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

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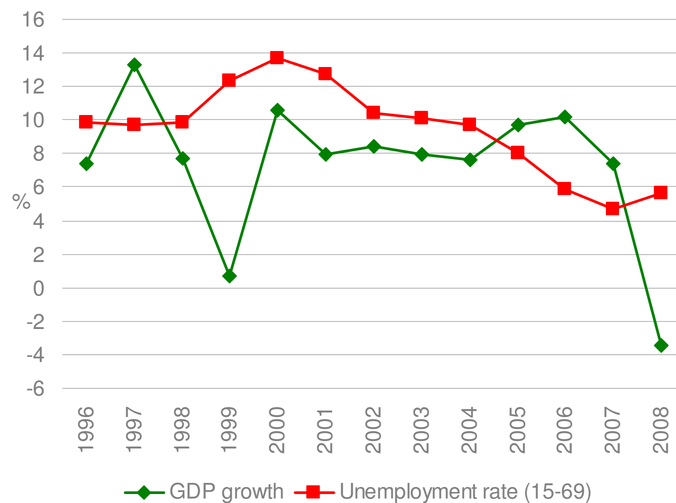
Outline

- macroeconomic context
- assessment of health financing policy
- projections
- options for change & stakeholder views
- recommendations

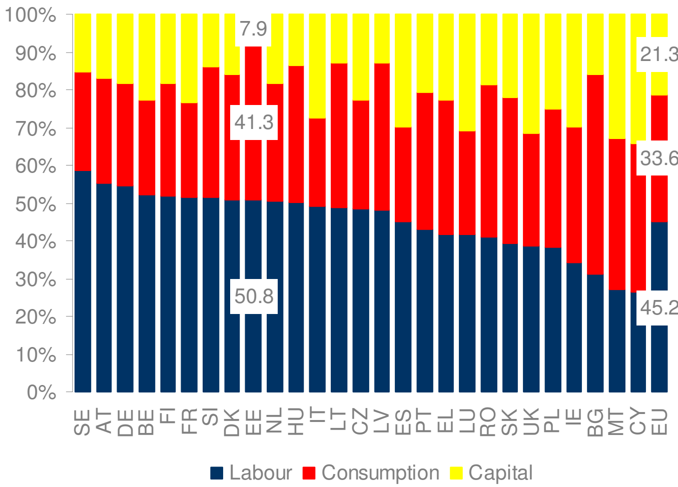
Macroeconomic context

Recent GDP & employment trends will not be sustained



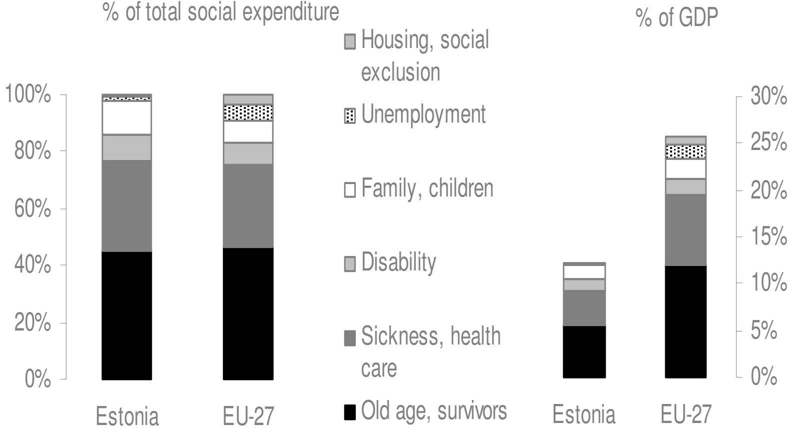
Source: Statistics Estonia

Estonia relies heavily on consumption & labour taxes



Source: Eurostat

Social expenditure is low as a % of GDP



