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How resilient is health financing policy in Europe to economic shocks? Evidence from the first year of the COVID-19 pandemic and the 2008 global financial crisis

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ABSTRACT

The COVID-19 pandemic triggered an economic shock just ten years after the shock of the 2008 global financial crisis. Economic shocks are a challenge for health systems because they reduce government revenue at the same time as they increase the need for publicly financed health care. This article explores the resilience of public health financing policy to economic shocks by reviewing policy responses to the financial crisis and COVID-19 in Europe. It finds that some health systems were weakened by responses to the 2008 crisis. Responses to the pandemic show evidence of lessons learnt from the earlier crisis but also reveal weaknesses in health financing policy that limit national preparedness to face economic shocks, particularly in countries with social health insurance schemes. These weaknesses highlight where permanent changes are needed to strengthen resilience in future: countries will have to find ways to reduce cyclical in coverage policy and revenue-raising; increase the priority given to health in allocating public spending; and ensure that resources are used to meet equity and efficiency goals. Although many health systems are likely to face budgetary pressure in the years ahead, the experience of the 2008 crisis shows that austerity is not an option because it undermines resilience and progress towards universal health coverage.

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1. Introduction: economic shocks, health financing policy and resilience

The COVID-19 pandemic triggered an economic shock just ten years after the economic shock of the 2008 global financial crisis. Economic shocks are a challenge for health systems because they reduce public revenue at the same time as they increase the need for publicly financed health care. Public revenue declines as unemployment rises, household income falls and the economy contracts. The need for publicly financed health care rises when people become eligible for means-tested benefits; can no longer afford to pay for privately financed treatment; or require more care because their health has deteriorated.

Health financing policy can help health systems to meet this challenge by ensuring they are prepared in advance and capable of responding effectively. Various sources have set out the attributes most likely to ensure resilience in health financing [1–3]. We summarize them as follows:

• Coverage policy – the way in which health coverage is designed and implemented – should ensure that there are no major gaps in any of the three dimensions of coverage (population coverage, service coverage and user charges); there is extra protection for those who need it, especially people at risk of poverty or social exclusion; and protection is countercyclical, increasing as the economy contracts.
• Revenue for the health system should be predominantly public – that is, compulsory, pre-paid, pooled and linked to ability to pay – so that the out-of-pocket payment share of current spending on health is low.
• Public revenue should be sufficient to meet the health needs of the population, countercyclical and with flexibility to reallocate and deploy existing funds or absorb new ones as circumstances change.
Resilience can be assessed on the basis of a country’s preparedness to meet a shock – the underlying strength of its health financing policy – and on the basis of its ability to adapt in response to a shock [4].

This article explores the resilience of health financing policy to economic shocks by reviewing policy responses to the 2008 financial crisis and COVID-19 in Europe. Data on gross domestic product (GDP) suggest that the initial COVID-19 shock was worse than the initial shock of the financial crisis: all country income groups in Europe experienced a deeper fall in GDP in 2020 than in 2009, although the difference between the two periods is particularly marked in middle-income countries (Fig. 1). International Monetary Fund (IMF) analysis assumes a rapid return to positive GDP growth once vaccine rollouts enable economies to function normally, but warns that the recovery may be uneven across countries due to unequal access to vaccines and differences in how effectively countries have used economic policy to prevent lasting damage [5]. The impact on employment, as told through the unemployment rate, was more muted in 2020 than in 2009, reflecting strong government support for businesses, employees and self-employed people [6]. It is important to note, however, that a high prevalence of zero-hour contracts means people in Europe are among those most likely to have been affected by reduced working hours, particularly in the southern and eastern parts of the region [6,7].

