCINES ARE A GLOBAL PUBLIC GOOD

We are now at a critical juncture of the COVID-19 pandemic. After initial success in suppressing transmission, many countries are now experiencing a resurgence of cases after easing some restrictions. WHO has urged countries to continue focusing on fully implementing the proven effective public health measures, and has provided comprehensive guidance on suppressing transmission of the virus.

Safe and effective vaccines, diagnostics and therapeutics will be vital for ending the pandemic and accelerating the global recovery. But these life-saving tools will only be effective if they are available for the most vulnerable equitably and simultaneously in all countries — essentially, to make these tools global public goods. The ***Access to COVID-19 Tools Accelerator*** (ACT-Accelerator) is the best global solution for speeding up the development of the tools we need to save lives as fast as possible, and to make them available for as many as possible as equitably as possible.

23 UHC2030 International Health Partnership, "Living with COVID-19: Time to get our act together on health emergencies and UHC", discussion paper, 27 May 2020, available at www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/Health_emergencies_and_UHC/UHC2030_discussion_paper_on_health_emergencies_and_UHC_-_May_2020.pdf.

24 WHO, *Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report*, available at www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1.

The ACT-Accelerator is already delivering concrete results – evaluating dozens of new game-changing rapid diagnostics; the only proven therapy for severe COVID-19 disease; the largest vaccine research portfolio and the establishment of a COVAX Vaccine Facility with over 156 economies now committed and more joining; and establishing consensus on the international allocation of these products. Through this mechanism, countries share risks and increase the likelihood of gaining access to the most successful, proven, effective and safe vaccines. This pooling of risk and return — as opposed to national vaccine efforts — is the only safe and certain way to rapidly reopen the global economy and restore livelihoods. In the first phase, the key is getting vaccines to those who need it most, including health and social care workers, the elderly and other vulnerable populations simultaneously across the world — regardless of wealth. The ACT-Accelerator needs now to move quickly out of its start-up phase to leverage this impressive early progress for impact at scale.

Investing in the ACT-Accelerator will accelerate every country's own recovery. The ACT-Accelerator urgently requires $35 billion to help it go from start-up to scale up to meet its goals — to produce 2 billion vaccine doses, 245 million treatments and 500 million tests.

2. Universal health coverage is important for an effective COVID-19 response

The current COVID-19 crisis has laid bare long-ignored global health risks, including inadequate health systems, gaps in social protection and structural inequalities. It has also brought home the importance of basic public health, and health services, to the resilience of a population in the face of a new virus or pandemic, lending ever greater urgency to the quest for universal health coverage.

Health is a fundamental human right, encompassing health services as well as the underlying determinants of health, and universal health coverage is a critical tool for achieving health for all. Universal health coverage is defined as a situation where all individuals and communities receive the health services they need without undue financial hardship. However, at least half of the world's population still do not have full coverage of essential health services, and over 800 million people spend at least 10 per cent of their household budgets to pay for health.[25]

The COVID-19 pandemic has also exposed inconsistencies in implementation. Universal health coverage, by definition, includes access to the full spectrum of services, including health promotion, prevention and treatment. All these, and health security, are included in the tracking of universal health coverage progress under SDG 3.8.1 (service coverage). But in practice, the focus has largely been on treatment, with less or no attention to promotion and prevention.[26]

2.1. COMMON GOODS FOR HEALTH

To respond to the pandemic efficiently and effectively, and build the foundations for a better future, governments need to expand their investments in core health system functions that are fundamental to protecting and promoting health and well-being, called "common goods for health" (see box 2.1).[27] In human-rights terms, this means committing the maximum available resources towards meeting the minimum core obligations under the right to health. These include access to essential medicines and the equitable distribution of all health facilities, goods and services. These functions are integral to the commitments that all Member States made in the *International Health Regulations*, as well as the *Political Declaration on Universal*

25 WHO, "Universal health coverage (UHC)", available at www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

26 UHC2030, "Living with COVID-19", available at www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/Health_emergencies_and_UHC/UHC2030_discussion_paper_on_health_emergencies_and_UHC_-_May_2020.pdf.