Source: Eurostat

Assessment
health financing policy

Financing policy goals

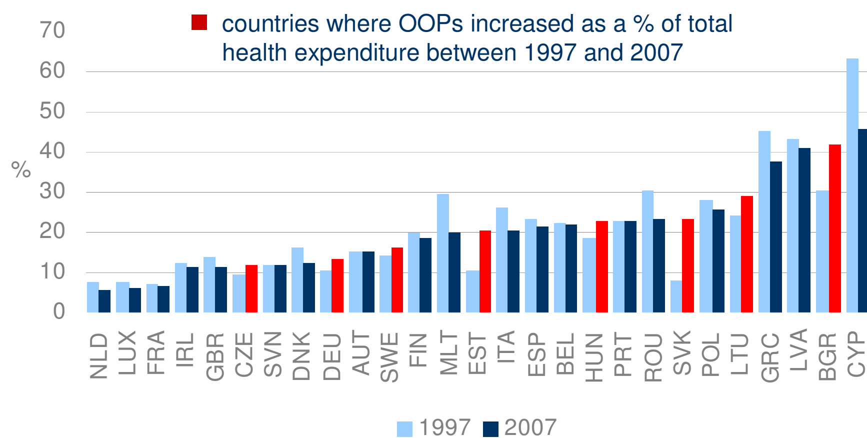
- financial protection
- equity in financing
- equity in service use
- quality & efficiency in service delivery
- administrative efficiency
- transparency & accountability to the public

Source: Kutzin 2008, WHO 2000

Financial protection & equity

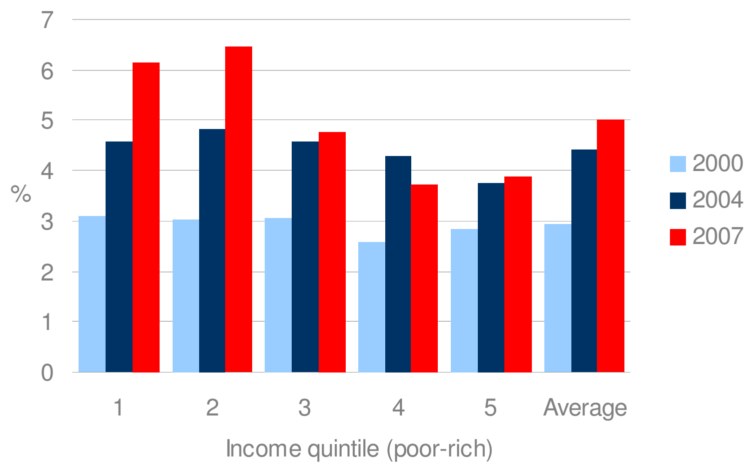
- coverage breadth: recently improved
- coverage scope: concerns about primary care for uninsured, dental care
- coverage depth: concerns about rising OOPs
- financial protection & equity have declined

