Chapter 5
Health Financing for Asylum Seekers in Europe: Three Scenarios Towards Responsive Financing Systems

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List of Abbreviations

EU	European Union
UHC	Universal Health Coverage
WHO	World Health Organization
UCL	University College London

Introduction

Europe has a long history of forced migration: both giving cause for flight and providing refuge for asylum seekers and refugees in numerous times of conflict in the past century. Since 2015, however, the issue has garnered sustained attention as the numbers of individuals seeking asylum within Europe have increased substantially. 3.7 million first-time applications for asylum have been registered in the 28 member states of the European Union (EU) since 2015, with Greece, Italy, and Spain repre-

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senting the most common entry points and Germany, France, and Greece being the most popular destination countries (Eurostat 2019). The EU is united by the principle of economic solidarity. Yet in the provision of funds for securing the health of asylum seekers, the burden still falls disproportionately on a few countries with already stretched financial systems.

This chapter will explore the possibilities for increased financial solidarity through the use of various financial mechanisms in the EU. We will start by looking at existing financial distribution mechanisms at a European level and current health financing models for asylum seekers in the EU. We will then present three scenarios for a more responsive financing system and discuss these in light of dominant political discourses of security, austerity, and eligibility.

Although the number of asylum seekers is dwarfed by the size of the refugee population in Middle Eastern countries such as Jordan, Lebanon, and Turkey, the political consequences of the recent population movements in Europe have made the issue a particularly salient one. This saliency is partly due to the uneven distribution of asylum seekers throughout Europe. As many asylum seekers from the Middle East and North Africa arrive on boat via the Mediterranean, coastal countries have become some of the largest hosts of asylum seekers within Europe. The Dublin agreement, which came into force in July 2013, upholds that asylum seekers must apply for asylum in the country within which they were first registered. Under its temporary relocation scheme starting in 2015, the European Commission has relocated several asylum seekers to countries such as the Czech Republic, Hungary, Poland, and Slovakia to alleviate some of the burden on arrival countries (European Parliament 2019). However, by March 2018, only 33,846 asylum seekers had been relocated, representing less than 1% of the total number of first-time applicants in the EU in the same period (European Parliament 2019). A comprehensive redistribution quota or a complete repeal of the Dublin agreement has fallen out of favour in the current political climate, as these ideas are superseded by issues of tightening control of the EU's external borders (Niemann and Zaun 2018).

The issue is further complicated by its timing: when the numbers of asylum seekers started increasing in 2013, many European countries were still reeling from the effects of the 2008/2009 financial crisis. Under the conditions of austerity, substantial cuts to social protection and public services were made in many affected countries, including education, social support, and public facilities but also health provision (Vasilopoulou et al. 2014; Legido-Quigley et al. 2013a; Thomson et al. 2015). It has been well documented that during this time, several affected countries became politically polarised, with the rise of new populist, right-wing movements rejecting internationalism and calling for increased restrictions to the free movement of people and goods within Europe (Inglehart and Norris 2016). This is in line with a long tradition of political analysis which has linked social inequality and populist movements (Golder 2016).

Thus, the same coastal countries that are the main countries of arrival for asylum seekers (Spain, Italy, and Greece) instituted severe financial austerity measures in order to comply with bailout demands (Kentikelenis et al. 2014). This had substantial effects on access to healthcare, as several countries decreased healthcare cover-

age and/or instituted (higher) user fees as part of the austerity package (Kentikelenis et al. 2014; Legido-Quigley et al. 2013a), as can be seen in the example of Spain (Box 5.1). This affected both migrants and the resident population. The potential costs of migrants to the national healthcare system have frequently been used in populist rhetoric as a reason for restricting entitlements and have led to a tightening of restrictions, for example, in Germany since the early 1990s (Pross 1998). The economic argument, and the lack of the European community to systematically address financing issues, has therefore added fuel to populist debates and acted to further drive divisions between those perceived as "deserving" and "not deserving" healthcare entitlements (also see Chap. 11 "Discrimination as a Health Systems Response to Forced Migration").

Box 5.1 Restrictions to Healthcare Under Austerity in Spain

The Spanish health system has a tradition of being very liberal and accessible. The right to equal access to healthcare for all with an "established" residence in the country, irrespective of citizenship, is anchored in the General Health Law of 1986 and has been reinforced in a number of reforms throughout the 2000s (Legido-Quigley et al. 2018). These migrant-friendly reforms established Spain as one of the few countries in the world with universal health coverage.

In 2012, however, the Royal Decree Law 1192/2012 undertook drastic changes to the Spanish healthcare system, replacing the National Health Service with a social health insurance system (Legido-Quigley et al. 2013b). The Spanish government stated at the time that public spending cuts, which also affected other sectors, were necessary to curtail spending in the aftermath of the financial crisis (Legido-Quigley et al. 2013b). These reforms expressly excluded undocumented migrants from comprehensive care, granting access only to emergency, maternity, and paediatric services. It has been estimated that some 500,000 undocumented migrants in Spain lost their health insurance as a result (Legido-Quigley et al. 2013a). In addition, increased co-payments for services and medications as well as the increased privatisation of medical services placed additional burdens on migrants and citizens alike. Although asylum seekers were still formally entitled to the same benefits as nationals, the introduction of the social health insurance system introduced additional bureaucratic hurdles to accessing care. The national non-profit organisation Accem reports that some asylum seekers were denied access because healthcare providers were not familiar with the new rules and regulations (European Council on Refugees and Exiles (ECRE) 2019).