The two economic shocks differ markedly in cause and may also turn out to differ markedly in size and duration. This makes it difficult to interpret the results of a direct comparison between health financing policy responses in the two periods. It is possible, for example, that many of the initial responses to COVID-19 were more a reflection of the health shock than the economic shock or were influenced by the fact that the economic shock was largely caused by government policy in the form of lockdowns. Despite this difficulty, we think that the review can be useful in highlighting areas in which health financing policy is persistently weak and resilience to economic shocks may be limited both in terms of preparedness and ability to adapt.

2. Materials and methods

The review of health financing policy responses to the 2008 global financial crisis draws on a study carried out by the European Observatory on Health Systems and Policies and the WHO Regional Office for Europe [3,8]. Based on a two-wave survey of country experts in 47 countries and case studies in six heavily affected countries, the study mapped health system responses to the crisis in Europe from 2008 to 2013 and assessed their impact on health system performance. In both waves of the survey, summary results were carefully validated; see the methods appendix in Thomson et al. [3] for details.

Health financing policy responses to the COVID-19 pandemic are based on information reported in the Health System Response Monitor (HSRM) in 2020. The HSRM is an online platform established in March 2020 to collect information on how countries (mainly in Europe) have responded to COVID-19. It is a joint undertaking of the European Observatory on Health Systems and Policies, the WHO Regional Office for Europe and the European Commission. Information on health financing policy was downloaded from the HSRM at the end of November 2020 and is summarized in Tables 1 and 2. These tables should be interpreted with caution, however, because the HSRM does not validate the information provided by country experts; HSRM information is updated more regularly for some countries than for others; and the level of detail country experts offer varies across countries.

The policy focus of the article is on two key aspects of health financing: coverage policy and revenue-raising. A third aspect – the way in which health services are purchased – is covered in an accompanying article in this volume. The geographical focus is on the 53 Member States of the WHO European Region, which includes Israel, Turkey, the Caucasus and some countries in Central Asia. Throughout the article we refer to this region as ‘Europe’.

3. Results: health financing policy responses to economic shocks in Europe

3.1. Responses to the 2008 global financial crisis

3.1.1. It is possible to mobilise additional public funds for health in response to an economic downturn, but it helps to be prepared in advance

Some countries acted quickly in response to the 2008 global financial crisis (referred to from now on as the 2008 crisis). They took immediate steps to protect the health budget using a wide range of mechanisms, including extending the levy base for social health insurance (SHI) contributions to non-wage income, intro-
Table 1
Summary of reported policy responses intended to mobilize additional funds for the health sector in 2020.

| Policy area | Responses |
|-------------|-----------|
| Health sector | Albania, Armenia, Azerbaijan, Bulgaria, Czechia, France, Hungary, Kyrgyzstan, Lithuania, Republic of Moldova, Montenegro, Norway, Romania, Russian Federation, Serbia, Slovenia, Turkey, Ukraine |
| Long-term care facilities | Austria, Belgium, Germany, United Kingdom |
| Ministry of Health, SHI scheme or purchasing agency | Albania, Austria, Bulgaria, Croatia, Cyprus, Czechia, Estonia, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Norway, Poland, Portugal, Romania, Serbia, Switzerland, Ukraine, United Kingdom |
| Health sector reserves and contingency funds | SHI scheme: Germany, Poland, Romania |
| Government reserves and contingency funds | Central government: Armenia, Bosnia and Herzegovina, Bulgaria, Czechia, Kazakhstan, Latvia, Norway, Poland, Portugal, Russia, Serbia, Ukraine, United Kingdom |
| Reprioritisation of the government budget | Bulgaria: regions for growth fund; Hungary: tax subsidies to political parties and municipalities; Slovenia: Ukraine |
| An increase in SHI contribution rates | Germany: increase in the rates set by individual SHI funds planned for 2021, France: increase in tax on VHI companies from 2021 on the grounds that they saved money from reduced health care use during the pandemic; Hungary: new tax on banks and selected companies; Romania: new law requires 3% of the health budget to be ringfenced for health promotion and preventive services |
| New taxes or new earmarking for the health system | France: increment in the VHI contribution from 2021 on the grounds that they saved money from reduced health care use during the pandemic; Hungary: new tax on banks and selected companies; Romania: new law requires 3% of the health budget to be ringfenced for health promotion and preventive services |
| Grants or loans from international partners (cash and in kind) | EU: Bosnia and Herzegovina, Georgia, Greece, Republic of Moldova, North Macedonia, Montenegro, Poland, Romania, Serbia, Ukraine, Uzbekistan |
| Donations from the private sector (cash and in kind) | Armenia, Azerbaijan, Belgium, Bulgaria, Cyprus, Denmark, France, Greece, Italy, Kyrgyzstan, Republic of Moldova, North Macedonia, Montenegro, Poland, Romania, Slovakia, Sweden, Ukraine |