OOPs have doubled as a % of total health expenditure



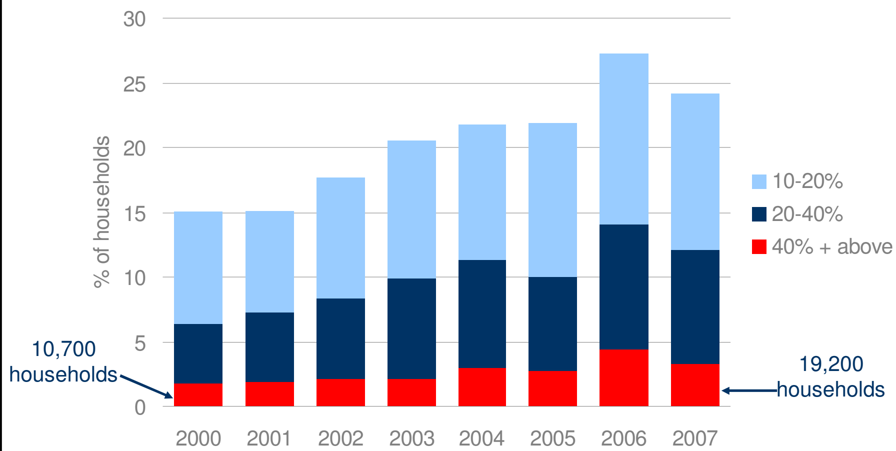
Source: WHO 2009

OOPs have become more regressive



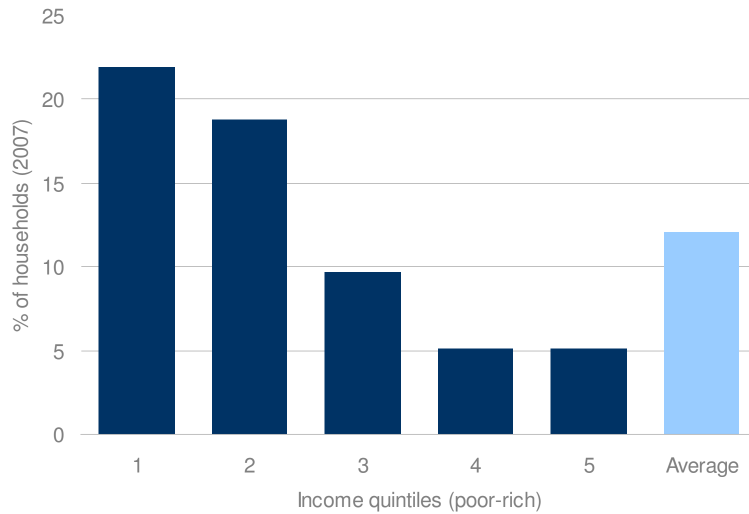
Source: Võrk et al 2009

Catastrophic health spending has increased



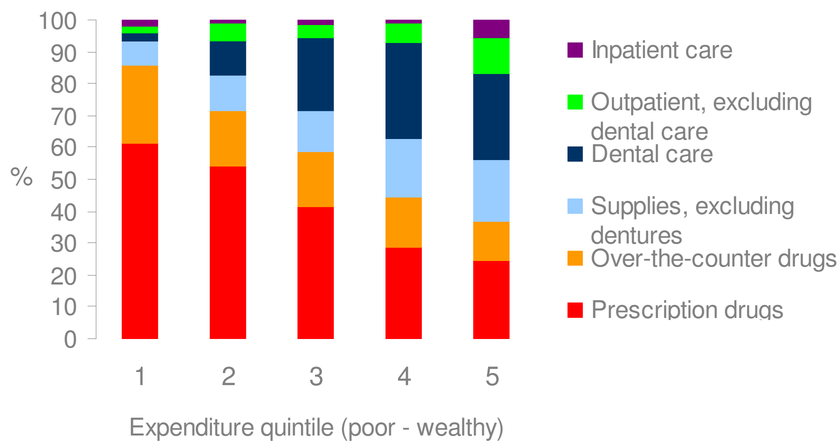
Source: Võrk et al 2009

Catastrophic spending is highest among the poor



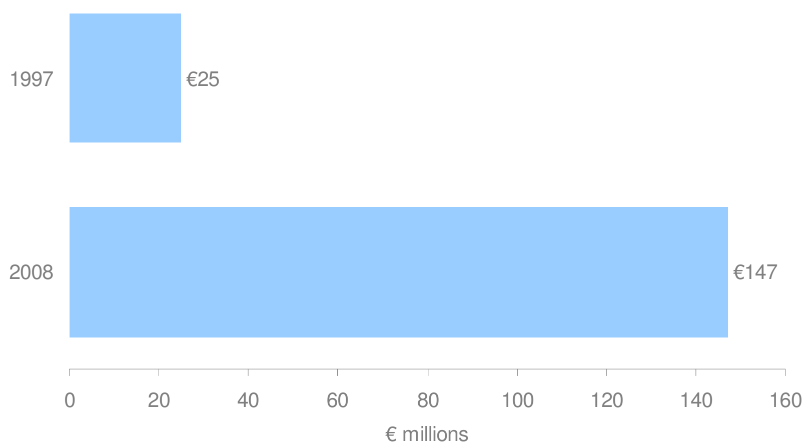
Source: Võrk et al 2009

The poor mainly spend on drugs



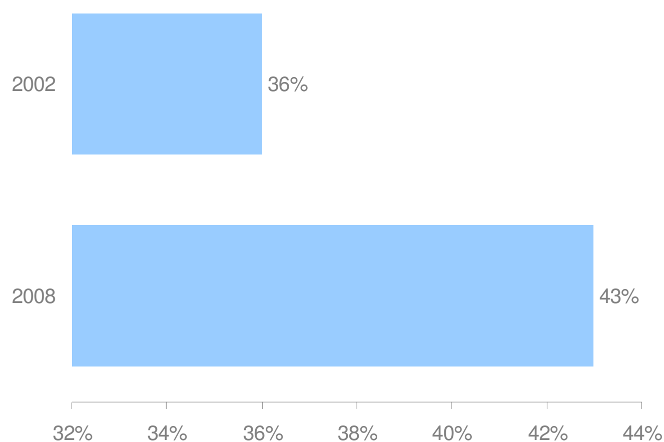
Source: Võrk et al 2009;data for 2007

Total spending on outpatient prescription drugs has grown



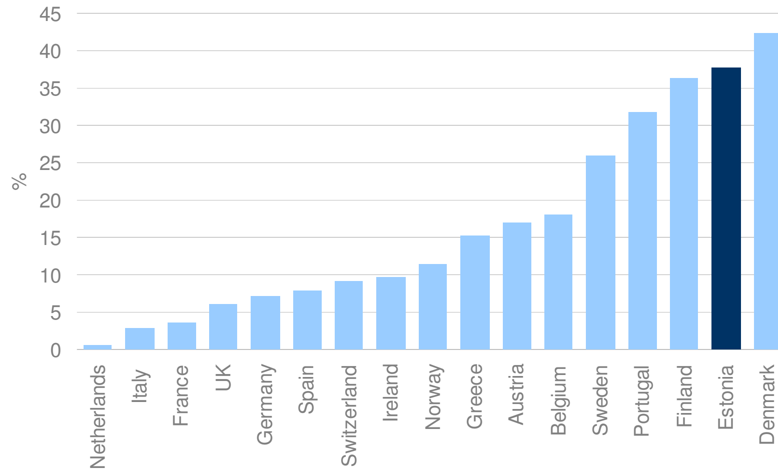