Mounting pressure on the Spanish government led to a partial repeal of the 2012 Royal Decree in 2018, and undocumented migrants' right to universal healthcare has been reinstated (European Council on Refugees and Exiles (ECRE) 2019). However, the future of the Spanish health system is unclear as the political situation remains contested.

In principle, all member states of the European Union subscribe to the principles of Universal Health Coverage (UHC), which ensures that "all people and communities can use the […] health services they need, […] while also ensuring these services do not expose the user to financial hardship" (World Health Organization 2019). However, both the austerity cuts introduced after the economic crisis and the increased numbers of asylum seekers entering Europe have demonstrated that UHC is not always an achievable or desirable objective for national governments. The Refugee Convention (1951) and the International Covenant on Economic, Social and Cultural Rights (1966) state that all individuals should have access to required healthcare services regardless of legal status (UN Committee on Economic Social and Cultural Rights (CESCR) 2000). However, in European law, this principle (equal treatment as nationals) has been translated for recognised refugees only (da Costa 2006), often leaving individuals seeking asylum and undocumented migrants with lower levels of entitlements to healthcare (Fig. 5.1).

Out of the 28 EU member states, 13 provide the same coverage to asylum seekers as to nationals, and 14 other member states have some restrictions in place, while one member state provides only emergency care (Abubakar et al. 2018). Even in those countries in which full coverage is granted, some countries require means testing (n = 3), require co-payments (n = 3), or are linked to residence in state

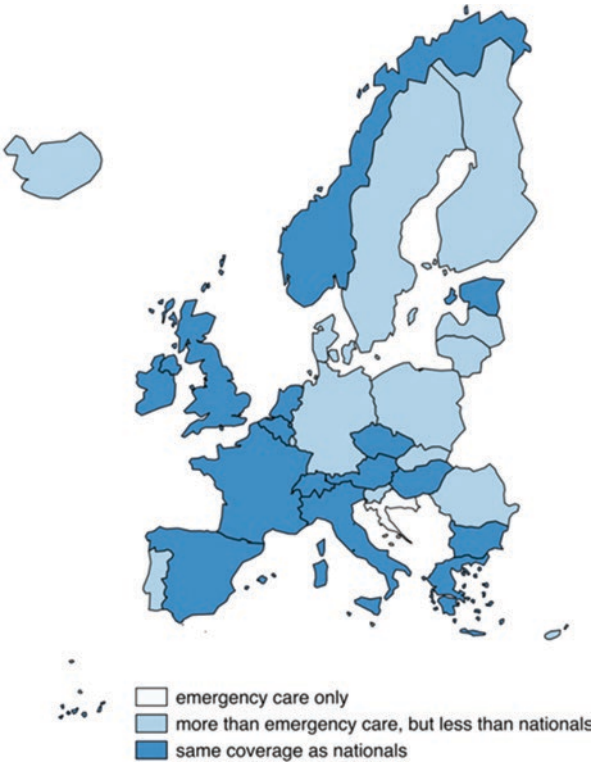

Fig. 5.1 Healthcare entitlements for asylum seekers across the European Union. Source: own illustration of data provided by Abubakar et al. (2018)

accommodation ($n = 5$) (Abubakar et al. 2018). While these figures apply to individuals formally applying for asylum, the coverage for undocumented migrants is often much worse, as was in the case of Spain (Box 5.1). But even if access is granted legally, a number of financial, bureaucratic, knowledge, and language barriers may prevent access to health services being realised for asylum seekers and refugees (Bradby et al. 2015). In order to increase access for asylum seekers to essential health services, a responsive health financing system would incentivise the removal of barriers and the provision of appropriate care for this population.

Existing Health Financing Mechanisms

To put potential financing mechanisms into context, it is worth exploring first what a "good" health financing system looks like. As defined by the World Health Organization (WHO), health financing systems have three primary functions (revenue collection, pooling, and purchasing) and three primary goals under UHC (utilisation relative to need, quality, and universal financial protection) (Kutzin 2013). In order to meet these goals, Kutzin (2013) defines three key intermediate objectives for universal health coverage (Fig. 5.2), which can be considered as principles of good practice for any health financing system. Firstly, the financing system must ensure equity in resource distribution, which includes both equity in revenue collection (i.e., progressivity of the financing system) and providing incentives for equity in access. Secondly, the financing system must promote technical, bureaucratic, and allocative efficiency (Cylus et al. 2017). In the purchasing of health services, the financing system will be efficient by obtaining value for money for the invested resources (including quantity and quality of services), for example, through health technology assessments or adequate provider payment mechanisms. However, the financing system can also demonstrate efficiency in pooling by using insurance

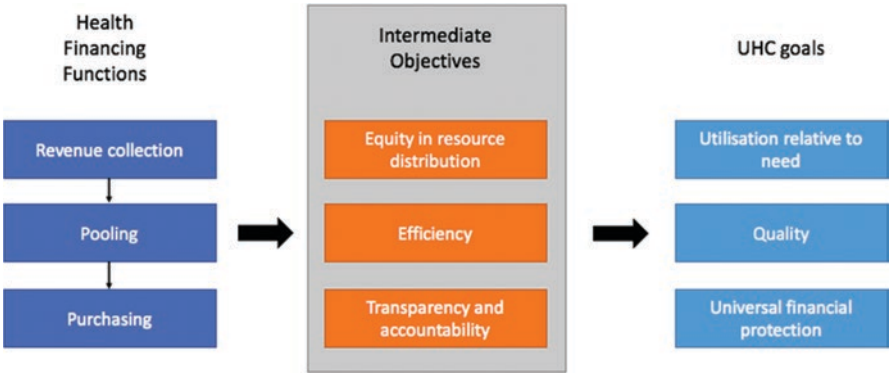

Fig. 5.2 Intermediate objectives of health financing systems. Source: own illustration, adapted from Kutzin (2013)

schemes with large risk pools, thus lowering the risk of the group, leading to lower contributions and a more efficient investment for each individual. Finally, transparency and accountability of the system should be encouraged both by helping individuals understand their rights and entitlements and increasing the accountability of health financing institutions.