27 WHO, "Common goods for health", 2019, available at www.who.int/health-topics/common-goods-for-health#tab=tab_1.

BOX 2.1. COMMON GOODS FOR HEALTH*

- Policy coordination
  - Institutional capacities (e.g. centre for disease control, public health institute, emergency operations centre)
  - Health labour market policies
  - Procurement and supply chains for personal protective equipment and other supplies
- Information and surveillance (e.g. centre for disease control, public health institutes, community-based surveillance for COVID-19 including information systems) and laboratory capacity (e.g. expanding COVID-19 testing capacity)
- Risk communication (e.g. outreach to empower individuals and families to better manage their own health and to strengthen community engagement and trust)
- Regulation
  - Food control and licensure
  - Medicines and health products quality regulation
- Fiscal instruments (e.g. health taxes, removal of energy subsidies to reduce respiratory illness)
- Public health programmes
  - Water and sanitation in health facilities
  - Immunization
  - Animal health
  - Environmental health

* Also known as essential public health functions

Health Coverage in 2019.[28, 29] Preparedness can be built into existing health system capacities rather than creating new structures or hiring new personnel. The COVID-19 experience has brought home the reality that the health systems of many countries were not adequately prepared to fully protect the health of their populations.

Strong health systems based on primary health care are the foundation of an effective response to COVID-19 as well as for universal health coverage. In some countries the emergency response has focused more on expanding intensive care beds than primary care. Both are needed. Facility-based services need to be delivered remotely, with personal protective equipment and ventilators, while primary care services that would routinely be delivered across multiple visits need to be integrated when possible. Inpatient admission processes may need to be adapted, as the risks and benefits associated with hospital-based care may change.

Alternative approaches to making essential medicines and services available should be urgently introduced when facility-based services are restricted. For example, telemedicine for key information and delivery of medicines by post, self-care interventions and task-sharing for outreach workers are all mechanisms that can increase access to essential health services when facility-based care is not possible.

Effective communication and community engagement are essential to maintaining public trust. While patient-provider encounters should be in keeping with physical distancing recommendations during the COVID-19 pandemic, patients should not delay seeking care for time-sensitive conditions and should maintain ongoing therapies for chronic

28 WHO, *International Health Regulations (2005) Third Edition*, 1 January 2016, available at https://www.who.int/publications-detail-redirect/9789241580496.

29 https://undocs.org/en/A/RES/74/2.

conditions. Clear messages about when and where to seek care, the suspension of user fees and reassurance about the safety of care are an essential part of the pandemic response. Community and civil society participation in national COVID-19 coordination task forces are essential to a more effective response.

Participation in and access to health information and education are essential for the full enjoyment of the right to health. Armed with accurate, timely and accessible information, available in all local languages, affected communities are able to make informed decisions about protecting themselves and others. Particularly where their active and meaningful participation in health decision-making is solicited and facilitated at the same time, communities are empowered for positive involvement in the health response. This is equally true of communities and groups who often find themselves on the margins of society, such as migrants, persons with disabilities, persons living in poverty and older persons.

COVID-19 reinforces the importance of governments seeing local communities, affected populations, relevant stakeholders and organizations, civil society and the private sector, as part of the solution to the epidemic. Gender equity and the empowerment of women are essential in shaping health emergency preparedness and response. An effective response depends on trust in government so that strategies are supported, as well as having strong management across multiple stakeholders and organizations, with clear accountability. The value of community groups has repeatedly been shown in contributing to community mobilization, awareness raising, linking suspected cases with care and services, as well follow-ups during recovery and support.

