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Responding to the challenge of financial sustainability in Estonia's health system: one year on

*By Sarah Thomson, Triin Habicht, Liis Roováli,
Tamás Evetovits and Jarno Habicht*



Eesti Haigekassa
Estonian Health Insurance Fund



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Executive summary

In April 2010 we published a report assessing Estonian health financing policy, with health sector revenue and expenditure trend projections from 2010 to 2030 that examined the impact of a range of demographic, labour market, macroeconomic and health system factors under different scenarios. All scenarios found that health expenditure will consume a greater share of national wealth in future, but health system factors – technological development and utilization patterns – were shown to have a much larger impact on expenditure than demographic factors such as population ageing. If health care use 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 increased use of prescription drugs, with serious implications for financial protection, equity and efficiency.

The 2010 report had three key messages:

- **The public revenue base for the health sector should be broadened to ensure that the 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.**

This brief document identifies the main changes to health financing policy since we began preparing the original report in April 2009. Its intention is not to measure the impact of the 2010 report, but to review progress in areas the report highlighted as likely to have a significant effect on the health system's financial sustainability. Following up would be a useful exercise under most circumstances; in Estonia's case it is particularly compelling due to the economic and political changes that have occurred in the last few years: joining the Organisation for Economic Cooperation and Development (OECD), the election of a new (but familiar) government and fiscal pressures created by a sustained recession, growing unemployment and entry to the Eurozone.

The fiscal constraints imposed by the financial crisis and Eurozone requirements have been instrumental in increasing the political feasibility of many of the health system changes introduced since the launch of the original report in April 2010. This is particularly true of the decisions to lower health care prices and increase maximum waiting times in 2010 and 2011, which were intended to maintain reasonably good access to health care during a period of severe economic recession. It is noteworthy that these changes were achieved without significant public or professional opposition.

During this challenging period, the Ministry of Social Affairs and the Estonian Health Insurance Fund (EHIF), in cooperation with the State Medicines Agency (SMA) and the Association of Family Physicians (AFP), have worked hard to encourage a more efficient use of resources through a range of initiatives such as extending price agreements and reference pricing to all reimbursed drugs, enhanc-

ing active-ingredient-based prescribing and dispensing, improving public and professional acceptance of generic drugs, extending gatekeeping to patients with chronic conditions, introducing a new DRG (diagnosis-related group) grouper to stimulate day-case care and continuing to encourage the use of health technology assessment (HTA), clinical guidelines and quality indicators. At the same time they have ensured financial protection for patients, particularly where primary care and prescription drugs are concerned.

These efforts have not been matched by political leadership in three areas of fundamental importance to ensuring the long-term financial sustainability of the health system. First, EHIF has had to lower health care prices and increase waiting times because the government has prevented it from using all of its reserve funds. One of the risks of short-term retrenchment is that it may have lasting adverse effects on the supply of human resources. Had EHIF been able to draw more fully on its reserve funds, it might have avoided this risk and it may have been possible to maintain coverage of sickness benefits and compensation for preventive dental care for adults. Instead, it was forced to shift these costs onto households, at the risk of undermining financial protection, and was not able to lift the cap on reimbursement of cost-effective drugs in the 50% category. Declining financial protection was highlighted as a concern in the OECD's 2011 economic survey of Estonia.

Second, the government has so far failed to take the opportunity to broaden the public revenue base. Our original report clearly showed how continued reliance on a payroll tax to finance the health system will not generate sufficient public revenue in future. We recommended two complementary measures: applying the social tax to non-wage income (effectively turning it into an earmarked income tax) and contributions by the state on behalf of pensioners. Recent debate in this area seems to have focused on capping the social tax (which would shrink rather than broaden the public revenue base), creating an expanded role for voluntary health insurance or some form of medical savings accounts and increasing "individual responsibility" for health. Such measures may appease stakeholders – especially those with a particular ideological perspective – but they are unlikely to help the health system secure goals such as improving health, providing financial protection and enhancing efficiency in resource use.

Third, our original report emphasized the need for more stringent and strategic control over investment in the health sector (particularly hospital infrastructure and expensive equipment). The OECD economic survey also identifies further rationalization of hospitals as a key means of securing efficiency gains. However, the absence of political will to pursue full implementation of the Hospital Master Plan is likely to put further pressure on health care expenditure.

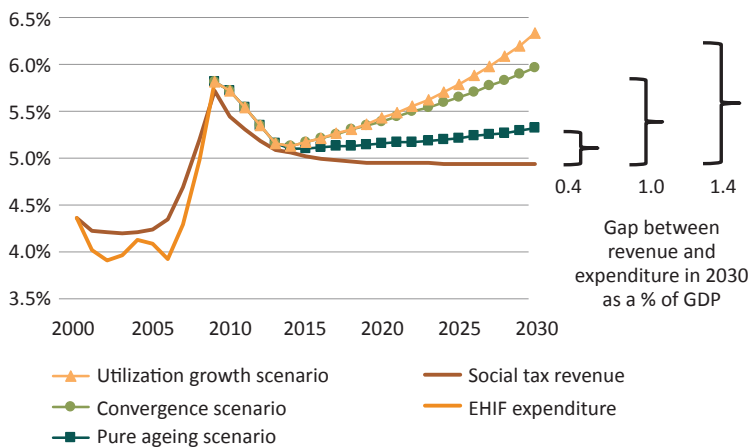
The recession has shown how well-equipped the health system has been to respond to a relatively short period of retrenchment, at least compared to many other countries. Much of this is the result of pragmatic but careful action on the part of EHIF and the Ministry of Social Affairs, notably their efforts to align incentives and preserve financial protection while having to make difficult cuts in prices and coverage. The recession has highlighted two further issues: the limits of heavy reliance on payroll taxes to finance health care when the ratio of economically active to inactive people is declining, which is likely to add to labour costs, jeopardize access to health services and shrink the valuable pool of health care professionals, and the vulnerability of non-earmarked spending such as state budget allocations for public health to economic fluctuation.

