TRANSFORMING DELIVERY OF ESSENTIAL HEALTH SERVICES DURING THE COVID-19 PANDEMIC

By: Erin Webb, Marie-Camille Lenormand, Nathalie Schneider, Sophie Augros and Dimitra Panteli

Summary: Managing dual delivery of care, for both COVID-19 and non-COVID-19 patients and services, has been a key challenge for health care providers for nearly two years, and essential health services have faced ongoing disruptions. Against this situation, several transformations in the delivery of essential health services have emerged in Europe. These include 1) adjusting coverage and payment systems, 2) introducing new care pathways, and 3) building on the strengths of primary health care. These transformations may continue post-pandemic in certain settings and can guide action for future preparedness.

Keywords: Health Systems, Essential Health Services, Service Delivery, COVID-19

Introduction

Health care providers have had to manage the novel demands of treating patients with COVID-19 while continuing to provide other health services – the dual delivery of care – for nearly two years. While the initial response across Europe during the first wave of COVID-19 was to postpone or cancel non-urgent services, as time passed, health systems had to readjust to a new normal and ensure the continuation of essential health services.

The World Health Organization’s (WHO) National pulse survey on continuity of essential health services during the COVID-19 pandemic found that out of 135 surveyed countries and territories, 94% experienced some kind of disruption to providing essential services between January and March 2021. These disruptions were recorded for 63 tracer services, of which 29% were disrupted on average in the WHO European region. These service areas covered reproductive, maternal and child health; immunisation services; communicable and non-communicable disease services; and mental health.

Unmet medical care needs increased across Europe

The disruptions in the provision of care in order to accommodate new demands from COVID-19 led to a large number of individuals across Europe reporting unmet medical care needs (see Figure 1). According to the Eurofound survey, around 1 in 5 people surveyed reported that they needed a medical examination or treatment that they have not yet received. These unmet needs related to the measures taken to protect health care facilities from becoming overwhelmed in light of the expected influx of COVID-19 patients. The adjustments often resulted...
in postponed or cancelled treatments and longer waiting lists (see also the article by van Ginneken et al. in this issue on backlogs and waiting lists).

For example, Denmark generally has a one-month waiting time guarantee for accessing diagnosis and treatment, but suspended this until September 2020 for psychiatric care and March 2021 for other types of care. Similarly, Norway suspended national waiting time guarantees between March 2020 and October 2020. Accordingly, the percentage of patients who did not receive hospital-based services within their individually set maximum waiting time targets in Norway rose from 2.4% in 2019 to 7.3% in 2020. In the Czech Republic, preventative appointments for adults dropped 70% between April 2019 and April 2020. Sweden experienced a drop in the percentage of individuals receiving same-day appointments in primary care from 93% to 87%. In Ireland, 67% fewer patients attended chemotherapy sessions in Irish public hospitals between January and April 2020 compared to the same time period in 2019. In Germany, mammography screening fell by up to 97% from March to May 2020 during the temporary suspension of the screening programme. While some of the missed cancer screenings occurred after the initial lockdowns, with evidence from Denmark and Norway suggesting that the treatment pathways were less affected, this lower level of screening requires continued assessment to understand the impact on health.

Even for emergency situations, some countries saw a drop in essential services especially in the early spring of 2020, potentially due to a patients’ reluctance to seek care. Belgium saw admissions for stroke decline by 19% in March and 16% in April 2020, but this recovered to more normal levels in May and June 2020. In part due to a possible reluctance to seek care, patients may have deferred treatment until their condition became more serious. The Spanish Society of Cardiology saw a near doubling of in-hospital mortality for acute myocardial infarction during the first wave of COVID-19.

measures were taken to maintain coverage for the general population

A transformation in the delivery of essential services has been developing

Given the persistent but volatile demands of COVID-19 on the health system over the past 18 months, a transformation in the delivery of essential health services can be observed across several dimensions. These include (as shown in Figure 2):

1. adjusting coverage and payment systems to incorporate essential COVID-19 services and maintain coverage
2. introducing new care pathways to meet patients, especially the most vulnerable, where they are;
3. building on the strengths of primary health care to deliver essential health services

Primary care, and activities such as cancer screenings, routine immunisations and check-ups, represented one area of unmet needs. In the Czech Republic, preventative appointments for adults dropped 70% between April 2019 and April 2020. Sweden experienced a drop in the percentage of individuals receiving same-day appointments in primary care from 93% to 87%. In Ireland, 67% fewer patients attended chemotherapy sessions in Irish public hospitals between January and April 2020 compared to the same time period in 2019. In Germany, mammography screening fell by up to 97% from March to May 2020 during the temporary suspension of the screening programme. While some of the missed cancer screenings occurred after the initial lockdowns, with evidence from Denmark and Norway suggesting that the treatment pathways were less affected, this lower level of screening requires continued assessment to understand the impact on health.

