Coordinating, financing and paying for COVID-19 health services:
A synthesis of lessons and best practices from country experience

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Globally, countries are grappling with unprecedented social and economic challenges posed by COVID-19. Health systems across all geographies are under enormous strain — few have been left unscathed. It has been a steep learning curve for many countries, as new information is released daily on the novel coronavirus. No country has all the answers, and many learn from previous mistakes and lessons. More than six months after COVID-19 was declared a pandemic, the Joint Learning Network for Universal Health Coverage (JLN) Primary Health Care (PHC) Financing and Payment Collaborative, has taken a step back to reflect on countries' COVID-19 experiences. The collaborative has 20 JLN member countries with a common interest to improve PHC financing and payment. This brief consolidates common lessons from six countries — Bangladesh, China, Kenya, Nigeria, the Philippines, and the Republic of Korea — that have shared their best practices and experiences with the collaborative. While experiences are often contextual and unique to each country, the objective remains the same: to better prepare health systems to respond to future epidemics and pandemics.

Strategic purchasing for COVID-19

Health systems across the world aspire to achieve universal health coverage (UHC) — providing access to quality health services and financial protection from the consequences of ill health. Strategic purchasing is a lever to achieve UHC goals, by using limited resources most efficiently to achieve equitable access to quality health services.

When COVID-19 struck, many countries mobilized resources to address the needs for the 3T's — tracing, testing and treatment — the pillars for containing the spread of the virus. To encourage the population to seek care, policymakers in all six countries resolved to remove financial barriers and ensured that COVID-19-related testing and treatment, including medical services and hospitalization, was free for all. While many countries directed resources for these entitlements through inputs and line-item budgets, bypassing institutions and systems set up for "normal" health services, the Philippines and the Republic of Korea shared examples of how existing institutions were leveraged for purchasing health services — transferring funds to health providers.

Generally, members of the Republic of Korea's National Health Insurance Scheme (NHIS) pay a copayment of 20% of health care service fees. For COVID-19-related services, these copayments were waived to guarantee access to health services without financial hardship. The NHIS also reduced their monthly insurance contributions to further ease the financial burden on the most vulnerable members. In the Philippines, all COVID-19-related care was free for patients, and providers were reimbursed through the existing single payer, PhilHealth.

To be effective, incentives for patients to access care need to be coupled with assurances to providers that they will receive the appropriate reimbursement for services. The Philippines leveraged PhilHealth to develop benefit packages for isolation, referral, testing and treatment of potential COVID-19 patients at PhilHealth accredited facilities. These packages were costed to determine provider payment rates. As Filipinos stayed away from health facilities due to the fear of COVID-19, PhilHealth stepped in and provided advance payments to protect accredited providers struggling from reduced patient visits at health facilities. Similarly, the Republic of Korea prepaid and expedited payment to providers — a policy based on learnings during the MERS outbreak as health care facilities faced financial difficulties due to the reduced number of patients.

To incentivize health providers, China provided per-person, per-day payment to providers caring for COVID-19 patients, along with paid rest time to prevent provider burn out. While in Nigeria, hazard allowances payable to health care workers on the frontlines was increased.

As demonstrated in these countries, strategic purchasing remains relevant in times of crisis such as a pandemic. Striking a balance between an increased demand in care and providing supply-side incentives provide a concrete foundation for health system responsiveness.

Leveraging primary health care and community health systems

PHC and community health are the first point of entry into formal health systems in many countries. Although many investments for the pandemic focused on "surging hospital capacity" with more intensive care beds and ventilators, and "flattening the curve," the reality is that many cases remain mild or asymptomatic, and PHC and community health systems remain the backbone to support contact tracing, testing and home-based care. In China, community health workers used a "grid-based" technique to log household health in their communities and provide support to those in isolation. In some instances, this support included delivering essential medicines from pharmacies to households whose members were unable to visit the store themselves. Bangladesh used established community health infrastructure for door-to-door community sensitization, household level testing and contact tracing by community volunteers. Kenya developed a home-based care model — designated community health workers support patients in their homes rather than in a hospital setting — allowing patients with mild symptoms to isolate in their homes. This approach drastically reduced the number of contacts and costs associated with out-of-home isolation. In Nigeria, the National Primary Health Care Development Agency leveraged community volunteers to support surveillance efforts and referrals to ensure that patients showing symptoms received timely care.

Governance and coordination across sectors and between levels of government

In times of crisis, governance arrangements play a critical role in building resilience to the COVID-19 pandemic and future epidemics or pandemics that may occur. The pandemic response goes beyond the health sector — all six countries have pandemic national coordination units that bring together all sectors, such as immigration, security, finance, transport, trade, education, and hospitality — including state and non-state actors — to develop multisectoral strategies that address the multiple facets of community life affected by COVID-19 and enforce their implementation. Effective pandemic responses require seamless coordination across sectors and between central and lower levels of government.