Current Health Financing for Refugees: Brief Overview of EU Country Policies

Very few studies to date have examined the financing arrangements for health provision for asylum seekers and refugees across the European region. However, existing studies have shown a high degree of fragmentation of financing sources in arrival, transit, and receiving countries (Bozorgmehr et al. 2018a).

A scoping study of six European member states finds that they can be divided into those who include asylum seekers in existing social health insurance or general taxation schemes and those who have specific ring-fenced budgets held by the ministry of health or the ministry of the interior. Some governments additionally rely on short-term funding from humanitarian agencies or non-governmental organisations (Bozorgmehr et al. 2018a). This pattern is likely to be extended across the European region, with governments using multiple funding mechanisms so help support the additional costs of newly arriving asylum seekers.

It is difficult to say, without further information, whether the current financing mechanisms adhere to the principles of "good" financing systems outlined above. However, the case of Germany (Box 5.2) shows how decentralised financing mechanisms, which are not integrated into existing health financing structures, can lead to problems with equity in resource distribution, efficiency, and transparency. Financial mechanisms operating independently for the group of asylum seekers are likely to suffer from problems related to small financial pools, lack of integration into national payment structures, and revenue collection in already stretched health and social care budgets for those countries operating under conditions of austerity.

Box 5.2 Fragmentation of the Health Financing Landscape for Asylum Seekers and Refugees in Germany

The German healthcare system is a statutory social health insurance system with an opt-out option to private health insurance, characterised by strong fragmentation and decentralisation. In the 1990s, the Asylum Seekers' Benefits Act established a financing system for asylum seekers parallel to the healthcare system of the general population. The financing of health services is strongly linked to the asylum process with shared responsibilities between authorities at different levels of administration. During their stay at one or

more state-level reception centres, the state-level authorities cover the costs of health screening and health assessments as well as individual medical care. Dispersal between and within the 16 federal states at the level of reception centres is common, leading to different authorities in charge to cover costs. Once asylum seekers reach their designated state, they are dispersed to one of the 412 districts, cities, and communities which in most cases are the designated authority to cover incurring healthcare costs.

Services provided at the population level in the context of hygiene and prevention and control of notifiable infectious diseases are financed by local public health offices. Further cost bearers, such as social health insurance, play a role depending on residence status, duration of residence, and employment status (Bozorgmehr et al. 2018b). A mixed-method evaluation of the health system response in 2015 (Bozorgmehr et al. 2016) showed that in some cases, there were indications of authorities in charge deliberately delaying delivery of needed health services, such as vaccination of the arriving population and health assessments, with the rationale that individuals would soon be dispersed to other states or districts who would then be in charge of covering costs.

Evaluations of notifiable diseases among asylum seekers (2002–2014) show that incident infections were mainly due to vaccine-preventable conditions, providing evidence of insufficient implementation of vaccination programs (Kuhne and Gilsdorf 2016). While it is hard to determine at the national level the extent to which the financing system contributed to the weak vaccination coverage, it can be argued that it incentivised a "watch and wait" behaviour which was beneficial to the local budget as long as there was no outbreak. Similar situations are observed in the health assessments: when asylum seekers are assigned to another state before undergoing their health assessment, assessments may not be performed in the first federal state as costs would burden the local budget. As such, the lack of timely health assessment (Bozorgmehr et al. 2016) and the lack of concrete regulations in state-level policies regarding the timing of the health assessment (Wahedi et al. 2017) may be a result of a financial disincentive to provide timely care.

Within the schematic laid out in the chapter by Spiegel and colleagues (see Chap. 3 "Innovative Humanitarian Health Financing for Refugees"; Table 3.2), shifting the health financing debate from the national to the supranational level would have several benefits. Akin to shifting from a *risk retention* to a *risk transfer* model, we can consider shifting the financing debate to a European level, that is, transferring financial risk from the host countries to another entity (viz. the EU). In doing so, the size of the financial pool could be substantially increased, thus alleviating the financial burden on those countries receiving the largest number of migrants. This in turn could provide incentives to increase access to appropriate care for this population,

as well as instating clear and transparent processes by which revenue is collected and funds are distributed among member states. A larger risk pool also means that crisis planning can be carried out with greater accuracy, allowing for innovative *ex ante* financing mechanisms, rather than relying entirely on *ex post* instruments.

Relevant European Health Financing Mechanisms

Several mechanisms currently exist at the European level to redistribute funds for refugees, asylum seekers, and migrants. These include four funds set up by the European Commission, as well as the European Health Insurance Card scheme. However, these mechanisms currently do not address the specific requirements of redistributing funds for the protection of asylum seekers' right to health.

The Asylum, Migration and Integration Fund has been instituted specifically to support member states accepting a large number of migrants, including asylum seekers, with regard to their asylum process, integration, and potential resettlement. The fund was set up in 2014 and runs for 7 years, replacing several funds which had previously been in place under the "Solidarity and Management of Migration Flows" programme. Initially, €3.137 billion were dedicated to the fund, which was increased to €6.894 billion in light of the increased number of asylum seekers during 2015 and 2016 (Directorate-General for Migration and Home Affairs (European Commission) 2018). All EU member states can apply for the fund by proposing specific project plans in line with stated objectives of the fund, one of which was to strengthen a common European asylum system. Member states are required to contribute 10% of the specified project budget, the remaining 90% being contributed by the fund. The fund specifies several regulation measures for national programmes, including audits, reports, and a midterm review to assess implementation and adjust budgeted funds if necessary (Directorate-General for Migration and Home Affairs (European Commission) 2018).