Even for emergency situations, some countries saw a drop in essential services especially in the early spring of 2020, potentially due to a patients’ reluctance to seek care. Belgium saw admissions for stroke decline by 19% in March and 16% in April 2020, but this recovered to more normal levels in May and June 2020. In part due to a possible reluctance to seek care, patients may have deferred treatment until their condition became more serious. The Spanish Society of Cardiology saw a near doubling of in-hospital mortality for acute myocardial infarction during the first wave of COVID-19.

even for emergency situations, some countries saw a drop in essential services especially in the early spring of 2020, potentially due to a patients’ reluctance to seek care. Belgium saw admissions for stroke decline by 19% in March and 16% in April 2020, but this recovered to more normal levels in May and June 2020. In part due to a possible reluctance to seek care, patients may have deferred treatment until their condition became more serious. The Spanish Society of Cardiology saw a near doubling of in-hospital mortality for acute myocardial infarction during the first wave of COVID-19.

Figure 1: Over 1 in 5 people in the EU reported unmet medical care needs during the first year of COVID-19

Source: [1]
Note: (*) Low reliability; the EU average is weighted (calculated by Eurofound). Figure shows the percentage of population reporting unmet medical care needs between February 2020 and March 2021.

Figure 2: Dimensions of transformation in service delivery

Source: Authors’ own
The following sections explore these three themes using illustrative examples from European Union (EU) Member States and the EEA/EFTA region.

1. Many countries have been adjusting coverage and payment systems

All EU countries considered COVID-19 treatment and vaccination as essential health services that were made available free of charge. Yet, COVID-19 testing was not necessarily covered during all phases of the pandemic, or may have required a doctor’s referral. Moreover, the number of performed tests further depended on availability of testing facilities and materials. Portugal’s National Health Service (NHS) fully covered the costs of tests, but only if prescribed by an NHS physician. France had low availability of PCR tests until the summer of 2020, and tests were only performed in hospitals for high-risk or already admitted patients. As accessibility increased, PCR tests were available without a prescription and free of charge from 25 July 2020 until 15 October 2021. After this time, only vaccinated patients have access to free PCR tests without a prescription. Norway’s Act on the Control of Communicable Diseases ensures that tests, health visits and treatments for infectious diseases are available to legal residents and visitors free of charge, and included COVID-19 in this list in January 2020. As such, testing has remained free in public facilities in Norway.

In addition, new payments related to COVID-19 were introduced to support new services. For example, France introduced several new reimbursements for care (see Box 1). A large adjustment to coverage and payments involved the use of digital health, which increased almost universally across Europe (see article by Williams et al. on digital health). Countries including Germany, France, the Netherlands, Sweden and Switzerland already reimbursed remote consultations to some degree, but entitlements were often extended early in the pandemic.

In France, teleconsultations have been available since 2018, but conditions of access and reimbursement changed to limit disruptions to care during the crisis. Before, the statutory health insurance covered 70% of costs for a video consultation with a physician, with the remainder covered by complementary insurance, and non-physician appointments were not reimbursed. Between March 2020 until the end of December 2021, teleconsultation costs were fully covered for patients and doctors in a similar geographic area so that remote and in-person consultations could be mixed throughout the patients’ health care pathway. In addition, teleconsultations for midwives and medical auxiliaries (nurses, physiotherapists, speech therapists, etc.) were reimbursed as a temporary measure. Longer-term provisions for remote consultations are planned for early 2022, for example the reintroduction of cost-sharing for teleconsultations and loosened restrictions for patients living in medical deserts so that they can have access to physicians in other regions.

Other countries, including Belgium, the Czech Republic, Denmark, Estonia, Italy, Lithuania, Luxembourg, Slovenia and Romania, introduced new payments for remote consultation. In the Czech Republic, health insurance funds did not generally reimburse phone or video consultations prior to March 2020, but this changed during the first wave to cover remote consultations for most outpatient appointments, and in September 2020, the funds introduced a new reimbursement code for general practitioner (GP) phone consultations that could be used during crisis periods. Denmark increased reimbursement fees to GPs and some specialists for video consultations, which were conducted via the national Min Læge (My Doctor) mobile application, fully funded by the Health Ministry. This contributed to an overall rise in GP consultations between 2019 and 2020, despite 13% fewer in-person visits. The Slovak Republic also allowed telemedicine for the first time with reimbursement from health insurance companies, but does not yet centrally regulate payment for these services as they differ by type of specialist.

2. Introducing new care pathways to meet patients where they are

Across countries, the need to ensure sufficient intensive care unit (ICU) beds capacity was prioritised in order to coordinate and integrate resources (see article by Winkelmann et al. in this issue). In some cases, private sector capacity was
Box 2: L’Assurance Maladie’s efforts to reach vulnerable groups during COVID-19

The statutory health insurance in France launched a comprehensive campaign of telephone calls to the most vulnerable people: those living with a disability, elderly people suffering from a long-term illness, isolated people, etc. During the first lockdown (March-May 2020), nearly 15,000 contacts were made. They were an opportunity to remind people of protective measures, to encourage them to make medical appointments when necessary and to respond – with partners – to problems such as the delivery of medicines or food shopping.