2.2. FINANCING OF HEALTH DURING COVID-19 CRISIS

Removal of financial barriers to accessing health services is a vital step to ensuring greater public health. This is challenging during an economic recession, but COVID-19 has shown that effective epidemic control benefits the economy. COVID-19 reinforces the need to remove financial barriers from individuals' decisions about whether to seek care.[30] Ideally, patients do not pay user fees (co-payments) at the point of care for essential services during the COVID-19 pandemic since the expectation of payment may pose a substantial barrier to seeking and receiving needed care. While this is generally a concern for ensuring equitable access, it takes on additional importance in the context of a highly communicable disease, affecting not only the person who might need care but the others who might be affected by that person.

Public and contracted private providers need to be compensated by advanced provider payments where feasible. In settings where informal payments (for example, for medical supplies or to health workers) are common, a mere declaration of free services may not be sufficient. Governments could establish reliable mechanisms to ensure no-fee delivery of essential services[31] and communicate this policy clearly to the public. If fees, or other financial barriers (e.g. transport costs), cannot be

30 UHC2030, "Living with COVID-19", available at www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/Health_emergencies_and_UHC/UHC2030_discussion_paper_on_health_emergencies_and_UHC_-_May_2020.pdf.

31 Prosper Tumusiime, "Domestic Health Financing for Covid-19 Response in Africa", *Social Health Protection Network*, 28 April 2020, available at https://p4h.world/en/bmj-domestic-health-financing-covid-19-response-africa.

eliminated, ministries of health could work with authorities that provide social cash transfers to ensure vulnerable households can obtain care.[32]

The experience with COVID-19 also reinforces messages about health financing for universal health coverage. In particular, where health coverage is linked to employment, an economic shock that leads to a loss of formal sector jobs also has negative consequences for health coverage. This is at odds with universal health coverage — the right to health coverage is not a mere employee benefit. Therefore, in countries that historically have relied on contributory, employment-linked coverage, it has been essential to inject general budget revenues into the system, both to reduce the vulnerability of the system to job losses and to ensure that the essential actions needed to respond to COVID-19 can be implemented.[33]

2.3. EQUITY IN HEALTH SERVICE PROVISION, INCLUDING COMMUNITY-BASED PROVISION

Universal health coverage embodies the goals of equity in the use of needed, effective services with financial protection, and progress towards these goals assessed at the level of entire populations. Systems that are organized to sustain progress towards universal health coverage are better organized to respond to a disease outbreak if they are people-centered and rights-based.

For individual services, the COVID-19 experience reveals that health systems with large inequalities in service entitlements and that are fragmented into multiple schemes and programmes are not only problematic for persons who are at risk of being left behind, but for societies and economies as a whole. Fragmented systems are also less able to respond effectively to a communicable disease outbreak than systems where benefits are more equal and key underlying subsystems, particularly for epidemiological and service-use data, operate at the level of the entire system, encompassing the public and private providers that serve the entire population.

Financing health through wage-based contributions proves to be particularly problematic at time of global economic crisis where unemployment increases, and where entitlement to services is linked to such contributions, it can reduce access to health services at the time people need it most. Countries could ensure that particular sub-populations most severely affected by COVID-19, including those affected by sexual violence, persons with disabilities (who represent 15 per cent of the global population), those with mental health needs, people living with HIV/AIDS, older persons, refugees and internally displaced persons and migrants no longer experience unmet health needs.

32 Joe Kutzin, "Priorities for the Health Financing Response to COVID-19", *Social Health Protection Network*, 2 April 2020, available at https://p4h.world/en/who-priorities-health-financing-response-covid19.