Introduction

Why another report?

In April 2010 we published a report assessing Estonian health financing policy and projecting health sector revenue and expenditure trends from 2010 to 2030.¹ The report's projections examined the impact of a range of demographic, labour market, macroeconomic and health system factors under different scenarios (Figure 1). All scenarios found that health expenditure will consume a greater share of national wealth in future, but health system factors – technological development and utilization patterns – were shown to have a much larger impact on expenditure than demographic factors such as population ageing. If health care use 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 increased use of prescription drugs, with serious implications for financial protection, equity and efficiency.

Figure 1. Projected trends in EHIF revenue and expenditure (as a % of GDP) under different scenarios, 2000-2030²



¹ Thomson S, Vörk A, Habicht T, Rooväli L, Evetovits T, Habicht J (2010). Responding to the challenge of financial sustainability in Estonia's health system, report prepared for the Ministry of Social Affairs in collaboration with the Estonian Health Insurance Fund and the World Health Organization. Copenhagen, WHO Regional Office for Europe. Available at: <http://www.euro.who.int/en/where-we-work/member-states/estonia/publications3/responding-to-the-challenge-of-financial-sustainability-in-estonia's-health-system>.

² The baseline pure ageing scenario captures the impact of changes in population size and structure on health expenditure, assuming that unit costs develop in line with per capita GDP growth. The utilization growth scenario assumes that unit costs will develop in line with growth in per capita GDP and that health service use reflects trends of the last five to ten years. It also assumes that there are unmet needs in areas like long-term care, that there will be increased use due to technical innovations in diagnosis and treatment and that there will be a trend toward more cost-effective services like day care or primary care. The convergence scenario assumes that health expenditure will grow faster than per capita GDP due to technological development, health sector salaries growing faster than those in other sectors, higher expectations due to improved living standards and a desire to catch up to more developed neighbours and political decisions about levels of health sector salaries and benefits.

The 2010 report had three key messages:

- The public revenue base for the health sector should be broadened to ensure that the 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.

This brief document identifies the main changes to health financing policy since we began preparing the original report in April 2009. Its intention is not to measure the impact of the 2010 report, but to review progress in areas the report highlighted as likely to have a significant effect on the health system's financial sustainability. Following up would be a useful exercise under most circumstances; in Estonia's case it is particularly compelling due to the economic and political changes that have occurred in the last few years: joining the Organisation for Economic Cooperation and Development (OECD), the election of a new (but familiar) government, and fiscal pressures created by a sustained recession, growing unemployment and entry to the Eurozone.

Recession, the Euro and a new government

The last two years have seen several important economic and political developments, all of which have had implications for health policy. In 2010 Estonia qualified for Eurozone entry; it officially adopted the Euro as its currency in January 2011. To meet the convergence criteria for entry to the Eurozone, economic policy has focused on lowering the budget deficit, debt levels, inflation and interest rates. At the same time, Estonia has had to cope with recession, which began in 2008. Although its economic situation has not been as critical as that in neighbouring Baltic countries, unemployment among people aged 15–64 has risen significantly, from 4.8% in 2007 to 14.1% in 2009 and 17.3% in 2010.³

In March 2011 Estonians went to the polls to elect a new government. As expected, the Reform Party gained more votes than any other party and formed a majority government with Pro Patria & Res Publica (the party with the third-highest share of the vote), maintaining the status quo. Health was not an important issue during the election campaign and did not feature in debates between the parties. However, all parties included health in their election platforms. The most common strategic risk identified across parties was the lack of a coherent approach to health infrastructure and the health workforce.⁴ Party differences on health policy generally reflect differing views on the role of the state. The prevailing view of the leading party in the new government is that economic growth will pave the way for greater spending on social welfare.

