

Responding to the challenge of financial sustainability in Estonia's health system

EXECUTIVE SUMMARY

*Sarah Thomson, Andres Võrk,
Triin Habicht, Liis Rooväli, Tamás Evetovits
and Jarno Habicht*

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From values to action:
implementing the Tallinn Charter
on *Health Systems for Health and Wealth* in Estonia

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Key messages

- The public revenue base for the health sector should be broadened to ensure that the health system is better able to achieve its objectives now and in the longer term.
- Health financing policy can be further strengthened to manage cost pressures better and improve performance.
- Action is needed on both fronts to generate sufficient revenue and manage expenditures.

Report aims and added value for decision-makers

Health system financial sustainability has always been a central health policy issue, but the recent financial crisis has forced it to the top of the policy agenda the world over. With the aim of supporting a financially sustainable, high-performing health system, this report assesses health financing policy in Estonia. It looks at how well-placed current financing policy is to enable goal attainment in the medium-to-long term (to 2030) and identifies ways to strengthen financing policy.

The report is the result of a year-long process of stakeholder consultations and expert analysis initiated by the Ministry of Social Affairs in 2009 in partnership with the Estonian Health Insurance Fund (EHIF) and the World Health Organization (WHO) Regional Office for Europe. It adds to previous analyses of the Estonian health system in three ways. First, it joins an assessment of current health financing policy in the context of broader macroeconomic

The report brings together the views and values of stakeholders, recent data on health financing and new revenue and expenditure projections from now to 2030.

The report's assessment of health financing in Estonia is based on the following objectives identified by WHO:

- *promoting universal protection against financial risk (financial protection)*
- *promoting a more equitable distribution of the financing burden (equity in financing)*
- *promoting equitable provision and use of services relative to need (equity of access)*
- *improving the transparency and accountability of the system to the public*
- *promoting quality and efficiency in service delivery*
- *improving administrative efficiency*

The strengths of health financing policy in Estonia are internationally recognized, but avoiding further fragmentation and strengthening purchasing will deliver better results.

concerns with projections of health sector revenue and expenditure trends. Second, the projections go beyond existing work by drawing on the most recent data and accounting for changes in utilization patterns. Third, the report's analysis and recommendations are not based on technical assessment alone but also on the views and values of health system actors and political representatives as expressed in interviews and workshops in Estonia.

Strengths and weaknesses of Estonian health financing policy

Estonia's health system is largely publicly financed through an earmarked tax on wages (the social tax). Around two thirds of total health financing comes from the social tax, around a tenth from the central government budget and just under a quarter from private sources.

Most public funds for health care are pooled by EHIF, an independent and autonomous agency responsible for purchasing a broad range of health services on behalf of its members. The proportion of the population entitled to EHIF benefits is high (over 95%) and has recently been extended to cover the long-term unemployed – a good example of an effective policy response to changing macroeconomic circumstances. The stated objectives of the health insurance system are solidarity, limits on cost sharing and equal access to care for all those covered. The central government finances services available to the whole population such as emergency care, public health programmes and immunization.

The single payer system has served well since it was established in the early 1990s. Central revenue collection, national pooling and centrally set prices contribute to efficiency in resource use, while the breadth, scope and depth of coverage result in generally equitable access to primary care and most specialist services. In addition, EHIF is internationally recognized for its efforts to engage in strategic purchasing, its high levels of transparency and accountability to the public and its low administrative costs. Stakeholders were unanimous in considering the earmarked social tax and EHIF's prudent management of resources to be major causes of stability.

The separation of health insurance from other forms of social insurance (e.g., pensions and unemployment benefits) is a further advantage, which should be preserved to ensure clear lines of accountability and transparency in the social sector as a whole.

Alongside these strengths, the report highlights some areas of concern. Public spending on health as a proportion of general government expenditure is low by European Union (EU) standards and fell between 2000 and 2007. This suggests that health spending is not being given priority within public spending as a whole. Public spending on health is also low as a proportion of gross domestic product (GDP), reflecting the relatively small size of government in Estonia. There was broad acknowledgement among stakeholders of the constraints posed by inadequate public spending on health. Many recognize that future reliance on the social tax may present challenges. However, while stakeholders favour more reliance on central government financing, they are concerned about its potential instability.