Two further project-based funds which have supported health and employment initiatives, the Health Programme and European Social Fund, have recently been joined with several other small funds under the new programme European Social Fund Plus. This is intended to strengthen the EU's response to crisis, strengthen health systems, support EU legislation on public health and implementation of best practices (European Commission 2018). Beneficiaries of this programme include national health authorities, public and private bodies, international organisations, and non-governmental organisations, which need to propose projects in line with the fund's objectives.

While these funds address some of the key social and structural determinants of health, none of them cover the financing of frontline healthcare services for the asylum-seeking population. This means that national governments are required to finance service provision, with no method for redistribution at a European level. Given the lack of European solidarity in this matter, national governments have no financial incentive to provide equitable entitlements to asylum seekers or provide

high-quality services for this population. Furthermore, the efficiency of the programmes is hampered by the long timescales of the project grants, which usually cover 6 to 7 years and have a lengthy application process. This reflects their aim of supporting long-term structural development. However, it means they are not responsive to the short-term changes in the numbers of or the composition of individuals in need of care which affects frontline service provision. A sustainable health financing mechanism for service provision requires balancing long-term financial support with responsive, transparent adjustments to the funding schedule on a shorter timescale. With regard to the more general health system improvement grants, the project-based funds represent an opportunity to shift towards migrant-friendly health systems by specifically addressing issues of crucial importance to refugee health, such as migrant-sensitive health monitoring, staffing, and service provision.

One of the funds that has previously supported the establishment of frontline health services is the emergency support provided by the European Civil Protection and Humanitarian Aid Operations (Civil protection and Humanitarian Aid Operations (European Commission) 2018). This emergency support was adopted in 2016 in the wake of sharply rising refugee numbers and has since supported the establishment of essential services. In Greece, the EU dedicated 643 million euro to support emergency support operation, including housing, healthcare, and hygiene infrastructure. This fund is a typical *ex post* financing mechanism, providing funds after the catastrophe has hit. It has been sharply criticised for failing to alleviate the situation for asylum seekers in Greece and suffering from issues of misallocated funds, lack of planning, and corruption (Leape 2018). Thus, while the distribution of funds through the EU has the potential to offer more transparency, this is not a given. Indeed, it may be particularly difficult to achieve in *ex post* humanitarian aid, where the crisis situation results in untransparent procedures and a lack of regulatory oversight (Maxwell et al. 2012).

Finally, only one *ex ante* European health financing scheme does not rely on project-based funding. However, it does not cover asylum seekers and refugees. The European Health Insurance Scheme ensures that citizens of EU member states can access public healthcare in any EU member state for temporary visits. Through the European Health Insurance Card, individuals are able to receive the same service package abroad as they would have been provided in their home country, if available. The costs can be claimed either by the member state in which treatment occurs or by the individual. In 2015, 91% of paid claims were issued by member states, demonstrating a high degree of integration of the reimbursement mechanism into existing financial systems (Directorate-General for Employment Social Affairs and Inclusion (European Commission) 2016). This scheme benefits from efficiency in process: funds go directly to frontline service providers rather than passing through the multiple hands of national and regional governments. Furthermore, it promotes equity in treatment as providers can claim the same costs for foreigners from within the EU as they can for nationals, especially when the process is well integrated and reimbursement is timely. Significant effort has gone into making the system transparent, by educating both patients and service providers about the rights and entitlements of EU citizens in a different member state (Directorate-General for Employment Social Affairs and Inclusion (European Commission) 2016).

In summary, the current funding mechanisms in the European region may offer support to tackle the social and structural determinants of ill health for migrants, but they only offer solutions to support frontline health services in emergency situations. The burden of financing currently lies on national governments, who have largely instituted parallel financing schemes or in some cases have restricted access to services out of fear for the financial burden. There are no Europe-wide financing mechanisms which offer a long-term solution to the problem to an uneven health burden on member states which is responsive to future changes in the number and composition of asylum seekers. Yet the number of asylum seekers and migrants to the European Union is not expected to cease.

In the following section, we explore what a responsive health financing system for asylum seekers, guided by the principles of "good" health financing systems, may look like at a European level. In doing so, we make two key assumptions: first, that there is political will for the principles of UHC and for European solidarity on the issue of forced migration. Although the political climate on the issue between member states is strained, there is reason to believe that the benefits of a European financing scheme would encourage member states bearing the financial burden for asylum seekers' healthcare to build alliances and lobby for change. Second, we assume that sufficient funding is available, or can be raised additionally, for the European budget to support either subsidies or full provision of healthcare by member states. The previous chapter by Spiegel and colleagues (see Chap. 3 "Innovative Humanitarian Health Financing for Refugees") has shown that several financing mechanisms are available which could raise additional funds. Furthermore, the current evidence suggests that funds in refugee health are often used inefficiently, and substantial additional funds could be made available by incentivising and increasing access to essential primary healthcare services (Bozorgmehr and Razum 2015) or avoiding securitisation of health issues (Wahedi et al. 2017) (see also Chap. 7 "Health Security in the Context of Forced Migration"). How and whether these assumptions may hold in each of the three presented scenarios will be discussed in more detail later.