³ http://pub.stat.ee/px-web.2001/1_Databas/Social_life/09Labour_market/12Unemployed_persons/02Annual_statistics/02Annual_statistics.asp

⁴ Valimislubaduste analüüs: selged valikud tervishoiupoliitikas, Poliitikauringute Keskuse Praxis väljaanne, nr 6 2011, (Analysis of election promises: clear options in health policy) available at: http://www.praxis.ee/fileadmin/tarmo/Projektid/Valitsemine_ja_kodanike%3BChiskond/OSI_valmisalanueesid/Valimislubadusteanalysys_tervishoid.pdf

In April the new government issued a coalition agreement including the following health system changes:

- *financing and coverage*: changing EHIF's budgetary responsibilities so that its resources are mainly spent on health care services (rather than on cash benefits for sickness leave); establishing a new scheme covering occupational health risks and temporary or permanent incapacity to work; exploring ways of expanding the role of voluntary health insurance (VHI);
- *human resources*: training more new family doctors and introducing grants to encourage newly qualified doctors to work in general hospitals in small towns and rural areas;
- *health promotion and prevention*: creating opportunities for family doctors to influence individuals' health behaviour, increasing the availability and use of health check-ups and screening programmes and revising national policy on tobacco and alcohol use;
- *pharmaceutical policy*: reviewing user charges for prescription drugs with a view to lowering out-of-pocket payments for patients and increasing the role of the government in negotiating drug prices;
- *health care quality*: adapting the quality bonus system for family medicine to enable practices to hire a second nurse for prevention and chronic care management, increasing provider competition and the extent to which money "follows the patient", introducing network-based cancer care and improving the supply of long-term care and home nurse care; and
- *user involvement*: increasing the extent to which people take responsibility for their own health and enabling people to track their EHIF-financed health care spending via the Internet.

The structure of this report

This document is divided into four main sections based on the recommendations made in the original report. Each section summarizes the rationale for the recommendations and comments on developments and debates that have taken place since April 2009.

1. Broadening the public revenue base

Key recommendations and their rationale

- 1.1 The key elements of the current system should be left in place.
- 1.2 The public revenue base should be broadened.
- 1.3 The central government should make contributions to EHIF on behalf of pensioners.
- 1.4 In the interests of fairness, the government should apply the social tax to capital investment dividends.
- 1.5 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 taxes (or parts thereof) for health, the government should establish a clear formula for allocating resources to avoid yearly fluctuations.

Estonia's single-payer system has served well since it was established in the early 1990s, providing a stable source of revenue. Central revenue collection, national pooling and centrally set prices contribute to resource use efficiency, while the breadth, scope and depth of coverage provide financial protection and 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, ensuring clear lines of accountability and transparency in the social sector as a whole.

While recognizing these achievements, the original report identified some concerns:

- Public spending on health as a proportion of general government expenditure is low by European Union standards and fell between 2000 and 2007. It is also low as a proportion of GDP, reflecting the relatively small size of government. There was broad acknowledgement among stakeholders of the constraints posed by inadequate public spending on health.
- As a result of population ageing and rising unemployment, EHIF's ratio of contributors to non-contributors will decline. Even with increases in average wages, its revenue will not grow sufficiently to match health expenditure in 2030 (Figure 1). There was 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 felt that public perceptions of the system's fairness might be undermined because older people benefit from EHIF coverage without contributing to its costs at the time of use. The report recognized 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. It also noted that investors can avoid paying some of the social tax if they choose to be paid mainly in dividends, but they still benefit from EHIF coverage.
- Some stakeholders expressed concern about the potential for greater reliance on transfers from the central government budget to undermine stability and transparency in financing the health sector.

Developments and outcomes

The government has not taken any steps to broaden the public revenue base. At the same time, the Ministry of Social Affairs has reduced the amount it allocates to the health sector. This has had some significant short-term consequences.

- Falling salaries and rapidly rising unemployment caused EHIF's revenue to decline in 2010. The decline in revenue, combined with government restrictions on the use of reserve funds, led to a 6% cut in health care prices. In 2011 prices rose slightly, but were still 5% lower than 2009 prices (only 3% lower for primary care). From 2012 prices will be restored to 2009 levels.
- In 2010 the salaries of health professionals fell by 4%.⁵ Civil servants experienced a more dramatic reduction in their salaries (a cut of 17% in the Ministry of Social Affairs, for example).
- As a result of price and salary cuts, waiting times have doubled, rising from 20 to 45 days for specialist outpatient care and from 30 to 60 days for inpatient care (EHIF *Annual Report 2010*). **Thus, the financial crisis has highlighted the risks to the health system of heavy reliance on labour-market-based financing.**
- The relative ease with which the government was able to cut the non-earmarked part of the health budget when it faced a fiscal constraint underlines the importance of securing a stable and transparent flow of funds to the health sector. There have been cuts in two areas in which health expenditure is not earmarked: public health spending and capital investment financing.
- In 2009 the government's budgetary transfer for public health was 18% lower than in 2008 and fell by a further 6% in 2010.⁶ Although it is set to rise in 2011, it will still be 6% lower than in 2008. The shortfall in government spending was made up for by grants from the European Structural Funds (ESF), whose share of public spending on public health rose from 0.5% in 2008 to 28% in 2010 and is projected to rise again to 39% in 2011.⁷ Greater reliance on EU funds presents a threat to financial sustainability since once these funds are no longer available (officially from 2013, but they could be depleted by 2012), it may be difficult to make up the shortfall from the government budget.
- Under legislation introduced in 2008,⁸ the government is required to finance capital investment in the health sector through transfers to EHIF. In 2008 the Ministry of Social Affairs allocated some funds (not the full amount), but since then it has not made any further transfers, effectively pushing financial responsibility for capital investment onto EHIF. Since 2010 facilities that have not already benefited from ESF can apply to the government for funds generated through carbon quota trading to renovate premises.⁹ While the value of the health facility renovations is relatively small (around €8 million), the policy does not seem to be in line with the national strategy for hospital infrastructure.
- **The financial crisis has also shown how some areas of health spending are more vulnerable to economic fluctuation than others.** Public spending on public health and capital investment are not secured through earmarking in the way that the public revenue pooled by EHIF is, nor does it benefit from accumulated reserves, as EHIF does. The government's decision to cut spending in

⁵ EHIF Annual Report 2010.

