Strengthening the health financing response to COVID-19 in Europe

Health Financing Policy Papers
WHO Barcelona Office for Health Systems Strengthening

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The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage. It works with Member States across WHO’s European Region to promote evidence-informed policy making.

A key part of the work of the Office is to assess country and regional progress towards universal health coverage by monitoring financial protection – the impact of out-of-pocket payments for health on living standards and poverty. Financial protection is a core dimension of health system performance and an indicator for the Sustainable Development Goals.

The Office supports countries to develop policy, monitor progress and design reforms through health system problem diagnosis, analysis of country-specific policy options, high-level policy dialogue and the sharing of international experience. It is also the home for WHO training courses on health financing and health systems strengthening for better health outcomes.

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The COVID-19 pandemic is having a huge impact on lives in countries across Europe. It is also affecting livelihoods, particularly among people who have lost work.

What began as a health shock has become an economic shock, and the two types of shock are closely intertwined:

- the sooner countries can control the spread of the pandemic, the more limited the consequences of the health and economic shocks will be;
- the larger the economic shock, the more likely it is to affect the financial sustainability of the health system in the longer term;
- if the economic shock is not adequately addressed, it may further undermine people’s health.

International experience shows it is possible to mitigate health and economic shocks through timely policy action with a focus on identifying and supporting the people most in need: shocks do not affect everyone equally.

This short paper sets out the key health financing actions countries can take to reduce the adverse effects of the pandemic as part of a broader health system response. It focuses on three policy objectives, highlighting the following steps to enable the diagnosis and treatment of COVID-19 and maintain essential health services for other conditions during the early phases of the outbreak.

**Remove financial barriers to access:** suspend all user charges (co-payments), including co-payments for non-COVID-19 health services; extend entitlement to publicly financed health services to everyone, regardless of residence or insurance status; and provide people with income support.

**Mobilize additional public funds for health:** reprioritize the government budget; remove administrative constraints so that new funds can be deployed quickly; and track and report spending for transparency and accountability.

**Give health service providers flexibility to respond:** provide incentives for surge capacity; ensure stability in provider revenue; and support innovation in service delivery.

Each step is illustrated using examples from countries in Europe. Unless otherwise indicated, country examples come from the COVID-19 Health System Response Monitor organized by the WHO Regional Office for Europe, the European Commission and the European Observatory on Health Systems and Policies.

The primary aim of the paper is to support health financing responses to COVID-19 in countries that rely heavily on out-of-pocket payments. Many of these countries experience significant gaps in health coverage, which can add to the challenge of mitigating health and economic shocks. The paper’s recommendations are relevant to all countries in Europe, however.
Remove financial barriers to access

Out-of-pocket payments create a financial barrier to access and lead to financial hardship for many people using health services in Europe. If people face concerns about health care affordability, they may delay seeking treatment or be prevented from obtaining the services they need. This makes the outbreak hard to control and puts the lives of many at risk.

To remove financial barriers to access, countries should take the following steps.

Suspend all user charges (co-payments), including co-payments for non-COVID-19 health services

A large body of evidence shows that co-payments are not a good instrument for rationing health care: they do not selectively deter ‘unnecessary’ use but reduce the use of all health services, particularly among people with chronic conditions and poorer people.

When co-payments are being suspended, communicate clearly to people that health services are free at the point of use.

Take other steps to prevent an increase in informal payments – for example, compensating health care providers for loss of revenue from co-payments.

Ensure people do not have to pay for COVID-19 services in private facilities that have been mobilized to meet increased demand during the pandemic.

Ireland has removed user charges for remote primary care consultations with people who may have COVID-19. Belgium has initiated teleconsultations in primary care and removed user charges for this new method of service delivery. France has simplified administrative requirements for people with chronic conditions benefiting from co-payment exemptions. Estonia has drawn on private facilities to increase access to testing that is free from co-payments. In North Macedonia, emergency regulation enables the health insurance fund to contract private facilities with intensive care unit capacity and ensure these services are provided without co-payments.

Extend entitlement to publicly financed health services to everyone, regardless of residence or insurance status

Two groups of people are at high risk of being excluded from coverage or only having access to a limited range of services.

In most health systems: undocumented migrants, refugees, asylum seekers and other non-residents are not entitled or have only limited entitlement to publicly financed health services.
In health systems that link entitlement to payment of contributions: many people may not be able to afford to pay contributions, particularly those working in the informal economy, self-employed people, people in non-stable work and unemployed people.