Source: Kanavos et al 2009

The patient share has also grown . . .



Source: Kanavos et al 2009; patient share of total spending on outpatient prescription drugs

. . . and is one of the highest in Europe



Source: Kanavos et al 2009; patient share of total prescription drug costs in 2006

Irrational drug use is expensive for patients and EHIF: the case of Ramipril

drug type	% patients dispensed	retail price (EEK)	co-payment (EEK)	patient share of cost
Brand	96.7%	170	76	44.7%
Generic	3.3%	131	48	36.6%

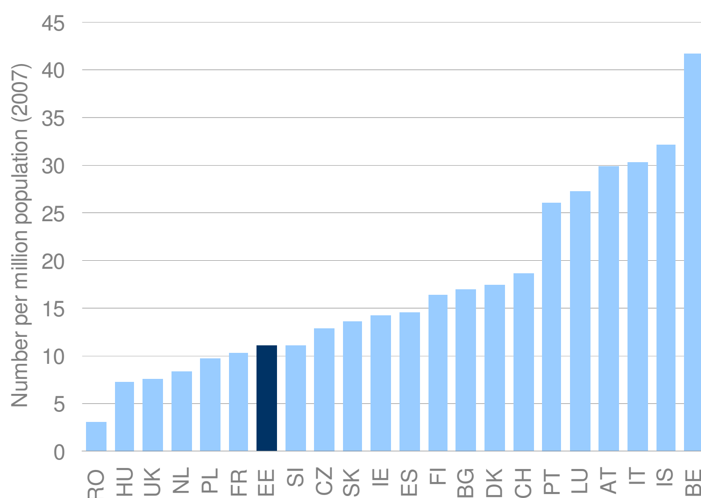
Source: Kanavos et al 2009; Ramipril is Estonia's most frequently used drug (in defined daily doses)