⁶ Ministry of Social Affairs calculations.

⁷ Ministry of Social Affairs calculations.

⁸ <http://www.riigikogu.ee/?op=steno&stcommand=stenoqramm&date=1291637100>

⁹ <http://www.rkas.ee/teenused/co2/co2-koondnimekiri>

these areas has been mitigated by the availability of EU funds, but relying on external funding does not address the issue and is unlikely to be a long-term option.

Debates

While many stakeholders acknowledge the importance of broadening the health system's public revenue base, no action has been taken in this area and it is not mentioned in the Coalition Agreement. The Ministry of Finance is due to publish a study of the financial sustainability of social spending in the autumn of 2011, which is likely to include some discussion of alternative options for financing health care. The three main options under debate in recent months are capping the social tax, breaking the link between the part of the social tax earmarked for health and the labour market and requiring the government to make contributions to EHIF on behalf of pensioners. The first two options are intended to lower labour costs, a key government objective.

A cap on the social tax has been heavily promoted by the Employers' Association, with the support of the Ministry of the Economy, to encourage employers to recruit higher-paid, innovative people. However, research has questioned the likelihood of this outcome being achieved.¹⁰ In our original report (pp103–104) we rejected the option of capping the social tax on the grounds that it would restrict rather than broaden the public revenue base and would be regressive, allowing richer workers to pay proportionately less than poorer workers. Following debate, the Coalition Agreement proposed only applying a cap to the part of the social tax earmarked for pensions.

Breaking the link between the health part of the social tax and employment would be a welcome step if: a) it were accompanied by an expansion of the levy base from earned income to all income, in line with the original report's recommendation to apply the social tax to dividends and b) the de-linked tax maintained its earmarked status, so as to allay concerns about the stability and transparency of public revenue for health. **France effectively transformed the earmarked payroll tax it used to finance social security into an earmarked income tax in the mid 1990s.**¹¹ Different rates for active and non-active people made the French tax more progressive tax as well.

The option of the government making contributions to EHIF on behalf of pensioners was discussed in the parliamentary Social Affairs Committee consultation of 2010 and in two parliamentary debates (December 2010 and January 2011).¹² This would also be a welcome step if: a) it were based on a clear resource allocation formula, such as a fixed percentage of average income and b) the formula were countercyclical (moving in the opposite direction to the current economic cycle). **In 2004 Slovakia changed from a system in which government contributions on behalf of the non-active population were arbitrary (based entirely on political decisions) to one in which the contributions are set as a proportion of the average wage in the year before last. Lithuania has a similar policy.**¹³ This ensures contributions are higher rather than lower during a recession (provided the recession is not prolonged). A clear and countercyclical resource allocation formula would allay concerns about stability and transparency, particularly in the context of economic fluctuation. This option would also allay

¹⁰ http://www.praxis.ee/fileadmin/tarmo/Projektid/Valitsemine_ja_kodanikeuuhiskond/Kodaike_ja_politikakujundajate_dialogo_VUF_/praxis_nr5_veeb.pdf

¹¹ Sandier, S. *et al* (2004). *Health care systems in transition: France*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

¹² Available at: <http://www.riigikogu.ee/?op=steno&stcommand=stenoqramm&date=1291878300>; <http://www.riigikogu.ee/?op=steno&stcommand=stenoqramm&date=1296111900#pk7977>

¹³ Szalay, T. *et al* (2011). *Health Systems in Transition: Slovakia*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies. Article 16 of the Lithuanian Law on Health Insurance.

concerns about the perceived unfairness of pensioners being key beneficiaries of the health system but not contributing to its costs at the time of use.

Some stakeholders have expressed interest in expanding the role of voluntary health insurance and introducing medical savings accounts. There has not been any structured debate on these issues and the interest of insurance companies seems to have declined over time.

Key issues

The government has not taken steps to secure the long-term financial sustainability of the health system or to address concerns about the stability and transparency of public spending on health. Recession, the absence of government action to broaden the public revenue base and strict constraints on EHIF's use of its reserve funds have led to cuts in public expenditure on health and increased waiting times for specialist health services. Some of the shortfall in public spending has been countered using EU funds, but this is very much a short-term measure and raises questions about what will happen when the current round of EU funds ends in 2013.