Countries should immediately extend entitlement to these groups of people and ensure that the process of obtaining or maintaining coverage is simple and rapid.

**Portugal** has granted entitlement to publicly financed health services to any migrant or asylum seeker who had applied for residence by mid-March 2020. France is automatically extending entitlement for already-covered migrants during the pandemic. **Belgium** has extended free access to health services to undocumented migrants for a limited period. **Croatia** has taken steps to maintain coverage for people who are unable to pay contributions. In **Greece** and **Slovenia**, the government will temporarily pay contributions on behalf of self-employed people. **Hungary** has reduced health insurance contributions for employees in heavily affected sectors. **Belgium** is allowing self-employed people to request a one-year deferral of health insurance contributions.

**Provide people with income support (multi-purpose cash transfers)**

Income support is vital to enable people to stay at home; ensure they can pay for food and other basic needs; and help alleviate the indirect costs of seeking health care, such as transport costs and lost labour time.

It should not be used as a justification for keeping user charges for health services in place.

The process for determining eligibility for income support should be simple and rapid.

Special effort is needed to ensure support is available to people who may not be reached through conventional mechanisms, including homeless people and migrants.

Additional measures to protect people include the deferral of rent, mortgage and loan payments.

**Many countries in Europe** have introduced new income support measures, increased public spending on existing programmes and lifted or simplified administrative requirements. Countries introducing new cash transfers include **Albania**, **Armenia**, **Bulgaria**, **France**, **Greece**, **Ireland**, **Italy**, **Kazakhstan**, **Montenegro**, **North Macedonia**, **Portugal**, **Romania**, **Serbia**, **Slovenia**, **Spain**, **Turkey**, **Ukraine** and **Uzbekistan**. Countries simplifying administrative processes include **Georgia**, **Italy**, **Kyrgyzstan**, the **Russian Federation**, **Sweden**, **Ukraine** and the **United Kingdom**.
Mobilize additional public funds for health

A strong health system response to the pandemic requires additional public funds that can be deployed quickly and transparently. Without additional public funding, the health system will not only struggle to control the pandemic but also fail to maintain essential health services for other conditions.

Simply reallocating the existing health budget is not a viable way of addressing the pandemic for two reasons.

First, it will not be enough to meet greater demand for health services, including new infrastructure, staff and supplies; outreach to ensure access to testing and treatment for all those who need it; and overtime and supplementary payments for health workers.

Second, many countries have postponed and cancelled the delivery of essential health services for other conditions to release capacity to respond to the outbreak in the short run. This is likely to result in unmet need and adverse effects on health and will require immediate attention once the most urgent phase of the pandemic has passed.

To ensure an adequate, timely and accountable response, countries should take the following steps.

Reprioritize the government budget

Additional public funds can be drawn from regular budget sources or national emergency reserves (contingency funds). Some countries are suspending national debt and deficit controls to facilitate access to resources.

In countries receiving donor funds, donors should be engaged in dialogue to help fill gaps in national response plans.Routing donor funds through the domestic system reduces the risk of duplication and increases efficiency.

All countries will need to establish processes to coordinate, ensure complementarity and align funds for a comprehensive, government-wide response cutting across health and finance authorities; national and sub-national levels of government; and purchasing agencies and health care providers.

Health and finance authorities should work closely together to ensure reallocated funds are drawn selectively from non-urgent activity rather than generated through cuts across the board; to provide robust cost estimates for funds reallocated to health; and to respond quickly if further allocations are needed.

Private donations (cash and in-kind) from individuals and businesses should not be relied on as a primary source of additional funding. Where they are available, it may be beneficial to find a way to coordinate them.
Many countries in Europe have allocated additional funds to the health sector in response to the outbreak. Greece has excluded spending on health and immigration from national budget deficit targets. Spain is also considering lifting national budget deficit restrictions. Armenia, Georgia, Kyrgyzstan, North Macedonia, Serbia and Ukraine have negotiated donor grants to complement additional government funds. In Italy, a non-profit start-up (‘Italia’) has established a fundraising platform for hospitals and uses it to track other private fundraising initiatives.

Remove administrative constraints so that new funds can be deployed quickly

Administrative processes should allow reallocations and budget transfers to be made immediately, through the usual channels where appropriate.

Some countries may need to activate exceptional spending procedures in the first phase of the crisis and then formalize these procedures using supplementary budget laws.

Declaring a state of emergency can facilitate the release of new funds and speed up public procurement by enabling simplified procedures for trusted suppliers.