Low levels of public investment in health mean that the private share has grown significantly, mainly from rising out-of-pocket payments (OOPs). The growing demand for health care is thus being met privately, rather than collectively. The changing balance between public and private financing, particularly the rise in OOPs, can undermine health system objectives in four ways. First, it compromises the efficiency gains of health insurance pooling. Second, financial protection for households has fallen as OOPs have increased, particularly among older and poorer people, mainly for outpatient prescription drugs.¹ Third, although health financing policy is mildly progressive overall, echoing stakeholder views about the extent of solidarity in the health system, the degree of progressivity (and thus equity in financing) has decreased significantly since 2000, mainly due to the rising share of OOPs. Fourth, coverage rules and user charges undermine the principle of access based on need rather than ability to pay. Evidence shows that poorer households forego seeking needed health care due to the out-of-pocket costs involved, which distorts equity in the use of health services.

Public spending on health is relatively low and could be increased to reach EU levels.

Rising levels of out-of-pocket spending have eroded financial protection and equity in financing.

¹ The share of outpatient prescription drug costs borne by households in Estonia is very high in comparison to other EU countries, reflecting heavy user charges, poorly enforced policy on rational drug use and perverse incentives for doctors and pharmacists. The absence of dental care coverage for adults also generates concerns for financial protection, while the fragmented and therefore potentially patchy coverage of long-term care is likely to become a key issue in future.

Weak government control over capital investment and the lack of incentives to balance and coordinate care across levels promote inefficiency.

Developments in health technology and patterns of health care utilization will have a much larger impact on future health care spending than population ageing.

The current system of raising revenue will not be sufficient to bridge the projected gap between health sector revenue and expenditure.

Other aspects of health financing policy also give cause for concern. In spite of EHIF's progress in developing cost-effective strategies for resource allocation, purchasing and provider payment, there are areas that require greater policy attention. For example, Estonia's poor performance in extending life expectancy, particularly for men, underscores the need for greater investment in public health and prevention. At present there is limited central steering to ensure that capital investment reflects long-term objectives, as reflected in weak central control of infrastructure development or the location of expensive equipment. Failure to link capital investment to population health needs wastes resources. Further weaknesses include insufficient support for moving from inpatient to outpatient care, a lack of incentives to coordinate care across providers and promote rational drug use and lack of a comprehensive long-term care strategy.

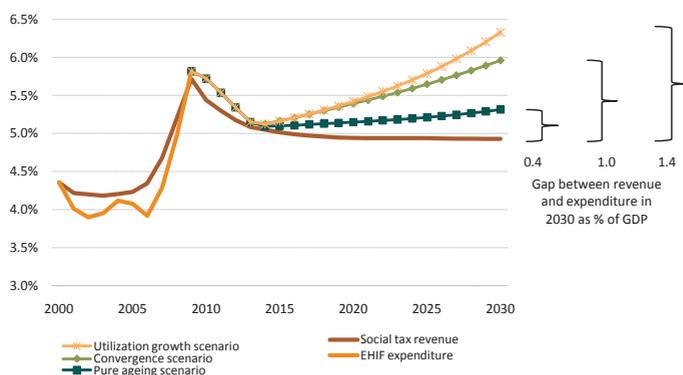
Projected revenue and expenditure trends from now to 2030

Many of the weaknesses of health financing policy are underlined by the report's projections, which examine the impact of a range of demographic, labour market, macroeconomic and health system factors under different scenarios. All scenarios show that health expenditure will consume a greater share of national wealth. However, health system factors – technological development and utilization patterns – have a much larger impact on expenditure than demographic factors such as population ageing. If health care utilization continues to grow at the rate of the last five to ten years, the effect on public spending will be great. In addition, private spending could more than double as a share of GDP by 2030, mainly due to greater use of prescription drugs, with serious implications for financial protection and equity.