Scenarios for Responsive Financing of Healthcare for Asylum Seekers in Europe

We present three scenarios for responsive financing of healthcare for asylum seekers in Europe. In line with the observations made by Spiegel and colleagues (see Chap. 3 "Innovative Humanitarian Health Financing for Refugees"), these require a shift from *ex post* donations to *ex ante* planning to enable the establishment of sustainable and reliable financing structures. Thus, we consider three mechanisms in the bottom left quadrant of Spiegel and colleagues' classification of financing instruments: traditional insurance, indexed insurance, and contingency pooled funds.

Scenario 1: European Health Insurance for Refugees (Traditional Insurance)

In our first scenario, we consider the opportunities of a comprehensive supranational health insurance programme for asylum seekers. Analogous to the EHIC system for citizens of the European Union, asylum seekers would receive a European health insurance card with which they can access healthcare services in all member states of the European Union according to the respective entitlements of the country's general population in line with the right to health requirements (non-differential treatment based on residence status) (UN Committee on Economic Social and Cultural Rights (CESCR) 2000). However, instead of providers claiming to the national governments of the nation states of the migrants, they claim directly to a large, central European healthcare fund. In practice, this represents a subsidy of the EU to national health systems, as the funds directly flow to the settings of service provision.

Such a system has several benefits. It works within the multiplicity of health systems of the EU and requires no special adaptation of the health system for refugees. This means that asylum seekers can be embedded in existing financing mechanisms without the need to set up parallel budgets for healthcare provision for this population. It guarantees financial protection for host countries, alleviating fears around the reception of asylum seekers on the grounds of healthcare costs. It removes the financial incentive to limit entitlements as costs are covered through EU funds. It also provides a flexible framework which accounts for individuals moving across multiple national or regional borders without the need for further shifting of budgets. It thus gives a financial baseline for an equitable health protection for asylum seekers throughout Europe, making it easier for host states to provide actualised equity through the accessibility of the health system, responsiveness of services, and the removal of other barriers to care for this population.

In addition, there are several financial incentives provided by such a system which makes a European healthcare fund attractive. The existence of a standardised financing mechanism allows for harmonisation of routine data collection mechanisms among asylum seekers across countries, which are currently either excluded from such data collection systems or integrated in systems which lack international comparability and interoperability (see also Chap. 9 "The State of the Art and the Evidence on Health Records for Migrants and Refugees: Findings from a Systematic Review"). This may improve optimisation of service delivery and, ideally, translate into more effective care. A major strength would be that it incentivises the—yet poorly implemented—identification of healthcare needs and vulnerabilities in line with the EU directive on the reception of refugees (European Parliament 2013), as EU-level structures pay for the costs of care without burdening the "own" (national or subnational) budget.

However, several important considerations need to be made before implementing such a financing mechanism. First off, there is the question of the timing of the scheme: when are asylum seekers formally covered by the insurance scheme, and

when is the financial responsibility for healthcare conferred to member states? Countries have varying legal processes around the asylum process and the question remains whether the scheme should only cover asylum seekers once a formal claim has been made, or once the intent of claiming has been voiced, either in the hosting country or in transit. The length of the asylum process also varies substantially between states, and an insurance scheme may introduce a financial incentive to extend this period if coverage is provided indefinitely during the process. It seems sensible to set such a limit to the insurance fund at 6 months after an asylum claim has been made—the recommended maximum time in which asylum proceedings should be concluded (European Council on Refugees and Exiles (ECRE) 2016)—with a further 6 months as a potential phase-out period where claims are partly covered. To prevent artificially prolonging an individual's asylum application, all newly arriving asylum seekers' healthcare costs should be covered for the period of 6 + 6 months, irrespective of legal status. A European insurance scheme therefore has the potential to act as a *bonus malus* incentive, where member states are encouraged to complete the asylum case within 12 months, before healthcare costs are transferred to national budgets. However, it needs to be ensured that the entitlements conferred by the insurance scheme are subsequently provided by the member states, even if the asylum process is not yet complete, so no gap in healthcare access is created. Similar considerations need to be made with regard to the population group covered (i.e. formal asylum seekers vs. irregular migrants) and the providers that are able to make claims through this scheme, acknowledging that in many countries, healthcare for asylum seekers is provided by a variety of actors, including non-governmental, charity, and for-profit organisations alongside public provision arrangements.

The introduction of such a scheme at the European level has benefits in terms of the sheer size of the insurance pool but also has drawbacks relating to the potential bureaucracy required to make it work. There is a large potential for high transaction costs in making and processing the claims made by the host countries at a European level, which could delay repayments and decrease the efficiency of the scheme. The successful integration of the EHIC scheme in national financing systems has shown, however, that efficient, expedient, and unbureaucratic claims processing is possible (Directorate-General for Employment Social Affairs and Inclusion (European Commission) 2016).

Finally, there is substantial financial risk involved in the first years following the introduction of the scheme. Due to the lack of routine data for asylum seekers currently utilising health services in Europe, estimations of the possible costs of such a scheme would have to be made with large margins for error. This financial risk is wholly conferred to EU budgets under an insurance scheme and thus requires significant political will from member states. However, increasing access to primary health services under the insurance scheme may even reduce the costs of service provisions overall, as costly specialist and emergency care is avoided (Starfield et al. 2005). Furthermore, net receiving countries will benefit substantially as the risk of financial expenditure is shifted from a national to a supranational budget. Based on the improved data collected through the insurance scheme, adjustments can be made over time to the relative and absolute contribution by member states.