Several countries are channelling additional funds through purchasing agencies, including Austria, Croatia, Estonia, Latvia, Poland, Romania and Serbia. Italy passed a law (‘Cure Italy’) to enable sole source procurement. Lithuania plans to simplify procurement rules for public health purposes.

Track and report spending for transparency and accountability

The fast release of funds and simplified procedures for spending and procurement should be accompanied by mechanisms to prevent fraud and build public trust.

These mechanisms may include the introduction of a COVID-19 accounting code to track spending and the publication of spending information in government portals.

Italy records all expenses in a special COVID-19 account and requires any spending to be published.
Give providers flexibility to respond

Health care providers need flexibility to be able to respond quickly to meet increased demand in the outbreak and to offer new methods of service delivery. The way in which providers are paid can be an obstacle to both objectives.

Giving providers greater control over the use of funds should be accompanied by processes to track and report spending for transparency and accountability.

Countries can take the following steps to ensure that payment methods allow providers to respond to the pandemic and maintain other essential health services.

Provide incentives for surge capacity

Additional funds will be needed to cover the costs of new infrastructure, staff and supplies mobilized in response to the outbreak; rises in the price of essential supplies; and overtime and supplementary payments for staff.

Where necessary, countries should develop or simplify mechanisms to enable existing private capacity for testing and treatment to be used, and agree on related payment methods, tariffs and reporting requirements. Payment should reflect the costs of service delivery in the public sector, including any extra costs linked to the outbreak. Rules for tracking and reporting COVID-19 spending should be applied equally to all contracted providers.

Germany pays hospitals €50,000 for each new intensive care unit bed. In the Russian Federation, Moscow’s territorial health insurance fund pays hospitals up to RUB 200,000 for each COVID-19 patient treated. General practitioners in the Netherlands receive an additional €10 for each registered patient and an additional €15 per hour for extra out-of-office care. Ukraine has introduced an hourly payment rate for physicians and other staff directly involved in treating people with COVID-19. Supplementary payments have been promised to staff in several other countries, including France, Germany, Hungary, Italy, Kyrgyzstan, Lithuania, Romania, the Russian Federation, Serbia, Slovenia and the United Kingdom. Ireland has reached agreement with private hospitals to draw on their space, staff and supplies, so that private hospitals are now accessible to the whole population. During the emergency period in Spain, private providers are paid using public provider payment methods and tariffs.
Ensure stability in provider revenue

In contexts where payment methods reflect service outputs and volume (case-based payment, for example), reductions in the delivery of non-COVID-19 services may lead to a sudden fall in provider revenue. This problem can be averted by front-loading budgets or capitation payments; pre-funding payments that would otherwise come through retrospective reimbursement of claims or patient co-payments; and committing to cover provider costs to prevent bankruptcy.

In the Netherlands, the Minister of Health and health insurers have agreed that no provider will be allowed to go bankrupt; the procedure to be established is under negotiation. Germany has introduced a temporary payment of €560 a day for every unoccupied hospital bed. Hungary is using budgets instead of case-based payment for hospitals during the pandemic. Poland has expanded hospital budgets by five per cent. Belgium, Bosnia and Herzegovina and Latvia are channelling lump sums directly to hospitals. The United Kingdom has written off historic debts held by National Health Service hospitals. Denmark has agreed to accept budget overruns by regional health authorities. Bulgaria, Germany and the Netherlands have entered into agreements with a range of staff unions to compensate providers for lost income.

Support innovation in service delivery

Many countries have rapidly adapted the way in which services are delivered in response to COVID-19, including making greater use of home-based care, teleconsultations and other forms of remote delivery. These innovations in service delivery aim to minimize the risk of COVID-19 transmission and maintain the provision of other essential health services.

The health insurance fund in Estonia allows some outpatient visits (specialist consultations, physiotherapy and mental health nurse consultations) to take place remotely, paying for them using the normal tariff. Ireland has negotiated new general practitioner fees for remote consultations for all conditions, not just COVID-19. Germany is adapting provider payment to remunerate new forms of delivery, including new outpatient clinics for people with fever. Luxembourg has introduced a new hourly tariff for outpatient consultations held by any type of doctor in any care setting. In the Netherlands, the Healthcare Authority allows initial patient consultations for non-COVID-19 care to take place by telephone or other remote means. Slovakia offers supplementary payments for remote consultations and has expanded the scope of services that can be provided remotely.
The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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