2. Strengthening financial protection

Key recommendations and their rationale

- 2.1 National policy on the rational use of drugs should be strengthened by introducing clear incentives for enforcing the compulsory generic prescription policy and establishing a policy of generic substitution for pharmacists.
- 2.2 User-charge policies for all health services should be reviewed with an eye to simplification, improved targeting and strengthened direct and indirect protection mechanisms; savings from a more efficient use of drugs could be used to exempt the poor and heavy health care users from charges.
- 2.3 The Ministry of Social Affairs should continue to monitor financial protection in the health system and make sure that services such as primary care continue to be free at the point of use.
- 2.4 In the medium term the government should review EHIF's benefit package and set a timetable for increasing the coverage of effective services such as adult dental care.

Current health financing policy ensures financial protection and generally equitable access to primary care (free at the point of use) and specialist care (subject to limited cost sharing). Nevertheless, the original report highlighted several concerns.

- 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 out-of-pocket payments. The OECD 2011 economic survey of Estonia also highlighted this decline.¹⁴
- There is evidence of financial barriers to accessing outpatient prescription drugs, dental care and specialist visits.
- There is also evidence that user charges and pharmaceutical policies have not only failed to contain costs but have also led to inefficient use of private and public resources.
- The rise in VAT on pharmaceutical products from 5% to 9% in 2009 has increased the cost of medicines and medical devices to EHIF and patients.
- In 2009 an EHIF survey of prescribing patterns based on 800 prescriptions from 90 providers found that about half of all prescriptions were not active-ingredient-based, in spite of legislation making active ingredient prescribing mandatory.¹⁵

Developments and outcomes

Rational use of drugs: 2010 saw several changes to pharmaceutical policy aimed at strengthening the rational use of drugs, reflecting a significant shift in thinking on generic drugs (previously an under-discussed issue). These changes show some positive outcomes.

¹⁴ http://www.oecd.org/document/42/0,3746,en_2649_34569_47468397_1_1_1_1,00.html

¹⁵ Summary report (2009) on medical record check-ups: http://www.haigekassa.ee/uploads/userfiles/uhuvalik_kodukale_2009.pdf

- In March 2010 the Ministry of Social Affairs initiated amendments to the ministerial decree on drug prescriptions to support active ingredient-based prescription and dispensing. The amendment did not change prescription rules, but does require pharmacies to provide patients with the drug with the lowest level of cost sharing and to note if patients refuse cheaper alternatives.
- In April 2010 the Health Insurance Act was amended to extend the application of price agreements and reference pricing to medicines in the lowest (50%) reimbursement category (some effective drugs and many less cost-effective drugs). Price agreements previously only applied to drugs reimbursed at higher rates (100%, 90% and 75%). The amendment – unsuccessfully proposed before – aims to lower the cost of these drugs to EHIF and patients.
- In September 2010 EHIF launched an annual generic drug promotion media campaign in cooperation with the Ministry of Social Affairs, the State Medicines Agency (SMA) and the Association of Family Physicians (AFP). The campaign has been actively supported by family physicians and has only encountered opposition from the pharmaceutical industry.
- At the beginning of 2010 EHIF and the Ministry of Social Affairs launched a new e-prescription system, which currently operates alongside paper prescribing. The new system makes active ingredient-based prescription easier and EHIF is using it to develop a quality bonus indicator related to generic prescription, which will become operational once e-prescription is fully implemented.
- Preliminary analysis shows that patient cost sharing per prescription has fallen, probably for the first time (data are only available for the last five years). In 2010 it was €0.32 lower per prescription than in 2009.¹⁶ Overall, out-of-pocket payments for prescriptions have fallen by €4 million since 2009.

User-charges policy: Existing user charges have not been increased and primary care remains free at the point of use. However, there have been some reductions in the depth of EHIF coverage:

- In January 2010 the government introduced 15% coinsurance for inpatient long-term care (LTC). This change was intended to allow EHIF to finance more LTC contacts in non-hospital settings (for example, through home nursing). It generated 31 million krooni (€2 million) in 2010, which was used to purchase more LTC cases.¹⁷ The original aim (set out in the Long-term Care Strategy 2015) was for the rate to be raised to 30% in 2014 and for out-of-pocket costs to be shared between patients and municipalities, but the raise has been set aside for now.
- In July 2009 EHIF reduced coverage of temporary sick leave benefits from 80% to 70% of salary. Patients are no longer covered on days two and three of sick leave and employers now cover days four to eight. EHIF coverage has therefore decreased from day two onwards to day nine onwards. The change decreased EHIF revenue by 8% in 2010. Following the reduction in coverage, the number of cases of incapacity to work has fallen by 29%.¹⁸
- In January 2009 EHIF also abolished a cash benefit for yearly preventive dental visits for adults (but coverage remains for pensioners, pregnant women and women with children under a year old). Cutting this benefit saves EHIF about €3.3 million per year.

¹⁶ In 2009 the average prescription cost was €8.02. <http://www.haigekassa.ee/haigekassa/uudised?news=patsientide-omaosalus-soodusra>

¹⁷ See EHIF's supervisory board decision on amending the Health Care Services List: [http://www.haigekassa.ee/uploads/userfiles/otsus%20nr_13%20TTL\(1\).doc](http://www.haigekassa.ee/uploads/userfiles/otsus%20nr_13%20TTL(1).doc)

¹⁸ EHIF Annual Report 2009.