In the context of the state of health emergency, France opened up additional accommodation places for homeless individuals. A joint outreach effort by the health insurance and the family allowance scheme aims to help them access health care and their social rights. By fall 2021, this new partnership had led to more than 1,500 meetings and 5,000 actions, inter alia around opening and monitoring social security benefits, providing support for care and the use of digital technology.

The ‘aller vers’ (“reaching out”) programme aims to bring vaccination closer to people with reduced mobility, isolated from the health care system, or in precarious situations. It encompasses assistance with travel to vaccination centres, a mobile vaccination centre, vaccination tents in certain neighbourhoods, local partnerships with associations, vaccination drives and more.

Health insurance data have been used to identify populations that are not being reached and for whom outreach actions could be implemented. Another application of this approach is currently being considered to improve participation in cancer screening programmes.

Source:  

used to enable the continuation of essential health services. Many countries adjusted care pathways within hospital facilities to continue essential services and reduce the potential spread of infection. These included treating (suspected) COVID-19 patients in separate buildings or wards, having dedicated rooms for COVID-19 patients, or specific treatment times.

New ways of treating patients were also introduced in primary and specialist ambulatory care. GPs in the Netherlands were advised to abolish walk-in hours, organise separate consultation hours for potential COVID-19 patients, and use remote consultations, but the volume of services still decreased. The Ministry of Health in Luxembourg quickly created a model in March 2020 of four patient access pathways: 1) teleconsultations, 2) medical visits to residents’ facilities or patients’ homes, 3) advanced care centres for COVID-19 patients and 4) emergency department visits.

Concurrently, Luxembourg launched a remote monitoring tool for COVID-19 patients who were isolating at home, with a team of professionals from the Health Directorate checking in on these patients. This tool is planned for expansion into a permanent telemedicine solution that will be integrated into e-health services.

The expansion of telehealth provided one way to continue to connect with patients during the restrictions brought on by the COVID-19 pandemic. Physicians in Norway were advised to switch to video, phone or digital consultations on 17 March 2020, and the percentage of remote outpatient consultations rose from 3% in early 2020 to 41% during the peak of the first wave. This trend is set to continue, as there are plans for at least 15% of specialists’ consultations normally conducted in hospitals to be conducted digitally in 2021. While the movement towards digital consultations does allow the continuation of some essential services, it does not necessarily reach the larger community, in particular vulnerable groups. Some countries have introduced new means of outreach to the most vulnerable people, including the statutory health insurance (L’Assurance Maladie) in France (see Box 2).

3. Building on the strengths of primary health care

Many essential services are delivered by primary health care (PHC) providers and the transformations described above had a direct impact on their work and interactions with patients and other staff. The setup and adequacy of PHC systems played a crucial role in whether the implementation of the required changes to coverage, payment and care pathways were successful, as well as the effectiveness of the pandemic response as a whole.

"The importance of care coordination became even more pronounced","/n

PHC providers in several countries worked in multi-disciplinary teams, prioritised vulnerable groups for outreach, and also took on digital innovations to respond to the new conditions. PHC centres in Iceland and Spain served as the designated entry point for beginning the patient care pathway for suspected COVID-19 patients, as they conducted testing and provided medical advice. In some countries, including the Czech Republic, PHC workers were involved with contact tracing. In many countries, PHC providers were instrumental in delivering the COVID-19 vaccination campaign, including for hard to reach groups.

The importance of care coordination became even more pronounced during the pandemic. In Finland and the UK, PHC providers in collaboration with local...
governments proactively offered PHC services to anyone using long-term care services. In France, (as of June 2021), 1,889 multi-professional health houses and 455 multi-professional health centres aim to organise care around the patient, while 172 territorial professional health communities coordinate all service providers (e.g., nursing homes, health centers, health establishments, medico-social structures) in a particular region. The territorial professional health communities, created in 2016, have played a key role in the pandemic by coordinating different actors and they were able to adapt at short notice to find effective solutions to tasks such as organising care for COVID-19 and non-COVID-19 patients, organising screening and vaccination centres, among other responsibilities. The health crisis has shown the strength of coordination in providing patient care and will help accelerate its use in the future, contributing to a better structuring of the organisation of primary care in France.

Conclusions

The continued provision of essential health services during the COVID-19 pandemic required new care pathways with adjusted payment methods and close linkages to primary health care. Some of these new experiences, such as remote consultations or using health insurance data to find hard to reach groups, are expected to continue post-pandemic in certain settings. The importance of strong primary care, care coordination and commitment to universal health coverage has been reinforced and can guide action for future preparedness.

References


* Multi professional healthcare homes” (maisons de santé pluridisciplinaires) are where professionals are self-employed, physically based in one or multiple practices, mostly in rural areas. “Healthcare centres” (centres de santé) – are where professionals are salaried, often based in a single group practice, mostly in urban areas.