The reform experience of Estonia

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- Dealing with a financial crisis
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Background

- 1.34 million inhabitants (falling slightly)
- GDP per capita in PPS: 64 (2009), 68 (2008), EU27=100
- Democratic parliamentary republic, member of NATO, EU and OECD
- Economy shrank by 14% in 2009
- Unemployment peaked early 2010
- Health expenditure (2008)
  - % GDP in 2008: 5.9% (EU12: 6.4%)
  - % government spending is similar to the EU27 average
  - PPP$ per capita: 1226 (EU12 1195) (WHO HFA)

Health Status

- Fertility rate 1.6 (EU12: 1.4)
- Life expectancy was 79.6 for men and 68.7 for women
- Main cause of death are cardiovascular diseases, followed by cancer
- Main public health challenge is premature mortality caused by external causes and life style related risk factors

Health reform in the early 1990s: securing sustainable financing

- Introduction of a decentralized SHI model
- Establishment of 22 non-competing sickness funds, purchaser–provider split
- Sickness funds collectors, no central pooling, no risk adjustment
- Funded through earmarked taxes (13% of salaries, paid by employers)
- The Ministry of Health (later of Social Affairs) steward of the health insurance system.
- No formal OOP payments until 1993.
- Many regional sickness funds recruited managers from outside the health sector

Mid-1990s: decentralizing the provider network

- Health service planning was delegated to the municipalities (Health Services Organization Act 1994)
- Substandard providers were closed
- Hospitals were granted full employer rights, including hiring and firing of personnel
- All medical staff began to work under private labour regulations
- PHC reform introduced family medicine as a separate medical specialty

But: lack of provider supervision and accountability and decentralized sickness funds widened inequalities between regions...

Therefore a recentralization of health financing

- Establishment of Central Sickness Fund (1994)
- Regional sickness funds were reduced to “only” 17
- Revenue was pooled centrally and reallocated to the regions on a capitation basis
- Introduction of hard budgetary constraints for regional sickness funds
- Only in 1999, did operating expenditure exceed revenue!
- Central fund eager to show its independence from the state budget and prove its ability to function autonomously in the health sector.
- Introduction of small co-payments for primary care and specialist visits

Late 1990s and early 2000s: further recentralizing the health system, clarifying the roles

- Stronger role for Ministry of Social Affairs in planning the provider network for specialized care primary care (Hospital Master Plan)
- Collection was assigned to the Tax Agency
- In 2001: establishment of the Estonian Health Insurance Fund (EHIF) as a public, independent legal body with seven regional departments (2003: four departments)
- Provider payment reforms (e.g. introduction of DRGs)
- Introduction of a positive list, a reference pricing system and price agreements
- Effective cost-containment

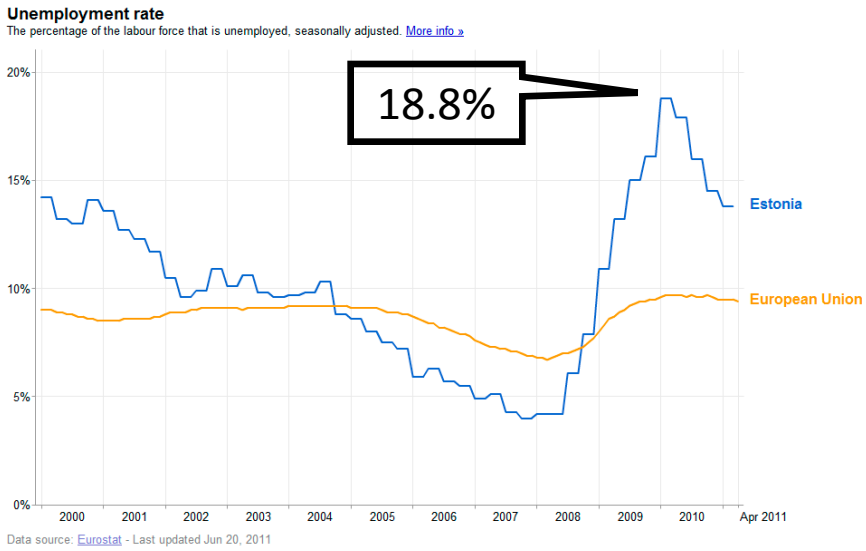
but OOP as % of THE doubled between 1997 and 2003 reaching 21%

Wrapping up:

- Estonia's health system has performed well
  - EHIF provided stable source of revenue
  - Central pooling and centrally set prices contribute to efficiency in utilisation
  - Generally equitable access to primary care and most specialist services
  - Transparency and accountability
  - Low administrative costs
  - Public spending on health as a proportion of general government expenditure fell between 2000 and 2007.

Financial crisis put the system to the test...

- Financial crisis led to shrinking revenues both in the public and private sectors drastically reducing funding for public health and investments in population health
- The bad labour market has had important repercussions for the funding of health care
- Although in 2007 EHIF coverage was extended to the registered and job-seeking unemployed, this contribution was lower than for an average worker



... but the system reacted vigorously

A tough austerity package was rolled out...

- Additional financial burden has been shifted to patients
  - cash benefits for dental checkups were excluded from the benefit package
  - VAT on pharmaceuticals was increased from 5% to 9% in early 2009
  - In 2010, a 15% co-insurance for inpatient nursing care was introduced
- Short term sick leave benefits weres shifted from the EHIF to workers and employers in mid 2009.
- Prices (6%) and salaries (4%) in the publicly financed health sector were cut
- The volume of contracted care was reduced by extending waiting times and by reducing treatment cases in specialist care by 5%, while simultaneously shifting more cases to day care and outpatient settings.
- Primary care volumes kept stable

Future challenges

- Challenges remain essentially the same as before the financial crisis
  - Reducing inequities
  - Improving regulation and governance of providers to ensure better public accountability and performance
  - Human resources and competences at all levels
  - The share of non-contributing individuals covered (such as children and pensioners) represents almost half of all the insured.
  - And thus ensuring sustainable health financing most probably by widening the revenue base
    - Contributions based on income rather than salaries
    - State contribution for pensioners

Further reading:

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