Notes: no HSRRM information available for Andorra, Tajikistan and Turkmenistan. Table excludes Monaco and San Marino. PPE: Personal protective equipment; SHI: social health insurance; VHI: voluntary health insurance. HSRRM information was downloaded at the end of November 2020. Source: authors, based on HSRRM entries in 2020.

Table 2
Summary of reported policy responses intended to remove financial barriers to access and financial hardship for people using health services in 2020.

| Population coverage | Belgium: deferral of SHI contributions for self-employed people for up to a year (on application); Croatia: measures to maintain coverage for people who experience loss of income; Czechia: suspension of SHI contributions for six months from self-employed people and small businesses (financed through an increase in government budget transfers to the SHI scheme in 2020 and 2021); Estonia: people to maintain coverage during the state of emergency even if contributions have not been paid; Greece: suspension for four months of tax and social security payments by businesses required to close during lockdown; the government pays social security contributions (including SHI) for self-employed people affected by the pandemic; Slovenia: deferral of SHI contributions |
| Deferring or suspending the payment of SHI contributions | Cyprus: deferral of planned increase from March to July 2020 |
| Deferring an increase in SHI contribution rates | Uninsured people (COVID-19 treatment): Albania, Belgium, Bosnia and Herzegovina, Bulgaria, Lithuania, Republic of Moldova (hospital treatment); asylum seekers: Belgium, Portugal; migrants: Bosnia and Herzegovina, France (non-citizens, citizens returning from abroad) North Macedonia (neighbouring countries) Malta, Portugal; undocumented migrants: Belgium, Bosnia and Herzegovina (COVID-19 treatment) Finland, Malta |
| Expanding entitlement to publicly financed health services | Germany: people allowed to opt for a cheaper premium and then return to their original policy without a health check; France: migrants & people with chronic conditions had entitlement automatically extended; Greece: disability benefits; Portugal: migrants, asylum seekers |
| Making private health insurance more affordable | Teledicine: Belgium, Czechia (in crisis situations only), France; COVID-19 tests: Belgium, France, Switzerland; COVID-19 medicines: Romania; COVID-19 rehabilitation: Netherlands; expanding coverage of flu vaccination: Germany, Ireland |
| Reducing administrative burden | Ensuring COVID-19 services are free of charge |
| Service coverage | Albania, Austria (insured people only), Armenia, Azerbaijan, Belgium, Bosnia and Herzegovina, Belarus, Croatia, Czechia, Cyprus, Denmark, Finland, France, Georgia, Germany, Greece, Hungary, insured people only), Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Lithuania, Malta, Republic of Moldova, Montenegro, North Macedonia, Norway, Poland, Portugal, Romania, Russian Federation, Spain, Serbia, Slovakia, Sweden, Turkey, Ukraine, United Kingdom |
| Reducing user charges for other health services | Belgium: teledicine free; limits on extra billing for PPE; France: people with chronic conditions, pregnant women; Greece: outpatient medicines for uninsured people; Ireland: regulation of remote GP consultation fees; Norway: co-payment for non-attendance at outpatient visits suspended; United Kingdom: deferred an increase in the migrant surcharge |

Notes: no HSRRM information available for Andorra, Tajikistan, Turkmenistan and Uzbekistan. Table excludes Monaco and San Marino. HSRRM information was downloaded at the end of November 2020. Source: authors, based on HSRRM entries in 2020.