Debates

In 2010 family physicians proposed areas in which they might introduce user charges for patients, including a fee per visit (50 krooni) and for preventive check ups to lower the number of unnecessary visits and to be on a par with specialists. The Ministry of Social Affairs has agreed to include some items on a negative list, meaning patients will have to pay for them in full. These items include sports-club related examinations, pre-cosmetic surgery consultations, travel vaccinations, etc.

The Ministry of Social Affairs has proposed abolishing the 200 krooni cap on EHIF reimbursement of 50% drugs (effective from January 2012) to provide patients with greater financial protection. This has not been implemented due to EHIF budgetary constraints, but it would be good to revisit this issue and exemptions from prescription drug cost sharing more generally. Savings from increased generic prescription and dispensing could make enhancing financial protection an expenditure-neutral option.

Key issues

New policies to facilitate generic prescription and dispensing and extended price controls seem to have paid off in terms of more use of cheaper drugs, better financial protection for patients and greater public and professional understanding and acceptance of rational drug use. However, there is still no state-level registry classifying generic drugs. Although classification presents technical challenges, the absence of a registry makes it difficult to monitor performance in generic prescription and dispensing.

Coverage reductions in long-term care, dental care for adults and sickness leave benefits need to be carefully monitored for their impact on financial protection, access to services and health outcomes.

3. Strengthening performance through better resource allocation and purchasing

Key recommendations and their rationale

- 3.1 The Ministry of Social Affairs should continue to tackle excess hospital capacity by fully implementing the Hospital Master Plan (HMP) and developing a stronger strategy for guiding investment in and design of hospital infrastructure – one that would adjust the balance of power in favour of the health system rather than hospital management.
- 3.2 The Ministry of Social Affairs and EHIF should establish a central policy to control investment in expensive hospital equipment.
- 3.3 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 and prevention and to promote Health in All Policies (HIAP), which could also help to alleviate cost pressures associated with the burden of chronic ill health.
- 3.4 The Ministry of Social Affairs should work with EHIF to boost the primary care focus of the health system, for example by strengthening GPs' gate-keeping and coordination function, equipping them with the tools to steer patients through the system, improving their governance and accountability and extending free primary care to the whole population (not just those entitled to EHIF benefits).
- 3.5 The two agencies should also cooperate to enforce existing strategies to encourage rational drug use and introduce new strategies such as financial and non-financial incentives for doctors and pharmacists.
- 3.6 EHIF should focus on aligning 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.
- 3.7 EHIF should also strengthen efforts to base reimbursement decisions on evidence of the comparative effectiveness and cost-effectiveness of different interventions, including use of tools such as HTA.

The Estonian health system already performs well in many areas and EHIF is internationally recognized for its achievements. Nevertheless, the original report noted that 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.

Developments and outcomes

Developing a strategy to tackle excess capacity: There has been no change in the government's strategy for capital investment or investment in expensive hospital equipment.

- The HMP review process led by the Ministry of Social Affairs ended in December 2009. Although it set new principles for hospital development, they do not seem to have had much impact.¹⁹

¹⁹ Habicht J, van Ginneken E (2010). Estonia's health system in 2010: improving performance while recovering from a financial crisis. *Eurohealth*, 16(2):29–32.

- There has not been sufficient political will to reclassify general hospitals as local hospitals, as envisaged in the HMP (government decision of 14 August 2009).

Generating sufficient investment in public health and prevention: State funding for public health programmes has declined since 2008.

- The shortfall has largely been covered by EU funds. While this presents an opportunity to set priorities for future funding of public health interventions, it is also a concern, as noted above. The prevention and health promotion share of EHIF's budget has not fallen.
- Alcohol and tobacco excise taxes have been raised four times since the beginning of 2008, with a further raise due in January 2012. Various EU-funded alcohol awareness campaigns were launched in 2010 by the National Institute for Health Development. The impact on health of VAT and excise tax increases has not been fully analyzed, but preliminary research shows that the affordability of beer fell for the first time in 2008, and that alcohol consumption has fallen since 2007.²⁰

Boosting the primary care focus of the health system: Several changes have taken place, and others are under consideration.

- In 2010 the Health Service Organization Act was amended to increase the role of nurses and midwives. From September 2010 school health services have been fully provided by nurses. Nurses have also been given some limited prescribing rights.
- AFP introduced a quality handbook for family doctors in 2010.
- In 2011 unit price reductions in health service prices were lower for care provided by family doctors to protect access to primary care.
- A draft amendment to the Health Insurance Act to restrict direct access to specialists is under consideration by the Ministry of Social Affairs, requiring a referral to specialist care for chronic diseases. Family doctors support the amendment, but there has been some negative feedback from TB doctors.
- There is debate about centralizing family doctor governance (currently the responsibility of the central government at the county level) in the National Health Board.
- The State Audit Office produced a report on the organization of family doctor services in April 2011,²¹ noting the importance of providing free access to primary care services and pointing out that the accessibility of family doctors had fallen in recent years. The report also suggested that family doctors over-refer patients to specialist care, at considerable additional cost to the health system. Strengthening primary care will require action on several fronts.