Scenario 2: Refugee Health Budget (Indexed Insurance)

A second option for a redistribution of available resources at a European level would be the institution of a refugee health budget. In contrast to an individual insurance scheme, the budget could "top up" member states' health budgets based on the size and composition of their asylum-seeking population. In contrast to other EU funding mechanisms, it would need to provide funds on a more short-term (e.g. yearly) basis if it is to adequately address the rapidly changing number of and composition in the asylum-seeking population in the member states, and funds must go directly to the financing of frontline services.

A specifically allocated budget has the benefit that it is paid for in advance with a predefined budget size. The specified revenue is pooled from member states' contributions and ring-fenced for the use in health services for asylum seekers. It could, therefore, act as a security blanket for member states in terms of their health expenditure while still protecting the EU budget from financial risk. As the fund is capped, it could not cover the entirety of healthcare spending for member states, leaving these partly responsible for the financing of healthcare services. However, funds could act as a buffer in times of increased in-migration, so that sustainable, long-term financing solutions can be found going forward.

However, such a scheme would also require a discussion of some key considerations before it could be implemented. A key question for consideration is how the budget would be allocated. A fair mechanism would be to link this to the distribution of asylum seekers across the European region. To be equitable in terms of health, however, the allocation would also need to consider the composition of the asylum-seeking population in terms of age, sex, socio-economic status, country of origin, etc.—as proxies for a differential distribution of health risk (Bozorgmehr and Wahedi 2017). Such risk equalisation models have been implemented in several national health insurance systems as a means to increase efficiency and equity of systems facing unequal distributions of risk in the insurance pool (Van de Ven 2011). Unfortunately, required information is usually not generally reliable, if available at all. Thus, member states may only be eligible for participation in the advance risk equalisation scheme if migrant-sensitive data collection mechanisms are strengthened; or else they will receive only post hoc funds as a lump sum based on generic data such as the number of asylum seekers and age/sex distribution. This would be a large drawback for member states as they do not have a concrete figure with which to plan service delivery.

Furthermore, a key consideration is how such a fund would be governed. The fund does not, as with a traditional insurance mechanism, ensure that the money is spent for on-the-ground services. Instead, it relies on the existence of specified budgets for healthcare services for asylum seekers and clear plans for service delivery. However, the way in which healthcare for this population is financed differs markedly between member states, so the question becomes how the allocation of funds for asylum seekers' health can be ensured. In scenario1, considerations regarding the timing of the scheme, migrant groups covered, and type of provider reimbursed

are explicitly linked to the release of funds. With a refugee health budget, however, these details can only be implicitly specified but essentially remain at the discretion of member states. Such issues require additional governance and legal arrangements to ensure funds are well spent while acknowledging that countries have different institutional arrangements which must be respected.

Finally, because a refugee health budget for health leaves some of the financial risk with member states, the incentive for increasing access to health services is less strong than it would be under an insurance scheme. Working with a refugee health budget therefore requires political negotiations regarding the size of the benefit package, degree of out-of-pocket-payments, and the population covered if the stipulation of equal treatment for asylum seekers and the general population are to be upheld. Given the current political climate in the European Union, the political will for taking on additional financial responsibilities through the provision of additional services for asylum seekers is likely to be weak, despite the potential reprise from an EU refugee health budget. Thus, the financial certainty of such a scheme potentially comes at the cost of less certainty regarding the equitable treatment of persons across Europe.

Scenario 3: Refugee Health Emergency Fund (Contingency Pooled Funds)

Finally, a third option for the redistribution of funds would be the extension of the current EU emergency funds to specifically cover asylum seekers' health. As with the refugee health budget, this fund would consist of a predefined, ring-fenced budget to be allocated to member states in times of health emergencies. In contrast to the health budget, however, it would not be automatically distributed every year or so based on an allocation formula. Instead, the budget is intended to provide support to member states in times of emergency, as laid down in clear, predefined criteria.

It could be argued that such a mechanism provides the least support to member states and thus provides the least incentives to increase access to full healthcare coverage for asylum seekers. However, it leaves member states in the knowledge that there are additional funds to fall back on if unprecedented costs in the health systems arise due to increased numbers of asylum seekers and thus gives more certainty to provide full access or at least preserve current coverage should numbers of asylum applicants rise again.

Using project-based funds would allow for additional contextual factors, including the intersection with other political, economic, social, or environmental challenges, to be taken into account. It does, however, also render the process much more subjective and prone to political influence and may only function on longer financing timescales due to the delayed release of funds through the application process.

In order to alleviate noted issues with the existing emergency fund, the governance and accountability of the refugee health emergency fund would need to be strengthened. This could be achieved by setting clear eligibility criteria, as well as specifying achievable goals which promote the equity and efficiency of healthcare services for asylum seekers in receiving countries. For example, subsequent rounds of funding could be made dependent on the achievement of specified goals and ongoing qualitative and quantitative evaluations of fund expenditures (Maxwell et al. 2012). However, increasing the efficiency and transparency of how funds are spent locally may come at the cost of increased central overheads for the management and processing of grant applications, monitoring and evaluation, and project management support for receiving countries.

Critical Reflections on Practicability and Feasibility of the Scenarios

We have presented three scenarios implementing the proposed financing mechanisms from Spiegel and colleagues in a European context. The proposed schemes have the potential to increase the responsiveness of refugee health financing at a European level to the needs of both member states and the asylum seekers themselves. However, the question remains whether these arrangements are practically possible, politically feasible, and financially realistic. In order to answer these questions, we will begin by reflecting on the three scenarios in terms of their ability to meet the intermediate objectives of financing systems (Fig. 5.2), before discussing their practical and political implications.

Adherence to Principles of "Good" Financing Systems

Each of the three scenarios presented demonstrates different properties with regard to their ability to achieve equity in resource distribution, efficiency, as well as transparency and accountability, ultimately affecting the utilisation relative to need, quality of care, and universal financial protection of the health system (Fig. 5.2).