Reducing or increasing government budget transfers, abolishing ceiling on SHI contributions and tax subsidies for voluntary health insurance (VHI) and selectively increasing SHI contributions from wealthier people [3]. These measures also helped to make health financing fairer. A small number of countries had countercyclical measures in place to prevent public spending on health from falling as the economy contracted [3]. For example, Lithuania had a formula to determine the level of government budget transfers to the SHI scheme. Based on the average wage two years before the transfer, the Lithuanian formula was designed to compensate the SHI scheme for revenue losses from unemployment and falling wages. It helped to smooth SHI scheme revenue as unemployment grew rapidly between 2008 and 2012, but it was not enough to fully compensate for lost revenue as the initial shock turned into a prolonged downturn. Many countries responded to budgetary pressure by cutting spending on health ministries, reducing or freezing government...
budget transfers to SHI schemes and introducing or tightening controls on growth rates of public spending on health [3].

3.1.2. Policy responses to the crisis led to a substantial slowdown in public spending on health

Fig. 2 shows the average annual change in GDP, public spending on health and out-of-pocket payments in Europe before, during and after the 2008 crisis. Before the crisis the region experienced strong economic growth; out-of-pocket payments grew at the same rate as the economy, but both were outstripped by growth in public spending on health. During the crisis a sharp contraction in GDP slowed spending through out-of-pocket payments; growth in public spending on health also slowed substantially. After the crisis economic growth and growth in out-of-pocket payments bounced back to close to pre-crisis rates, but growth in public spending on health did not recover so quickly: at 1.8% a year on average, the annual growth rate was only half what it had been before the crisis (3.6%).

The regional aggregate shown in Fig. 2 masks significant variation across countries. Public spending on health per person fell in many countries in Europe in the years following the 2008 crisis [10]. In 2018 it was lower than it had been before the crisis in Croatia, Cyprus, Greece, Iceland, Ireland, Italy, Luxembourg, Portugal and Spain and barely above the pre-crisis peak in the United Kingdom [10]. In Cyprus, Greece, Ireland and Portugal economic adjustment programmes imposed by the European Commission, European Central Bank and IMF required substantial reductions in public spending [3]. In Spain and the United Kingdom austerity was largely self-imposed.

3.1.3. Austerity undermined health system performance and progress towards universal health coverage

Cuts and slower growth in public spending on health led to staff shortages, longer waiting times and coverage restrictions. Six countries restricted entitlement to publicly financed health care, typically reducing population coverage for people in precarious situations; 17 countries restricted service coverage through ad hoc reductions in publicly financed benefits; and 24 countries increased user charges [3]. Many countries in the region already had major gaps in coverage before the 2008 crisis, illustrated by heavy reliance on out-of-pocket payments to finance the health system. Policy responses to the 2008 crisis widened these gaps.

Several studies have noted the negative impact of austerity on health system performance [11–13]. Here we focus on two indicators to show how austerity affected progress towards universal health coverage. First, foregone care, measured in terms of unmet need for health care due to cost, distance and waiting time, had been falling steadily in European Union (EU) countries before the crisis, but this trend was reversed after 2008 [14]. Unmet need for health care rose on average between 2009 and 2013, widening an already large gap between richer and poorer households [15]. In countries that experienced significant reductions in public spending on health during the crisis, unmet need for health care doubled over time (Fig. 3). Second, financial hardship among people using health services, measured in terms of catastrophic out-of-pocket payments, also increased in the six countries shown in Fig. 3, even in contexts where out-of-pocket payments were falling in absolute terms as households experienced growing financial insecurity.