Sustaining the shift from inpatient to outpatient care and day case surgery: EHIF analysis shows that in the past many day cases were actually ambulatory surgical procedures (of less than four hours' duration) and EHIF had therefore been overpaying hospitals.

²⁰ Lai, T. and J. Habicht (2011). Decline in alcohol consumption in Estonia: combined effects of strengthened alcohol policy and economic downturn. *Alcohol and Alcoholism* 46(2): 200-203.

²¹ Available at: <http://www.riigikontroll.ee/Suhtedavalikkusega/Pressiteated/tabid/168/ItemId/596/View/Docs/amid/557/language/et-EE/Default.aspx>

- EHIF has focused on shifting the relative volume of ambulatory, day and inpatient cases, targeting day cases in its budgeting and contracting. However, there has been some resistance from hospitals.
- A new DRG grouper introduced in 2011 distinguishes between one-day and longer cases to encourage day-case development. This provides more opportunity to look at the actual content of day cases.

Promoting evidence-based medicine: EHIF has been promoting and supporting HTA development in Estonia in an ongoing process to develop common understanding of the need for evidence to support decision making and clinical practice.

- In 2010 the Department of Public Health at Tartu University began to carry out health technology assessments.
- In 2010 EHIF began to update the clinical guideline development process to make guidelines more evidence-based. The process aims to involve more university-based medical faculty, raise awareness of evidence-based medicine among doctors, encourage doctors to be more critical of evidence sources, adapt guidelines to the Estonian situation, secure guideline dissemination, implementation and uptake and monitor progress.
- A change in legislation in September 2008 came into force in 2010. As a result, there is a more transparent basis for assessing medical devices before including them in the benefits package for reimbursement (similar to the process for health care services and pharmaceuticals).

Key issues

The continuing absence of a strong national strategy for guiding investment in health infrastructure and expensive equipment represents a major challenge to the health system's financial sustainability in the medium and longer term. A 2010 report by the State Audit Office on the HMP criticized the government for failing to develop a clear strategy for the hospital sector. The OECD's 2011 economic survey also highlights further rationalization of the hospital sector as a priority. Nonetheless, the Coalition Agreement makes no mention of plans to develop a strategy for investing in health. Greater reliance on external funding for investment in public health is also a concern. EU funds are unlikely to be a long-term source of financial support and restoring pre-recession levels of state funding may be difficult.

Positive developments include steps to strengthen primary care and enhance efficiency in the use of family doctor and specialist resources. If carefully supported by appropriate financial arrangements, extending GP gatekeeping to people with chronic conditions could be a significant achievement, resulting in less unnecessary use of specialist care and better coordination for patients. However, obtaining genuine change in care patterns will require more than just thinking about how providers are paid, as the recent State Audit Office report on family doctors suggests. EHIF's introduction of a new DRG grouper for day cases is another welcome development.

The financial crisis has forced EHIF to lower the unit price of health services and increase maximum waiting times, but it has enabled it to do so without significant public and professional opposition. Sustained pressure on hospitals to operate at lower levels of reimbursement may adversely affect the adequacy of inputs, however, and there are real concerns about potential shortages in human resources for health, particularly nurses.

4. Maintaining strong governance

Key recommendations and their rationale

- 4.1 EHIF should continue to invest in and improve the monitoring and evaluation of 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.
- 4.2 Along with 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 into the health sector (especially for those areas financed from the central government budget, such as emergency care and public health), supporting institutions in carrying out their mandates and being accountable and promoting Health In All Policies.
- 4.3 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.
- 4.4 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.

Developments and outcomes

Improving the monitoring and evaluation of provider activity across the health system: EHIF continues to support the development of quality indicators, with the help of e-health.

- The new e-prescription system allows EHIF to include a quality bonus indicator for prescribing by family doctors. E-health development has not been so fast in the hospital sector, where an e-registration system would make waiting time data more transparent and useful for referrals from primary care, but is being resisted by hospitals. Also, more attention should be paid to improving the quality of e-health data input so that they can be used to support clinical decision making.
- The Ministry of Social Affairs is developing a cancer care quality strategy. The initial aim was to focus on two national centres of excellence, but following resistance from hospitals the Ministry of Social Affairs is aiming to complement this approach by supporting the development of network-based care.

Providing policy direction for the whole health system and promoting Health In All Policies: EHIF and the Ministry of Social Affairs continue to make progress in this area.

- Public health issues were discussed in a series of six public Social Affairs Committee discussions in 2010, concluding with two special sessions of Parliament on public health and health care as matters of significant national importance (December 2010 and January 2011).²² Following these debates it was decided to enlarge the Public Health Development Plan 2009–2020 steering com-

²² Available at: <http://www.riigikogu.ee/?op=steno&stcommand=stenoqramm&date=1291878300>; <http://www.riigikogu.ee/?op=steno&stcommand=stenoqramm&date=1296111900#pk7977>

mittee (which approves public health action plans and reports) to include all political parties in Parliament.

- The National Institute for Health Development and the Ministry of Social Affairs have led active debate on the importance of good nutrition and addressing harm from alcohol consumption in improving public health, including discussion of the impact of marketing and the policies of other sectors.
- Health promotion (HIV, risky behaviours, etc.) will be added to the school curriculum in autumn 2011.