In terms of equity, all three financing mechanisms demonstrate equity in revenue collection: revenues are taken from the contributions made by member states, with disproportionally larger contributions made by the wealthier economies. In terms of redistribution of funds, all scenarios presented operate on the principle of a redistribution of funds to those countries receiving the largest numbers of asylum seekers, additionally considering the composition of the population. However, while in all three scenarios distribution equity is ensured for the size and composition of the asylum-seeking population, in scenario 1 and 2, this does not factor in the countries' ability, i.e. their resilience (see also Chap. 6 "Understanding the Resilience of

Health Systems"), to cope with the newly arriving asylum seekers. Thus, allocation of funds for Germany or Sweden, for example, would be carried out just the same as in Italy or Greece, even though their resilience in the face of increased asylum seekers may be quite different. In scenario 3, in contrast, these contextual factors could be taken into account.

Furthermore, the presented scenarios differ in the incentives they give for providing equity in access. It could be argued that these incentives are strongest in scenario 1. As all costs incurred in the provision of care for asylum seekers are covered by the EU insurance pool in this scenario, governments would be encouraged financially to increase entitlements for asylum seekers to match those of the resident population. In scenarios 2 and 3, however, potential equity issues need to be explicitly mitigated. In scenario 3, the strength of incentives depends on the grant structure and the quality of auditing and evaluation processes. In scenario 2, the funding mechanism alone provides arguably the least strong incentives for equity in access to care, as funds are distributed based on a redistribution formula irrespective of local arrangements. In these scenarios, and depending on how comprehensive the scheme is, improving access to healthcare for asylum seekers may actually create inequity in favour of asylum seekers in countries where access to healthcare is limited for the resident population (e.g. Greece). If the specified budget for healthcare is small, on the other hand, this may have no impact on equity, despite the best governance efforts. Furthermore, the pitfalls of specifying a "minimum benefit package" must be acknowledged, which may actually be less comprehensive than what was previously provided, and could thus harm equity as well as quality of care. However, a health budget or emergency fund may provide an additional argument to push for increased equity in access in bilateral and multilateral negotiations, especially if these are supported by strong institutions and governance arrangements.

Turning to the efficiency of the financing system, all three scenarios benefit from the additional technical efficiency gains made through risk pooling at a European level. At the same time, this must be balanced with the potential administrative inefficiencies arising as the result of a centralised management of funds. It could be argued that these are least troubling in scenario 2; as long as adequate information on the size and composition of the refugee population are available, distribution could occur with very little additional managerial burden. In scenario 1, administrative efficiency losses could be minimised if reimbursement mechanisms are well integrated in national financing structures and clear processes have been set up to enable healthcare providers to make claims. The initial evaluation of the EHIC has shown that this is possible (Directorate-General for Employment Social Affairs and Inclusion (European Commission) 2016). Arguably the largest bureaucratic investments would need to be made in scenario 3, the health emergency fund, if it is to support the delivery of effective care in a transparent fashion.

Not only the efficiency of central management, but also of the funds reaching frontline services (allocative efficiency) must be considered. While scenario 1 allows for funds to directly reach the providers of frontline services, with the potential to directly improve quality of care on the ground by linking reimbursement to quality standards and clinical guidelines, scenarios 2 and 3 rely on the existence of

good national service delivery plans and efficient local financing arrangements and in absence of these entail the risk of misuse or ineffective use of funds. The allocative efficiency of scenario 1 could be harmed, however, if the insurance scheme promotes moral hazard on the supply or the demand side, for example, through supplier-induced demand or unnecessary utilisation among the asylum-seeking populations. Policy options to counter this issue, including co-payments for specific services or a combination of insurance with global budgets, should be explored (Mossialos et al. 2002). Furthermore, current practices which are not supported by available evidence, such as the indiscriminate screening of newly arriving asylum seekers for rare infectious illnesses (Bozorgmehr et al. 2017)—a practice which has arisen out of fear of immigrants as "carriers" of dangerous epidemics—should be discouraged to maintain the efficiency of the financing schemes and avoid driving up costs for all member states.

Finally, in terms of transparency and accountability, all three scenarios have the potential to provide asylum seekers with an increased understanding of their rights and entitlements to healthcare. However, only scenario 1 provides specific incentives to do so, as member states benefit directly if asylum seekers' care is financed through the European insurance scheme rather than by national budgets. This could directly improve the responsiveness, or non-technical quality of care, of healthcare services (also see Chap. 12 "Health Systems Responsiveness to the Mental Health Needs of Forcibly Displaced Persons"). Scenario 1 also maximises the accountability of financing institutions, as all transaction can be tracked and monitored, potentially exposing fraudulent of inefficient spending, as well as large, unexplained spending discrepancies between member states. In the other two scenarios, accurate monitoring and evaluation mechanisms with regular, transparent reporting would be required to increase accountability and could also be used to ensure eligibility of member states to receive funds.

Practical and Political Implications

Reforming financing systems in Europe to support responsive and equitable healthcare services for asylum seekers requires political will. In order to push for change, those countries which could benefit from the proposed financing mechanisms need to form coalitions to support financial reform. During renegotiations of the Dublin agreement, we saw how difficult it can be to make progress regarding European asylum policies, with those countries in disfavour of alternatives to Dublin gaining the upper hand and pushing instead for stronger political support to secure the EU's external borders (Niemann and Zaun 2018). However, even if the arrival of asylum seekers now occurs on a somewhat smaller scale, current numbers are not expected to cease. Therefore, as the UCL-Lancet Commission on Migration and Health has noted, a discussion needs to take place on the future of national health systems given the reality of increased human mobility across geopolitical borders (Abubakar et al. 2018). What do health systems beyond geopolitical borders look like? What regula-

tory and governance mechanisms need to be instituted to protect the health of mobile populations? In this chapter, we have provided three options to move towards an international health system, outlining some of the key financial considerations at stake.