The rise in unmet need and financial hardship in these countries followed significant increases in waiting times, the imposition of new or increased user charges and reductions in entitlement to publicly financed health services [3,16–21]. In Greece, for example, around 25% of the population lost SHI scheme coverage between 2011 and 2016 due to increases in long-term unemployment and the inability of many self-employed people to afford SHI contributions [22,23].

3.1.4. Efficiency gains are difficult to achieve in a crisis and unlikely to relieve budgetary pressure

Budgetary pressure was widely regarded as an opportunity to introduce needed changes in health systems. It was also expected that some of these changes would generate savings for the health budget. For example, economic adjustment programmes exerted strong pressure on countries to make quick savings and, at the same time, to implement complex reforms in a one- or two-year window [3].

Policy responses show that it was difficult to enhance efficiency at a time of severe or prolonged budgetary pressure. Countries struggled to achieve transformative change while lacking resources, capacity, time and political support [3]. Faced with these constraints, many resorted to blanket reductions in input costs rather than taking a more selective approach – for example, staff numbers and salaries were cut without differentiating between lower- and higher-paid health workers; benefits were reduced without ac-

Fig. 2. Average annual change (%) in GDP, public spending on health and out-of-pocket payments in Europe before, during and after the 2008 global financial crisis. Notes: the figure includes 53 countries in the WHO European Region. Average annual growth rates are based on unweighted data in real values. Source: WHO Regional Office for Europe [9].
counting for their relative value; and user charges were increased without exempting households at risk of poverty or social exclusion. Several countries closed or merged public health bodies and cut spending on public health, including preparedness for a pandemic [24].

Pressure to save money, arbitrary cuts and rushed or partial implementation of reforms often failed to address inefficiencies, created gaps in responsibility for key areas like public health and added to health system costs [3,24]. The only genuine efficiency gains many countries were able to achieve came from reductions in medicine costs that did not also result in medicine shortages; strategies included multiple efforts to lower prices and improve prescribing and dispensing [3,25].

3.2. Responses to COVID-19 in 2020

3.2.1. Governments rapidly mobilized additional funds for health systems

According to responses reported in the HSRM, almost every country transferred additional funds from the government budget to the Ministry of Health, purchasing agency or SHI scheme and health service providers (Table 1). A few countries reported drawing on health sector reserves or contingency funds. Several reported using EU grants, other donor funds or loans and donations from the private sector.

Additional funds were primarily intended to be spent on items relating to the outbreak itself, including personal protective equipment, clinical equipment and infrastructure, but countries also needed support to maintain the delivery of other health services. For example, countries with SHI schemes needed government support to compensate for revenue immediately lost due to rising unemployment and falling wages or to cover the cost of new measures to reduce financial barriers to access such as the suspension of SHI contributions for self-employed people and small businesses (see below). In many countries SHI revenue was indirectly bolstered through government support for companies, employees and self-employed people.

The HSRM includes isolated examples of strategies countries used to finance the health system response to COVID-19. France increased taxes on companies selling private health insurance because many companies saved money in 2020 as the use of health services fell. Germany planned to increase its SHI contribution rate in 2021.

Levels of public debt grew significantly in many countries in 2020, which suggests that some of the additional funds allocated to health systems may have been financed through government borrowing, made more feasible by historically low borrowing costs and a temporary loosening of EU fiscal rules [28].

Estimates indicate that in 2020 the additional funds allocated to health systems were highest in the region’s high-income countries in absolute terms, but highest in middle-income countries in proportional terms, ranging from around 8% of the 2018 health budget in high-income countries to 13% in upper middle-income countries and 23% in lower middle-income countries [9]. Given widespread disruption in the delivery of non-COVID-19 health services in 2020 and 2021, however [8,27], the effect of extra funds
on public spending on health is likely to be lower than these estimates.

