HOW TO RESPOND TO THE COVID-19 ECONOMIC AND HEALTH FINANCING CRISIS?

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**Summary:** While the initial response to the COVID-19 pandemic was focused on preventing and mitigating a public health crisis, it has rapidly spiraled in many countries into a full blown economic and public finance crisis. We describe this evolution and consider how health financing, as well as population health, are likely to be affected by the economic crisis. We find that countries have applied a variety of measures which include making extra financial allocations available to the health sector, supporting workers experiencing job loss, and compensating health professionals for lost income and extra expenses.

**Keywords:** Health Financing, Economy, Public Finance, Unemployment, COVID-19

Background

In response to the COVID-19 pandemic, the majority of countries around the world were forced to “lockdown” in an ultimate effort to reduce exponential growth in transmission rates. Among other actions, this has involved closing schools, businesses with perceived high risk of transmissions (restaurants, retail, shopping centres, hairdressers), sports activities, large social gatherings (churches, concerts, conferences) and travel routes, effectively shutting down entire societies. These interventions have proven effective at ‘flattening the curve’ and preventing health systems from becoming overloaded by COVID-19 patients. However, they have caused a number of unintended consequences; among others, they have led to many people forgoing much needed care and, as we focus primarily on in this article, they have resulted in a severe global economic slowdown.

The economic impact of the crisis becomes clear

The magnitude of the economic impact varies substantially across countries and within countries across sectors. Hospitality and tourism have been devastated as one might expect, but even the broader health care sector has faced huge losses in many countries as non-COVID patients reduce their use of services, both due to facilities being reserved for COVID patients or otherwise closed, and due to fears of becoming infected by other patients.

Figure 1 gives a sense of the magnitude of the economic impact in European Union (EU) countries. Across the EU-27 in Q4 2019, gross domestic product (GDP) per person in nominal terms grew by 0.1% compared to the previous quarter. By Q2 of 2020, it fell by 11.4% compared to the previous quarter, an annualized decline of 38.4%. The largest Q1 to Q2 declines in GDP have occurred in the United...
Kingdom (20.4%), Spain (18.5%), Croatia (14.9%), and Hungary (14.5%) with every EU country experiencing a contraction. Unemployment rates have increased as well, rising by a half a percentage point overall in EU-27 countries between June 2019 and June 2020, with the largest increases in the EU over that time period in Estonia (3.3%), Sweden (2.7%), Lithuania (2.6%) and Latvia (2.5%); some of these figures may even appear worse were it not for job support schemes in place.

Although many analysts had hoped for a quick return to normal levels of economic activity after lifting lockdowns (referred to as a V shaped recovery) there is little evidence that this is occurring. Some forecasts suggest economies in Europe will not return to pre-COVID levels for many years to come. This is due in part to continued travel restrictions and social distancing guidance affecting many sectors but is also a consequence of peoples’ safety concerns about being in public places. In fact, some economists are beginning to refer to a K shaped recovery to reflect the uneven nature of the post-COVID economy going forward, as some sectors (like e-commerce) are expected to thrive while others (like aviation and retail) are decimated. Regardless, it is clear that the economic implications of COVID-19 will be with us for the foreseeable future.

What are the consequences for health financing?

The lockdown and the subsequent economic crisis have implications across society, including potentially major effects on health financing flows. Here we briefly describe these.

**Lower revenues for health systems**

Most health expenditure in Europe emanates from government or compulsory sources that can be highly susceptible to economic fluctuations since they are funded primarily through taxes and/or social (e.g. employer/employee) contributions. During the economic crisis, the slowdowns in consumption expenditure, increases in unemployment and reductions in salaries each put significant downwards pressure on these funding sources. In health systems that depend heavily on social contributions from the labour market, the revenue shortfalls have occurred almost overnight as the labour market dried up.

While countries such as Lithuania have had counter-cyclical systems in place that provide general revenues to substitute for lost contributions due to unemployment and other countries like Estonia and the Netherlands have built up or were legally required to build up financial reserves, these practices are generally the exception rather than the norm and may be insufficient to deal with a prolonged crisis of this magnitude.

But even in systems that depend more heavily on general tax revenues to finance health care, there are likely to be shortfalls that will result in reductions in health expenditure (due to either maintaining the priority given to health within a shrinking budget or prioritising other sectors above health) or will require borrowing to fill budgetary gaps and maintain or increase expenditure levels. Precisely how this decreased revenue and budgetary choices will affect health system allocations and consequently expenditures are subject to a great deal of uncertainty at this stage.

**Lower revenues for some providers**

Very few people would expect in the first instance that a global pandemic could be bad for business in the health sector. However, the pandemic and the lockdown in response has led to massive, practically instantaneous shifts in patterns of care with many patients forgoing care and capacity being reserved for COVID patients. This has had important implications for health provider finances and sustainability. It also has led to unforeseen expenses because providers had to reshape their premises to implement new distancing measures, hygiene and safety regulations and purchase personal
protective equipment (PPE), in addition to expensive new equipment like ventilators and intensive care unit (ICU) beds.

Some of the most significant effects are among providers who have had to shut during the pandemic, generally to reserve PPE for hospital use, including dentists, ophthalmologists, but also outpatient health professionals (general practitioners, allied health professionals, etc.); hospitals and care homes were also severely affected (see the articles by Langins et al. on protecting care homes and by Webb et al. on restarting routine hospital activities in this issue). The crisis made it clear that health professionals and providers that are not paid on the basis of activity, i.e. based on (predominantly) capitiation or a salary, are less vulnerable to this type of shock than those that are largely paid based on activity, i.e. through fee-for-service (FFS) or pay-for-performance (PMP) or diagnosis-related groups (DRGs). For those who rely on volume-based payments, the crisis has severely disrupted income flows.