Population ageing means that people aged 15 to 74 will comprise a slightly smaller proportion of the population. As a result, EHIF's ratio of contributors to non-contributors will decline and, even with increases in average wages, its revenue will not grow sufficiently to

match even the most conservative projections of health expenditure in 2030 (Figure 1). Thus, there will be a significant gap between public revenue and public expenditure. Figure 1 shows that the gap may be between 0.4% and 1.4% of GDP, but it could be twice as large depending on when and how quickly health care prices start to rise and whether utilization patterns will reflect trends seen in the last five to ten years. EHIF's current financial reserves could be depleted by as early as 2012 or 2013.

Figure 1. Projected trends in EHIF revenue and expenditure (as a % of GDP) under different scenarios, 2000-2030



Note: Includes temporary sick leave benefits.

Projected gaps between health sector revenue and expenditure are particularly sensitive to assumptions about how expenditure develops. A key assumption underlying the projections is that health care unit costs will fall slightly during the current financial crisis and will not start to rise again until 2014, after which there will be a continuous increase in expenditure to 2030. However, sensitivity analysis shows that if unit costs start to rise in 2010, spending levels will be even higher in the short, medium and long terms. This suggests that pricing decisions made in the near future will have a key impact on expenditure.

Additionally, the projections do not account for changes in health status or changes in age-related expenditure, both of which could have a significant impact on spending. Other projections have shown how even modest improvements in healthy life expectancy – healthy ageing – can lower the rate of expenditure growth.

The rapid growth of private spending on health should be controlled.

Decisions about managing expenditure in the short term will determine expenditure growth rates and spending levels in the coming decades.

Investing now in healthy ageing can lower the rate of health expenditure growth.

Challenges for health financing policy

The projections show how trends in publicly generated health sector revenue and expenditure will diverge. The challenge this gap presents stems from two main factors. On the revenue side, heavy reliance on the labour market to finance health care and reluctance to transfer greater amounts from the central government budget mean that the public revenue base will shrink due to the impact of population ageing on employment. On the expenditure side, weaknesses in resource allocation, purchasing and provider payment lead to inefficiency now, and if unchecked will contribute to rapid spending growth.

There are three potential responses to bridging the projected revenue–expenditure gap: cutting public entitlements to health care, broadening the public revenue base and increasing health system efficiency. If financial sustainability is seen purely as an accounting problem, then any of these responses would be appropriate as long as they succeeded in preventing deficits. The easiest option would be to cut entitlements to match expected revenue. However, the concept of financial sustainability is essentially meaningless unless it is linked to the objectives of the health system. Thus, while part of the purpose of the report is to quantify the challenge facing health financing policy – by estimating the size of the financing gap in 2030 – its ultimate aim is to identify ways in which health financing policy can be strengthened so that the system is better able to meet its objectives.

The report considers a wide range of options in four areas: broadening the public revenue base and generating additional revenue; changing coverage breadth (universality), scope (benefits) and depth (user charges); improving resource allocation; and strengthening governance. Many of the options were identified by stakeholders during the interviews and workshops; some emerge from the report's technical assessment of financing policy and reflect the concerns identified by the projections. Among the options considered, several were discounted on the grounds that they would not contribute to greater achievement of health system objectives, e.g., the option of blanket reductions in coverage breadth, scope and depth. The report therefore does not recommend an

There are many options for change, but only some will help the health system to achieve its objectives.

The report rejects the option of blanket reductions in coverage breadth, scope and depth. It does not recommend an expanded role for private health insurance in Estonia.

expanded role for private health insurance (the corollary of cuts in coverage), since this would not improve financial protection for the poor or older or less healthy people. It would also add to regulatory complexity and administrative costs without enhancing efficiency or relieving financial pressure on EHIF.

Recommendations for strengthening financing policy to meet health system objectives

The report makes the following recommendations on the grounds that they have significant stakeholder support, reflect the health system's values, are politically feasible and likely to enhance the system's ability to meet its objectives.