3.2.2. Governments in many countries adapted coverage policy to reduce financial barriers to COVID-19 treatment

The HSRM reports changes in all three dimensions of coverage policy – population coverage, service coverage and user charges (co-payments) [Table 2]. The majority of the changes reported affected population coverage.

Population coverage: A few countries reported extending entitlement to COVID-19 treatment to migrants, undocumented migrants and asylum seekers. Twelve countries reported extending entitlement to COVID-19 treatment to people not covered by the SHI scheme (‘uninsured’ people) or enabling people to maintain coverage by allowing them to defer or suspend the payment of SHI contributions – a policy change that commonly targeted self-employed people and small businesses. The German government allowed people who rely on substitute private health insurance to opt for a cheaper premium during the pandemic and then return to their original policy without undergoing the usual health check, which might result in having to pay higher premiums. A handful of countries reduced administrative barriers to entitlement to ensure rapid access to health care should it be needed, targeting migrants, people with chronic conditions and people receiving disability benefits.

Service coverage: Reported changes largely focused on ensuring that the publicly financed benefits package included new items needed to address COVID-19, including teleconsultations, tests, medicines and vaccines. Germany and Ireland also reported increasing entitlement to flu vaccines.

User charges (co-payments): Many countries reported that services related to COVID-19 were exempt from co-payments. It is not always clear if exemptions were an unplanned response to the pandemic or the result of pre-existing policy to waive co-payments for treatment of communicable diseases or in the event of an outbreak or other type of health emergency. In some countries protection from co-payments was extended to health services not directly related to COVID-19. Examples include making teleconsultations free, reducing co-payments for outpatient medicines for uninsured people, suspending penalties for non-attendance at outpatient visits and deferring an increase in user charges for migrants.

4. Discussion: what do responses to economic shocks tell us about the resilience of health financing policy in Europe?

Many health systems in Europe were not well prepared to face an economic shock in 2008, particularly those that relied heavily on out-of-pocket payments and had relatively low levels of public spending on health. Responses to the 2008 crisis further weakened their resilience: after the crisis health systems in Europe had more gaps in coverage than before; out-of-pocket payments grew at a faster pace than public spending on health in the region as a whole (see Fig. 2); and public spending on health remained below its pre-crisis level, even in 2018, in countries heavily hit by the crisis. Measured using two key indicators – unmet need for health services and catastrophic health spending – progress towards universal health coverage deteriorated (see Fig. 3), clearly demonstrating the costs of austerity.

The rapidity and quality of national and international responses to COVID-19 in 2020 suggest that lessons were learnt from the 2008 crisis. It is possible, however, that the real test is yet to come. Budgetary pressure is likely to grow in the years ahead and, unless countries act now to address underlying weaknesses in health financing policy, they may not be adequately prepared to face economic shocks in the future.

4.1. The glass is half full: lessons have been learnt from the 2008 crisis

Responses to COVID-19 were swift and forceful in 2020. Countries rapidly mobilized additional resources for the health system and there was a clear focus on removing financial barriers to access. In Greece, for example, the government immediately suspended the payment of SHI contributions for businesses forced to close due to the lockdown introduced in March 2020 and paid SHI contributions on behalf of self-employed people affected by the pandemic. These actions would have prevented many people from losing SHI coverage if they had been introduced following the 2008 crisis. Similarly, most countries moved fast to ensure that co-payments would not undermine access to COVID-19 treatment; some also reduced co-payments for non-COVID-19 health services. Again, this contrasts with the 2008 crisis, when around half of the countries in the region increased co-payments [3].

National responses were bolstered by strong support from international financial institutions such as the European Commission, the European Central Bank and the IMF. These entities promoted austerity in response to the 2008 global financial crisis, but their response to the pandemic has been very different. The EU quickly loosened its fiscal rules and established a recovery and resilience facility worth nearly €7 billion to mitigate the social and economic impact of COVID-19 [29]. The EU and the IMF, with the OECD, have also been vocal advocates for higher public spending on health and social protection, better tax systems and urgent action to address socioeconomic inequalities [5,29–32].