In Bangladesh, private individuals and enterprises supplied inputs to testing centers, and private facilities were mobilized to provide free testing and treatment services that would be later reimbursed by the government. Similarly, in Kenya, the private sector provided in-kind support to supply and distribute essential commodities, such as oxygen supplies and personal protective equipment for essential health workers and high-risk groups in the transport industry.

In Nigeria, where health care service provision is a function of autonomous state governments, the Nigeria Centre for Disease Control, Federal Ministry of Health and other federal agencies require close collaboration with State Ministries of Health and health departments to define testing and treatment protocols and their implementation, and fund flows to the providers under the mandate of the state governments. In the Republic of Korea, within 24 hours of the first confirmed case, an emergency quarantine system was enacted between the central and local governments. Local governments were responsible for establishing hospital sites, while the central government stepped in where the local government faced shortages with supplies or manpower.

Evidence-based strategies

Data is a vital component in helping governments, researchers, and policymakers battle the COVID-19 pandemic. With accurate, timely and complete data, governments can make informed decisions to ensure the safety of the population. In Bangladesh, the Ministry of Health used data to identify clusters for transmission, define criteria to zone parts of the city and target different levels of restrictions and safety precautions depending on new cases, recoveries and deaths. These localized, targeted measures allowed the pandemic response unit to focus resources on areas where the burden was highest, avoiding generalized restrictions for less affected areas. Kenya has prioritized efficiently analyzing incoming data, collected and synthesized, at both the national and county level. This data-driven approach has allowed the Kenyan government to stay abreast of the rapidly evolving situation, monitoring human resource, test kits, drugs and personal protection equipment levels to more effectively direct resources to where they are needed.

Innovation and technology

The unfolding crisis has driven abundant creativity and innovation at the national, institutional, and individual levels. the Republic of Korea pioneered drive-through testing for COVID-19 — an innovation that was adopted by many countries as a safe and effective method of testing. The innovative and rigorous testing measures are credited with reducing case numbers and fatalities. Kenya developed the Jitenge (Swahili for self-isolate) application, that allows patients to self-register or be registered by a health official at the initiation of quarantine, either in home isolation, quarantine, or at a point of entry. Users receive daily reminders and prompts to report on their health status providing an inexpensive way to track new symptoms and identify cases requiring further testing and treatment.

Sheltering populations through the 'infodemic'

The most important agents of change in a country are the people themselves. In the context of the pandemic, the behaviors of the population are crucial to curbing the virus. The COVID-19 pandemic is unique in that the wider population is learning about the coronavirus concurrently with healthcare professionals, researchers, and policymakers. With scientific information circulated and widely spread in a matter of seconds, without being thoroughly vetted by the scientific community, trust in health institutions and programs can be severely undermined. The pandemic has been proof of how information can be powerful, yet dangerous.

Bangladesh, Kenya, Nigeria and the Republic of Korea utilized existing resources to track contacts, and address stigma and fear, due to misinformation. Recognizing that public fear can derail efforts led by health officials and government leaders to contain the virus, Bangladesh and Kenya's television and radio media outlets broadcast health messages that were developed by the Ministry of Health, with key messages being further amplified by the local administration, community leaders and community health infrastructure. Nigeria mobilized community volunteers to share accurate COVID-19 information, including the signs patients should look for and when to seek medical care. the Republic of Korea used credit card transactions, CCTV recordings and GPS data on mobile phones to track and test those who had been in contact with confirmed COVID-19 patients and then alerted the public that they have been exposed to a confirmed case and encouraged them to go for testing.

Investing now for future pandemic preparedness and response systems

China, Nigeria and the Republic of Korea shared an important lesson — as countries grapple with addressing this pandemic, investments being made now — if well-organized, with clear institutional frameworks and organizational arrangements, will benefit countries in the future. In China, Nigeria, and the Republic of Korea, investments for previous epidemics have played a pivotal role in enabling quick responses for COVID-19. They built foundations for their public health disease surveillance and emergency response dating back to when each country faced an epidemic — SARS, Ebola, and MERS, respectively. For example, combating the Ebola epidemic in Nigeria strengthened the capacity to rapidly deploy disease surveillance, including screening at ports of entry and contact tracing. In the Republic of Korea, investments made for MERS were quickly deployed to link immigration records with health providers, track movement and contacts of suspected cases using mobile phone GPS systems, credit card transactions and security surveillance, and initiate research and development to quickly develop and ramp up production of test kits. These previous investments allowed for the setting up of quick response systems to the pandemic.

In summary, the COVID-19 pandemic has been rapidly evolving. We learn something new every day and course correct as needed. Progress can be made by ensuring that lessons and best practices are rapidly transferred across geographies to inform country response strategies and strengthen health systems to be more resilient and better prepared for the next crisis.