1. Broaden the public revenue base

Health financing policy in Estonia has provided a stable source of revenue. The report therefore recommends leaving the key elements of the current system in place: the earmarked tax for health, national pooling of public funds and the single payer. However, there is nearly unanimous agreement among stakeholders on the need to broaden the public revenue base through greater reliance on non-employment-based taxes on capital and consumption. Some stakeholders also feel that ensuring that those who benefit from EHIF coverage contribute to its costs – particularly older people – would enhance public perceptions of the system's fairness. To address both concerns – while recognizing that many older people have either already contributed to EHIF while working or would not be financially able to contribute due to the country's low pensions – the report recommends that the central government make contributions to EHIF on behalf of pensioners.

In the interests of fairness, the report also recommends that the government apply the social tax to dividends from capital investment, since investors can avoid paying some of the social tax if they choose to be paid mainly in dividends, but they still

Keep in place key elements of the current system: the earmarked tax for health, national pooling of public funds and the single payer.

Broaden the revenue base by increasing allocations from the central government.

benefit from EHIF coverage. While the numbers affected by such a move would be small, it does not seem appropriate to single out pensioners as a source of unfairness in the health system when other, possibly better-off groups contribute little or nothing to EHIF. Applying the social tax to dividends would also address the current imbalance between labour and capital as sources of health financing.

The mechanisms used to allocate revenue from the central government budget to EHIF need to be stable and transparent. If there is no new earmarking of specific tax funds for health, the government should establish a clear formula for allocating resources to avoid yearly fluctuations.

2. Improve financial protection by curbing out-of-pocket payments

Health financing policy in Estonia ensures a degree of solidarity and equitable access to primary care (free at the point of use) and specialist care (subject to limited cost sharing). Nevertheless, the extent of financial protection and equity in financing has declined in recent years for all income groups, but especially among poorer and older households, largely due to the rapid growth of OOPs. In addition to evidence of financial barriers to accessing outpatient prescription drugs, dental care and specialist visits, there is evidence that user charges and pharmaceutical policies not only fail to contain costs but actually lead to inefficient use of private and public resources.

The report therefore recommends that the Ministry of Social Affairs and EHIF take urgent action to bolster their policy on the rational use of drugs. The report specifically recommends introducing clear incentives for enforcing the compulsory generic prescription policy and establishing a policy of generic substitution for pharmacists.

At the same time the Ministry of Social Affairs and EHIF should review user charge policies for all health services – starting with outpatient prescription drugs – with a view to simplifying, improving targeting and strengthening direct and indirect protection mechanisms. These agencies should set a timetable for exempting the poor and heavy health care users from charges. The savings resulting from a more efficient use of drugs would offset the cost of exemptions (and even abolition of charges), making this a revenue-neutral option.

The allocation mechanism to broaden the revenue base has to be stable and transparent.

Financial protection and equity in financing have declined in recent years.

User-charges policy needs to be simplified, better targeted and more effective at protecting the poor and heavy users of health care.

The government should also review the benefits package and set a timetable for increasing the coverage of effective services such as adult dental care. The government's decision to extend EHIF coverage to the long-term unemployed in 2009 demonstrates its ability to respond effectively to changing circumstances.

3. Continue to improve health system performance through better resource allocation and purchasing

The Estonian health system already performs well in many areas and EHIF is internationally recognized for its achievements. Nevertheless, there is scope for realizing further efficiency gains by improving investment and resource allocation processes. Although efficiency gains alone will not be sufficient to bridge the projected revenue-expenditure gap, they will improve outcomes. If accompanied by clear communication, efforts to enhance efficiency can also reassure patients, the wider public and politicians that resources for health are being put to good use.

On these grounds the report recommends action in the following areas. First, continued effort to tackle excess hospital capacity and implement the Hospital Master Plan. The Ministry of Social Affairs should develop a stronger strategy for guiding investment in and the design of hospital infrastructure. A better strategy would adjust the balance of power in favour of the health system rather than hospital management. The Ministry of Social Affairs and EHIF should also establish a policy to control investment in expensive hospital equipment.

Second, in light of Estonia's relatively poor gains in life expectancy (especially for men) and evidence of the importance of ensuring healthy ageing and the positive economic effects of investing in health, the Ministry of Social Affairs should work closely with other ministries to generate sufficient investment in public health programmes and prevention.