Incentives for quality & efficiency in care delivery

✓unified pooling & progress in strategic purchasing – but concerns about:

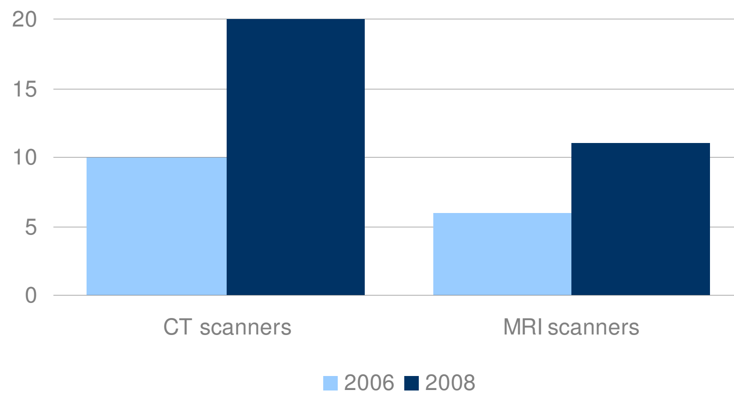
- matching resources to population needs
- delivering care at the right level
- unacceptable variation in care
- ensuring efficiency gains benefit the health system

CT scans per million: low by EU standards



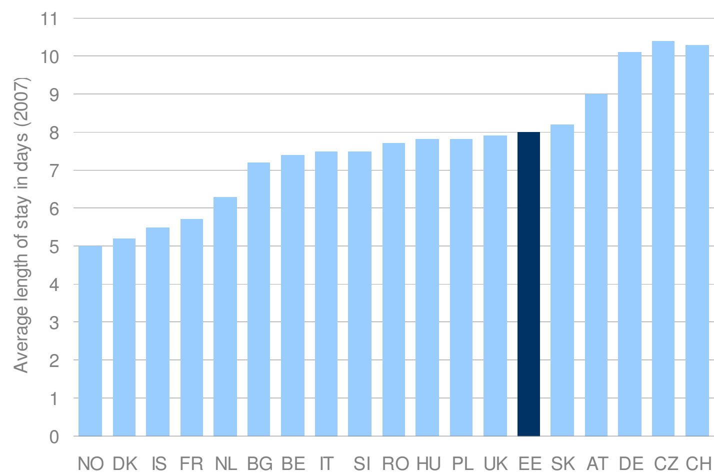
Source: Eurostat and OECD 2009

But growing fast . . .