On a political level, there is some cause to believe that a financing reform would enjoy greater support than renegotiations of the Dublin agreement. A financing reform would benefit politically powerful member states with many asylum seekers, such as Germany and Sweden, just as it would benefit Mediterranean receiving countries. Arguably, scenario 1 is the most radical reform presented here, requiring a lot of upfront political and technical effort. However, it has several advantages such as flexibility across borders and direct investment in frontline services which make it particularly attractive from a sustainability perspective. Once integrated in current national financing systems, the scheme could work very efficiently. However, the idea may encounter political opposition due to the different health systems the scheme would need to cover. Because health systems across the European region have developed quite differently, with different service configurations, technological developments, payment mechanisms, and entitlements, they are likely to incur varying costs which may cause tensions at a European level if the scheme is perceived not as a subsidy for the healthcare of asylum seekers but instead for the relatively more "expensive" health systems themselves. Within countries, these issues are often addressed through the use of Diagnosis-Related Groups (DRGs), which ensure that treatments for specified illnesses have the same costs despite being carried out in different districts or regions. However, extrapolating this mechanism across national boundaries could be substantially more complicated given different pricing regulations, organisational structures, and health service arrangements. Other supranational financing mechanisms, such as the remuneration of UN staff in countries with different costs of living, have circumvented these problems using weighted contributions. A similar scheme may work in this context to alleviate subsidy concerns. Currently, the overall cost of a comprehensive health insurance scheme is unknown, which may be another factor hindering the implementation of scenario 1. Modelling studies to estimate the overall costs of such a scheme based on the demographic of this population and epidemiological data should be performed in the future to facilitate and inform policy discourses regarding the feasibility an implementation of such a scheme. If scenario 1 is not politically possible, scenarios 2 and 3 represent viable alternative options, but with lower potential impacts on health equity and drawbacks on accountability. These two options could also be helpfully used in conjunction, by providing members states with a needs-adjusted fund to support frontline services (scenario 2) as well as providing emergency relief to those countries showing less resilience in the face of rising numbers of asylum seekers (scenario 3). Since these funds are based on existing European financing schemes, they may require less political will to actualise.

Furthermore, it must be noted that responsive financing reforms for the healthcare of asylum seekers cannot act as a panacea for the failings of the Dublin agreement. Even with sufficient financial resources, leaving the fate of refugees in Europe to a few European member states puts these under substantial economic, infrastruc-

tural, and political strain. On the other hand, if Dublin was replaced—either with a quota system or one of free choice of asylum claim (Bozorgmehr and Wahedi 2017)—the issue of responsive financing would not be solved. The alternatives to the Dublin agreement do not necessarily ensure that the burden of health would be evenly distributed among member states, and the problem of individuals seeking care in multiple countries would remain. Thus, the same considerations must be made regarding responsive health financing for asylum seekers at a European level.

This chapter has focused on the financing of services for formal asylum seekers. However, a 2008 estimate suggests that between 1.9 and 3.8 million irregular migrants reside in the European Union (Kraler and Rogoz 2011), a figure which is likely to have increased in recent years. Thus, it is worth exploring the impact of the presented scenarios on the equity of service provision for this group of migrants in the future.

Finally, the political and ideological dimension of healthcare restrictions must be acknowledged. Although the rise of populism can be attributed, in part, to concerns of social and economic inequality, addressing solely the financing dimension of the current refugee debate will not reshape populist discourse. Political and ideological conceptions about refugees, their reasons for migration, and their treatment in host countries are powerful determinants of restrictive health policies. For example, in Germany healthcare restrictions have been expressly instituted not because of a lack of funds but to deter additional asylum seekers from entering the country. In fact, myths around free healthcare as a pull factor for migration remain endemic in several European countries (Bozorgmehr and Razum 2016). In several European countries, discourses around the "deservingness" of asylum seekers to receive free healthcare have blossomed, questioning the automatic right to health of anyone stepping onto the soil of the hosting country (Holmes and Castañeda 2016). In Greece, tensions have flared among citizens as they have to make substantial co-payments to services, while asylum seekers are exempt, being classed as a "vulnerable group". Thus, different ideas about who "deserves" to receive free care on a political level shape the entitlements that are granted. While a responsive health system could help to alleviate the financial strain under which these discourses have arisen, nevertheless they have an ideological dimension which needs to be discussed within each member state. If we want to increase the accessibility of health services for asylum seekers and extend Universal Health Coverage to all migrants, responsive financing systems must go hand in hand with citizen engagement and political collaboration across Europe.

Conclusion

An increasingly mobile population has challenged the financing of health services within geopolitical boundaries. Yet the existing financing mechanisms at a European level are currently not fit to provide responsive and equitable care to the asylum seekers, a particularly vulnerable population group. We have presented three options

at the level of the European Union to increase economic solidarity and support member states which currently bear largest responsibility for asylum seekers' health. While the three scenarios have different implications in terms of equity, efficiency, and transparency of the financing system, all three represent viable options to incentivise increased access to essential healthcare services at a national level. Financial reform is sorely needed in order to protect the health of newly arriving asylum seekers to the European Union. However, the technical considerations of the financing options must be accompanied by political leadership, evidence-informed discourses, and citizen engagement in order to succeed.

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