33 For example in Germany (www.covid19healthsystem.org/countries/germany/livinghit.aspx?Section=4.1%20Health%20financing&Type=Section) or the Czech Republic (www.covid19healthsystem.org/countries/czechrepublic/livinghit.aspx?Section=4.1%20Health%20financing&Type=Section)

3. Healthy societies and better pandemic preparedness for the future

COVID-19 has exposed dangerous gaps in preparedness and health coverage and access. Pandemic preparedness and response require a standardized outbreak alert system linked to concrete actions by national and local health authorities. Only one third of countries have put in place the capacities for their public health emergency management systems, as required under the *International Health Regulations*. Accordingly, the United Nations is providing technical and operational guidance to countries. This ranges from tools for emergency response planning to coordination and financing, risk communications and community engagement, health surveillance, infection prevention and control and laboratory testing. Strong solidarity and support from G20/OECD countries is needed for prevention and preparedness in lower income and fragile countries.

A principal challenge will be to obtain data safely and in a timely fashion. Routine health information systems have been unable to generate updated information on service deployment and health investment. Household surveys planned for 2020 have largely been postponed until 2021, with fewer than 10 active, while health facility surveys are almost non-existent. Member States could invest in reliable data systems as current information systems are unable to provide up to date data on the status of programme deployment and health investment. Where possible, health management information systems could aim to disaggregate data by sex, age, income, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts.

3.1. HEALTHY AND PREPARED SOCIETIES REQUIRE A WHOLE-OF-GOVERNMENT APPROACH AND ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

Coming out of the COVID-19 pandemic will require a whole-of-government, whole-of-society and a global coordinated approach. Pandemic preparedness can be seen as a global public good with commensurate global and national-level investments. Public health systems need to evolve towards a more holistic focus on universal health coverage and primary health care and social protection. It is important that responses to the pandemic avoid locking in inequalities or even worsening them. The world needs to ensure that lessons are learned and that COVID-19 provides a watershed moment for health emergency preparedness, addressing the social determinants of health that requires cross-sector collaboration and for investment in critical twenty-first century public services.

COVID-19 is a human tragedy but has also created a generational opportunity to build back a more equitable and sustainable world. For the health sector of each country, this means that the value of getting the right policies in place to enable progress towards universal health coverage is more important than ever. Responding to COVID-19 and preparing for future pandemic threats requires a population-wide, system-wide response.

COVID-19 has reinforced the existing evidence that investments in health have long-term returns, while underinvestment has potential large-scale global social and economic effects. Strong national health systems are at the core of this agenda, both to ensure outbreak preparedness and response, and to enable sustained progress towards universal health coverage. Not least is the need for smart investments within and beyond the health system in the "common goods for health" to ensure pandemic preparedness. There is a need for countries to update their national health plans in light of COVID-19, to ensure that preparedness and response capacities are integrated into health systems support as well as wider whole-of-government preparations, to align with WHO's Strategic preparedness and response plan, the Framework for a socio-economic response to COVID-19 and Global humanitarian response plan of the United Nations. Key global donors could support countries' efforts to strengthen their health systems to achieve health security and sustain progress toward universal health coverage. Ultimately, it is a political choice to ensure a pandemic of this scale and impact does not occur again.

4. Recommended actions

1. **URGENTLY CONTROL FURTHER TRANSMISSION OF COVID-19 TO CONTROL THE PANDEMIC:**

(a) **Continue to strengthen public health measures to reduce local COVID-19 transmission to zero.** These have included school and workplace closing, cancelling public events, restrictions on gathering size, reducing public transport, stay-at-home requirements and restrictions on internal movement and international travel — while preserving fundamental rights, including access to asylum. These measures have been effective in reversing the rising numbers of COVID-19 cases and deaths.

(b) **Make universal provision for COVID-19 testing, isolating and contact tracing.** Contact tracing and isolation is an integral part of reducing transmission to zero and forms the basis of COVID-19 surveillance systems. Clear, consistent messaging is needed from government on the population behaviours that are necessary to control the spread of the virus.