What will the economic crisis mean for population health?

In addition to the impact of the economic crisis on health financing, there are likely to be health effects of the economic crisis. These come on top of the negative effects on population health caused by the virus itself and the detrimental effects on population health of those that have in great numbers been forgoing vaccination, screening and treatment services. Disentangling these factors may prove challenging but it is safe to say that each factor contributes substantially.

Evidence from the financial crisis that began in 2008 in Europe shows that there are links between economic downturns and declines in mental health, including increases in suicides and alcohol-related deaths. The effects have been shown to be predominantly, though not entirely, among the unemployed. Of course, the lockdown itself and the associated loneliness that comes with decreased social contacts have their own effects on mental health independent of the economic pathways. At the same time, economic crises have been associated with reductions in road traffic deaths due to reduced travel, something which is likely to have been magnified during the current crisis as people were required to spend most of their time at home.

How have countries responded to these challenges?

The decline in economic activity naturally leads to reductions in tax collection, which has serious implications for the sustainability of public finances. At the same time, many countries have put in place costly measures to support households and businesses to try to limit the economic fallout, which also has come with high costs leading to increases in public debt. Briefly we discuss three types of policy responses countries are taking including: changes in public sector revenue raising, public sector efforts to support the economy, and efforts to support health financing flows.

Some countries may opt to alter the mix of taxes in an effort to ensure more sufficient and stable public revenues. A few countries have considered changing the structure of taxes in response to changes in economic activity. For example, in Latvia there have been discussions to reduce the reliance on labour market taxation in favour of more consumption taxes. Likewise, prior to the crisis, Poland had planned to reduce the value added tax (VAT) rate but has now delayed this change until the economy stabilises. In countries where altering tax collection may not be feasible, some countries have either increased their borrowing, taking on public debt, or sought emergency financing from international lenders to meet urgent needs.

Within the EU, a €750 billion recovery fund composed of a mix of grants and loans was agreed at the end of July to support Member States.

Regarding health sector revenues, some countries have taken steps to make extra allocations available to the health sector, but it may take months to figure out the actual costs and how to divide the bill between the different payers and (local) governments and ultimately the public (via higher contributions and or taxes). Austria, Croatia, Czeuchia, and Estonia, for example among many other countries, have injected additional financing into their social health insurance funds.

Additionally, countries have supported their economy through measures that support workers experiencing job loss during the crisis. For example, furlough schemes have been put in place in many countries including the UK (Coronavirus Job Retention Scheme), Germany (Kurzarbeit) and France (Chomage Partial), among others, to cover lost wages for a period of time. These types of initiatives are not only important for the economy but are also likely to mitigate the health effects of the economic crisis itself. Evidence from the United States, for example, suggests that generous unemployment benefit programmes have the potential to reduce suicides during times of high unemployment and improve mental health. Labour market measures also are likely to have implications for health financing where there is a high reliance on contributions from employers and employees.

Countries have also used different mechanisms to compensate providers and health professionals for their losses in income or revenue and extra expenses due to COVID-19. Essentially, these consist of mitigation of losses (e.g. a shift towards more payments for eHealth), compensation of revenue losses (e.g. higher FFS, capitations, DRGS, per diems, shift to global budgets) and generously reimbursing extra expenses for needed renovations and purchasing of equipment. For example, Hungary has shifted from case-based payments for hospitals back to global budgets during the crisis to maintain hospital financial
flows. Other countries, like Belgium and Croatia, have transferred additional funds directly to hospitals. Two articles in this Eurohealth edition detail the various options for compensating professionals and hospitals (see Waitzberg et al. on compensating health care professionals and Quentin et al. on adjusting hospital inpatient payment systems in this issue).

Conclusion
Health and the economy are inextricably linked and so it is natural to expect that a pandemic and the accompanying policy responses will have consequences for the economy, and ultimately for health financing. Countries have largely been proactive in their attempts to mitigate the economic and health financing implications; however, a major challenge will be adjusting these responses during the full length of the crisis and whether positive responses can be maintained.

The Changing Role of the Hospital in European Health Systems

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This new study provides a timely analysis of the changing role of the hospital across Europe. The hospital is one of the most recognisable and central parts of a health system. Yet, its fundamental design has changed little in decades, even though the burden of diseases it must respond to is constantly evolving – most recently with the emergence of COVID-19 and, less dramatically, with the growth of multimorbidity and frailty. Also evolving are the things that can be done in hospital, or in some cases, things that would once have been done there but are now better done elsewhere. For these reasons it is time to look again at the role of the modern hospital, not as a building filled with beds but rather as a concept, as a care deliverer and as a workplace. It seeks to challenge existing models of hospital care, review best practice from different countries and give pointers to the future.

This study looks at many developments that challenge traditional ideas of the role of the hospital. They include: changes in technology for diagnostics and treatments; changes in patients, who have become older, frailer and often more socially isolated; changes in models of care, involving multidisciplinary teams, networks and integrated care pathways; changes in staffing and concepts of specialists and generalists.

Written by and for clinicians, hospital managers and those who design and operate hospitals, this study argues that hospitals need to change as the patients they treat change and as the technology to treat them advances. They also show why hospitals need to be planned as part of the wider system in which they sit, with specialists developing new collaborative ways of working with primary care.

References