Third, the Ministry of Social Affairs should work with EHIF to boost the primary care focus of the health system. Measures to support primary care include strengthening family doctors' gate-keeping and coordination functions, equipping them with the means to steer patients through the health system, improving their

Efficiency gains alone will not be sufficient to bridge the projected revenue-expenditure gap.

Stronger oversight of capital investment in infrastructure and equipment will enhance efficiency and help to control expenditure growth.

More and better investment in public health can contribute to healthy ageing and economic development.

Strong, accountable and free primary care at the centre of the health system is cost-effective and encourages responsiveness throughout the health system.

governance and accountability and keeping primary care free at the point of use for the whole population (not just those entitled to EHIF benefits).

Fourth, EHIF should align incentives across the health system, making better use of provider payment methods to sustain the shift from inpatient to outpatient care and day case surgery. It should also strengthen efforts to base reimbursement decisions on evidence of the comparative effectiveness of interventions and cost-effectiveness, including greater use of tools such as health technology assessment.

4. Maintain strong governance of the health system

EHIF already has relatively strong (transparent and accountable) governance arrangements in place. The report recommends that these be reinforced by better investment in monitoring and evaluating provider activity across the health system, with particular emphasis on clinical outcome indicators. Investment in e-health may contribute to clinical quality through better exchange of information and less frequent duplication of tests and investigations.

Alongside EHIF, the Ministry of Social Affairs should take the lead in providing policy direction for the whole health system, ensuring a sufficient flow of resources, supporting other institutions and promoting health in all policies. Recognizing the landmark approach adopted by the Tallinn Charter – Health systems for health and wealth – the Ministry of Social Affairs should work more closely with the Ministry of Finance to highlight the positive economic effects of investing in health.

Estonia's single-payer system is effective and should not be dismantled and replaced by a competitive model. The central government should make every effort to avoid any further fragmentation in the flow of resources, which results in inefficiency and can create conflicting incentives. Where a degree of fragmentation exists – for example, in the financing of public health and emergency care – the Ministry of Social Affairs should take the lead in ensuring effective coordination.

Aligning incentives across the health system and greater use of technology assessment will help to reduce inefficiencies.

Good governance of the single-payer system and efforts to avoid fragmentation are central to strengthening health financing policy.

Conclusions

Health financing policy in Estonia faces several challenges. Population ageing poses a moderate challenge to long-term financial sustainability. The major challenges come from factors directly related to financing, notably, relatively low public investment in health, public contribution mechanisms linked to the labour market and weaknesses in resource allocation, purchasing and provider payment. The good news for policy-makers is that these challenges are amenable to multiple policy levers. Strengthening health financing policy can address many of the inefficiencies in resource allocation and health care utilization that exacerbate cost pressures.

Nevertheless, the projected gap between revenue and expenditure is too large to be closed through efficiency savings alone. One way of narrowing the gap is to cut entitlements to publicly financed health care, but this would be counter-productive since it would undermine the system's objectives and values. Depending on the severity and timing of the cuts, they might also undermine economic recovery and growth. In addition, radical cuts in health care prices and benefits may not be easily reversed when the economic outlook improves if they have provoked an exodus of health professionals.

An alternative is to broaden the public revenue base. Heavy reliance on a wage tax alone is not a sustainable option in light of declining employment, rising old age dependency ratios and payroll tax sensitivity to economic fluctuation. Increased transfers from the central government budget to the health sector, in tandem with other efforts to strengthen health financing policy, can tackle the revenue-expenditure gap, bring public spending up to EU levels and most importantly, improve the system's ability to meet its objectives. Greater central government allocations should be based on a clear formula to ensure transparency and stability.

The health system's financial sustainability rests on political decisions about how, and how much, to invest in health and how resources should be allocated. These decisions need to be made sooner rather than later since the projections and evidence of existing inefficiencies suggest that the costs of inaction will be high.

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World Health Organization Regional Office for Europe

Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 39 17 17 17. Fax: +45 39 17 18 18. E-mail: postmaster@euro.who.int
Web site: www.euro.who.int