(c) **Ensure access to care for COVID-19 patients to reduce number of deaths.** Interventions for the management of patients with severe COVID-19 can result in a range of impairments known as post-intensive care syndrome; where appropriate palliative interventions should be integrated with curative treatment. Treatment decisions should be based on medical need and not on discriminatory factors, such as ethnicity, nationality, religion, sex, age, disability or political affiliation. Again, enabling good practices to be put into place demands effective leadership by government.

2. **PROTECT DELIVERY OF OTHER ESSENTIAL HEALTH SERVICES.** To minimize morbidity and mortality, countries could ensure priority health services are delivered during the acute phase of the COVID-19 pandemic. These will include: the management of emergency health conditions, including emergency obstetric care; prevention and treatment services for communicable diseases; services related to sexual and reproductive health, core services for vulnerable populations, the provision of medications and auxiliary services, such as basic diagnostic imaging, laboratory and blood bank services.

3. **MASSIVELY EXPAND ACCESS TO NEW RAPID DIAGNOSTICS AND TREATMENTS AND ENSURE FUTURE COVID-19 VACCINES ARE A GLOBAL PUBLIC GOOD WITH EQUITABLE ACCESS FOR EVERYONE, EVERYWHERE:**

(a) It is in every country's national and economic self-interest to **take a global approach to ensuring equitable access to new COVID-19 tools.** The most effective way to achieve this is through the Access to COVID-19 Tools Accelerator (ACT-Accelerator), which requires $35 billion to go from start-up to scale up to meet its goals. It must be fully funded, with

$15 billion of that needed in the next three months to advance its work immediately.

(b) **Urgently address the spread of misinformation and false rumours about vaccine safety.** Intentional investments in enhancing public confidence in the thoroughness, effectiveness and safety of vaccines are urgently needed. This will be critical in building public confidence in the safety and efficacy of future COVID-19 vaccines to allow for effective immunization campaigns.

4. ACHIEVE UNIVERSAL HEALTH COVERAGE:

(a) **Invest in** core health systems functions that are fundamental to protecting and promoting health and well-being, known as **"common goods for health"**. Governments need to expand their investments in common goods for health so that the world does not face this situation again when outbreaks occur. Having these functions in place is integral to the commitments all Member States made in the *International Health Regulations*, as well as the *Political Declaration on Universal Health Coverage* in 2019. These include policy coordination, surveillance, communication, regulation for quality products, fiscal instruments, and subsidies to public health programmes.

(b) **Suspend user fees for COVID-19 and other essential health care.** The reduction of financial barriers to service use is an important measure for countries to move towards universal health coverage. Ideally, patients do not have to worry about paying user fees at the point of care because, particularly at this time, financial considerations should not enter into an individual's calculus as to whether and where to seek care. Public and contracted private providers could be compensated by advanced provider payments where feasible during the COVID-19 pandemic.

5. STRENGTHEN NATIONAL AND GLOBAL PANDEMIC PREPAREDNESS AND AIM FOR HEALTHY SOCIETIES FOR THE FUTURE.

COVID-19 reinforces the importance of governments adopting a whole-of-society and whole-of-government approach that considers local communities, affected populations, civil society and the private sector, as part of the solution to the epidemic. Pandemic preparedness and response require a standardized outbreak alert system linked to concrete actions by national and local health authorities. There will need to be commensurate global and national-level investments that are integrated to strengthen overall national health systems and achieve universal health coverage.

Conclusion

Universal health coverage is built on foundations of equity and can be a powerful social equalizer if countries move swiftly to full population coverage in an equitable way. It has proven to be a catalyst for economic growth that benefits individuals, families, communities, businesses and economies. Good health is both an outcome and a driver of economic and social progress. That is why universal health coverage is at the centre of the 2030 Agenda.

Achieving health security and progressing towards universal health coverage are not alternative courses of action; strengthening health systems is core to both. Prioritising health and equity, and health systems that protect everyone, is a political choice. Systems that are organized to sustain progress towards universal health coverage, by having this whole-population perspective, are also better organized to respond to a disease outbreak.