Highlighting the positive economic effects of investing in health: More could be done in this area. Securing sufficient financial and human resources for health is a major concern.

- The number of requests for papers to permit health professionals to work abroad rose by 35% in 2009,²³ and new medical graduates seem to be leaving the country, making emigration of health professionals a key issue.
- This trend may reflect cuts in remuneration, as health professionals' salaries fell in 2010 (4% for doctors, 2% for nurses and 1% for carers).²⁴ During the same period salaries in all sectors of the economy fell by 5%.²⁵

Avoiding further fragmentation in the flow of resources: Greater use of EU funds and government funds from carbon quota trading may have introduced some additional fragmentation. The use of the carbon quota funds to finance facility renovation also seems out of line with the national strategy for hospital infrastructure. The Ministry of Social Affairs should continue to try to ensure that new sources of funding are co-ordinated and aligned with existing priorities.

Key issues

Positive developments include a continuing focus on clinical quality indicators and parliamentary debate about public health and health care. However, it would be good to stimulate further public debate about the economic value of strategic investment in the health sector, including the importance of finding ways to secure a sufficient supply of skilled health professionals. **Policy makers should be aware that sustained cuts in health service prices can adversely affect the adequacy of inputs and it may be a challenge to replace depleted human resources.** It would also be prudent to remain vigilant about avoiding further fragmentation in financing flows to the health sector.

²³ 254 requests in 2009 vs 188 in 2008; <http://www.terviseamet.ee/tervishoid/tervishoiutootaja-registreerimine/aruanalus.html>

²⁴ EHIE Annual Report 2010.

²⁵ Data on average salaries of health professionals available at: http://pxweb.tai.ee/esf/pxweb2008/Database_en/HCresources/06PersonnelWages/06PersonnelWages.asp; http://www.tai.ee/failid/Tunnipalk_2010_esitus.pdf

Conclusion

The fiscal constraints imposed by the financial crisis and Eurozone requirements have been instrumental in increasing the political feasibility of many of the health system changes introduced since the launch of the original report in April 2010. This is particularly true of the decisions to lower health care prices and increase maximum waiting times in 2010 and 2011, which were intended to maintain reasonably good access to health care during a period of severe economic recession. It is noteworthy that these changes were achieved without significant public or professional opposition.

During this challenging period, the Ministry of Social Affairs and EHIF, in co-operation with SMA and AFP, have worked hard to encourage a more efficient use of resources through a range of initiatives such as extending price agreements and reference pricing to all reimbursed drugs, enhancing active-ingredient-based prescribing and dispensing, improving public and professional acceptance of generic drugs, extending gatekeeping to patients with chronic conditions, introducing a new DRG grouper to stimulate day-case care and continuing to encourage the use of HTA, clinical guidelines and quality indicators. At the same time they have tried to ensure financial protection for patients, particularly where primary care and prescription drugs are concerned.

These efforts have not been matched by political leadership in three areas of fundamental importance to ensuring the long-term financial sustainability of the health system. First, EHIF has had to lower health care prices and increase waiting times because the government has prevented it from drawing fully on its reserve funds. One of the risks of short-term retrenchment is that it may have lasting adverse effects on the supply of human resources. Had EHIF been able to draw on its reserve funds, it might have avoided this risk and maintained coverage of sickness benefits and compensation for preventive dental care for adults. Instead, it was forced to shift these costs onto households, at the risk of undermining financial protection, and was not able to lift the cap on reimbursement of cost-effective drugs in the 50% category.

Second, the government has so far failed to take the opportunity to broaden the public revenue base. Our original report clearly showed how continued reliance on a payroll tax to finance the health system will not generate sufficient public revenue in future. We recommended two complementary measures: applying the social tax to non-wage income (effectively turning it into an earmarked income tax) and government contributions on behalf of pensioners. Recent debate in this area seems to have focused on capping the social tax (which would shrink rather than broaden the public revenue base), creating an expanded role for voluntary health insurance or some form of medical savings accounts and increasing “individual responsibility” for health. Such measures may appease stakeholders – especially those with a particular ideological perspective – but they are unlikely to help the health system secure goals such as improving health, providing financial protection and enhancing efficiency in resource use.

Third, our original report emphasized the need for more stringent and strategic control over investment in the health sector (particularly hospital infrastructure and expensive equipment). The OECD's 2011 economic survey of Estonia also identifies further hospital rationalization as a key means of securing efficiency gains. However, the absence of political will to pursue full implementation of the HMP is likely to put further pressure on health care expenditure.

The recession has shown how well-equipped the health system has been to respond to a relatively short period of retrenchment, at least compared to many other countries. Much of this is the result of pragmatic but careful action on the part of EHIF and the Ministry of Social Affairs, notably their efforts to align incentives and preserve financial protection while having to make difficult cuts in prices and

coverage. The recession has highlighted two further issues: the limits of heavy reliance on payroll taxes to finance health care when the ratio of economically active to inactive people is declining, which is likely to add to labour costs, jeopardize access to health services and shrink the valuable pool of health care professionals, and the vulnerability of non-earmarked spending such as state budget allocations for public health to economic fluctuation.

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