4.2. The glass is half empty: the real test is yet to come

Health financing policy responses to COVID-19 in 2020 may have been a reaction to the health shock rather than the economic shock. A focus on controlling the pandemic meant countries were willing to mobilize funds and expand coverage to achieve this objective. As the pandemic is gradually brought under control, however, and policy attention turns to the economic situation, finance ministries may balk at the level of public debt, even though borrowing costs are very low [26].

Revenue constraints and greater need for expenditure are likely to increase pressure on health budgets in the coming months. In spite of optimistic forecasts for economic growth in 2021, the IMF has suggested that government revenue in Europe will not revert to its 2019 share of GDP before 2026 [7]. It has also forecast an uneven recovery, meaning budgetary pressure may be more severe or prolonged in some countries.

On the expenditure side, countries may need to spend significantly more on health in the medium term to meet multiple challenges arising from the pandemic: treating COVID-19 and post-COVID-19 conditions [33]; mass vaccination, with booster shots, to prevent further spread and reduce disease severity; widespread disruption in the delivery of non-COVID-19 health services in 2020 and 2021, resulting in a backlog [27,28]; the impact of delayed or foregone care [34,35]; growing mental health problems in the general population and among the health and social care workforce [36]; and an increase in socioeconomic inequalities [37].

Countries will also need to invest in ensuring that health systems are better prepared to face future shocks and to mitigate the already evident impact of climate change [38,39].

4.3. Weaknesses in health financing policy undermine resilience to economic shocks

Health financing policy responses to COVID–19, combined with data on health spending and coverage policy, indicate persistent weaknesses that limit resilience to economic shocks. In this section
we draw on the resilience framework set out in the introduction to illustrate key weaknesses and highlight areas that need attention in the post-pandemic era.

Many of these weaknesses are concentrated in countries with SHI schemes, the main approach to organizing health financing in 28 out of the 53 countries in the region [9]. SHI schemes have traditionally been closely linked to employment and are therefore highly cyclical and susceptible to labour market fluctuations [10,40].

In 2020 14 of the 17 countries that reported taking steps to extend population coverage were in countries with SHI schemes (see Table 2). Most actions targeted groups of people in relatively precarious situations – migrants in a few countries and uninsured or self-employed people in countries with SHI schemes. Around 40 countries reported efforts to ensure COVID-19 services were free from co-payments; some also reduced co-payments for other health services. These policy responses reflect the following weaknesses in coverage policy:

- **Population coverage is often cyclical in countries with SHI schemes, falling as the economy contracts**: A third of the countries in the region fail to cover the whole population and the largest gaps in population coverage are in countries with SHI schemes [9]. Linking entitlement to publicly financed health services to payment of contributions or health insurance status – a design feature that is widespread in countries with SHI schemes – removes coverage from people who cannot afford to pay contributions. This is cyclical because the number of people unable to pay contributions is likely to rise in an economic downturn. The loss of contribution revenue also adds to budgetary pressure, especially in countries without countercyclical measures (see below). Countries can learn from the experience of Cyprus, France and Spain, all of whom have changed the basis for entitlement from employment or payment of taxes and contributions to residence. France took this step in 2000 to address concerns about unemployment among younger people [23]. Spain and Cyprus did so in 2018 and 2019 respectively, reversing restrictions introduced following the 2008 crisis and putting this aspect of coverage policy on a more resilient footing before the pandemic [16,19].

- **Gaps in population coverage systematically affect people in precarious situations**: The two broad groups of people most likely to be excluded from publicly financed coverage or entitled to a limited range of services are migrants and, in countries with SHI schemes, people in informal or non-stable work, self-employed people and unemployed people who are not eligible for unemployment benefits [23]. Migrants are more likely than residents to be employed in the informal economy [41] and both broad groups are at high risk of poverty or social exclusion [15].

- **Co-payment policy often fails to be countercyclical**: Co-payments constitute a barrier to access and are found to be a key driver of catastrophic health spending in Europe [23]. Recognizing this, most countries exempt some health services and some people from co-payments, but many do not specifically exempt low-income households – a strategy that would help to reduce unmet need and financial hardship in an economic downturn. Latvia used a World Bank loan to introduce exemptions from co-payments for very poor households in response to the 2008 crisis. The limited scope of the exemptions meant that they were not able to prevent an overall increase in unmet need and catastrophic health spending, but they were effective in ensuring people were able to return to work after being ill [21].

Almost all countries reported mobilizing funds for COVID-19 in 2020 (see Table 1), but many countries with SHI schemes also needed to find money to replace revenue lost through unemploy-
• In some countries levels of public spending on health are too low to meet population health needs: In 2018 public spending on health accounted for 6% of GDP on average in EU countries. It accounted for less than 5% of GDP in 29 out of 53 countries in the region, however, and less than or very close to 3% of GDP in 13 countries [10]. Many of the countries with low levels of public spending on health are also those that rely heavily on out-of-pocket payments.

The pandemic gives countries a chance to reconsider public spending priorities and take more account of strong societal preferences for better health and social protection systems when allocating the government budget. Cross-country surveys show that people in Europe place a high value on affordable access to health care for themselves and for others, regarding it as a priority for public spending [43,44,45,46].

Some governments may be reluctant to spend more on health in the medium term. Some may also be reluctant, in the years ahead, to address the cyclicity of coverage policy and revenue-raising. It is clear from policy responses to COVID-19 that only a few countries used the post-2008 crisis period to do this. Without action, however, especially in countries where public spending on health is relatively low, health systems are likely to experience a deterioration in current performance and lack resilience to future shocks. Supported by priority-setting processes and other instruments, additional spending is most likely to strengthen resilience if it is directed towards under-served people and under-resourced parts of the health system and used to reduce fragmentation, duplication and other forms of waste.

5. Conclusions

The evidence presented in this article shows that some health systems in Europe were weakened by policy responses to the 2008 global financial crisis. Austerity clearly undermined resilience and progress towards universal health coverage.

Policy responses to COVID-19 suggest that some lessons have been learnt from the 2008 crisis. Countries acted swiftly to mobilize additional funds and reduce financial barriers to access, with strong support from international financial institutions: the European Commission, the European Central Bank and the IMF – united in promoting austerity in response to the earlier crisis – now advocate for higher public spending on health and social protection, better tax systems and urgent action to address socioeconomic inequalities. These are reasons to be cautiously optimistic about the ability of health systems to adapt to economic shocks in the future.

It would not be wise to be complacent, however. Much of the health financing policy response to COVID-19 so far has been in reaction to the health shock. Countries have focused on ‘doing what it takes’ to bring the pandemic under control. Once this is achieved, the new post-austerity consensus could prove to be fragile, even as evidence of the many ongoing health and health system challenges arising from COVID-19 grows.

In the face of uncertainty, policy makers can recall a key lesson from the 2008 crisis and the pandemic: policy matters. The persistent weaknesses in health financing policy identified in this article limit national preparedness to face another economic shock. They also show what is needed to strengthen resilience now: the implementation of policies to enhance the countercyclicality of coverage policy and revenue-raising; to reduce financial barriers to access for people at risk of poverty or social exclusion; to increase the priority given to health in allocating public spending, in line with societal preferences, especially in countries where public spending on health is relatively low; and to ensure that resources for health are used to meet equity and efficiency goals.

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We declare no competing interests.

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Baktygul Akkazieva: Investigation, Writing – review & editing, Trinh Habicht: Investigation, Writing – review & editing, Visualization.
Jonathan Cylus: Conceptualization, Writing – review & editing, Tamás Ewertovits: Conceptualization, Writing – review & editing.

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