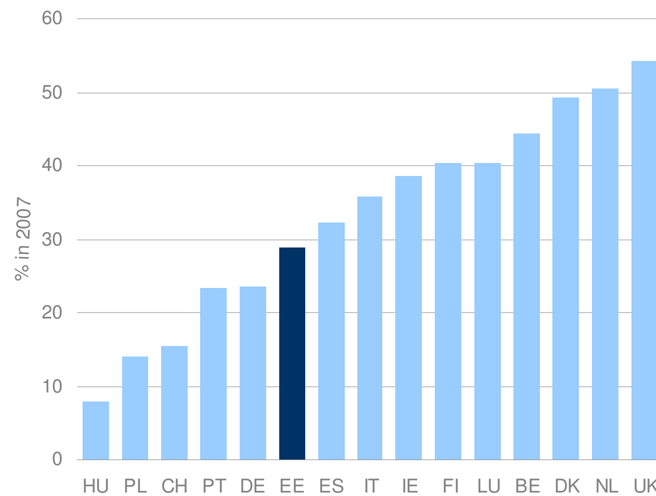
Source: EHIF 2009

Some progress in hospital throughput



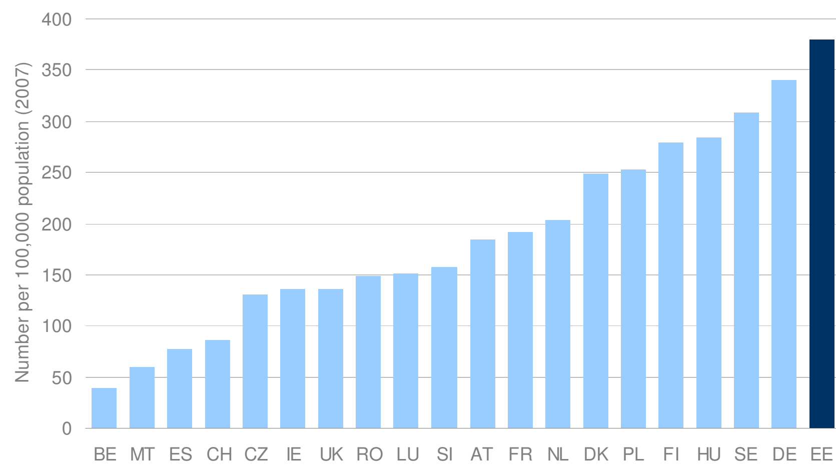
Source: Eurostat 2009

Day cases rising but still low as % of total surgery



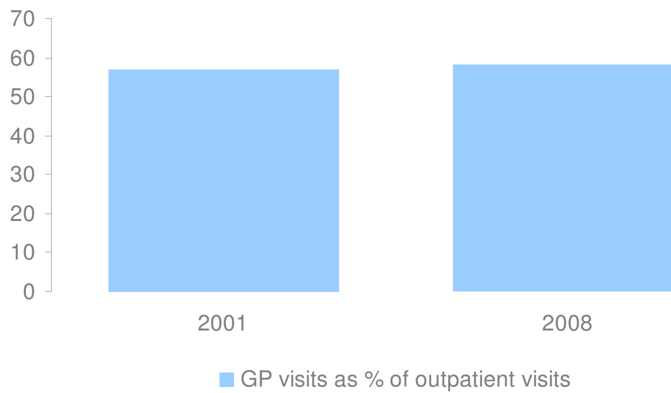
Source: OECD 2009 and EHIF 2009; 2006 data for Spain, Italy, Belgium

Avoidable hospitalisations are high (eg for angina pectoris)



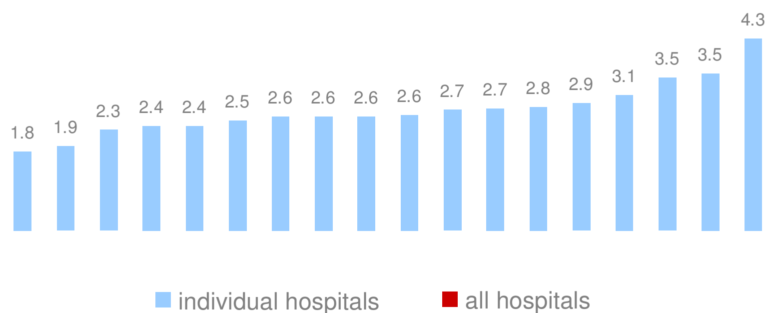
Source: Eurostat 2009

GP visits as a % of total outpatient care have not increased



Source: EHIF 2009

Too much variation across hospitals in length of stay?



Source: Eurostat 2009

Transparency, accountability

- ✓EHIF internationally recognised for its competent management
- ✓annual satisfaction surveys (EHIF/MOSA)
- ✓control of informal payments
- not enough provider monitoring
- keep health separate from other funds

Summary of assessment

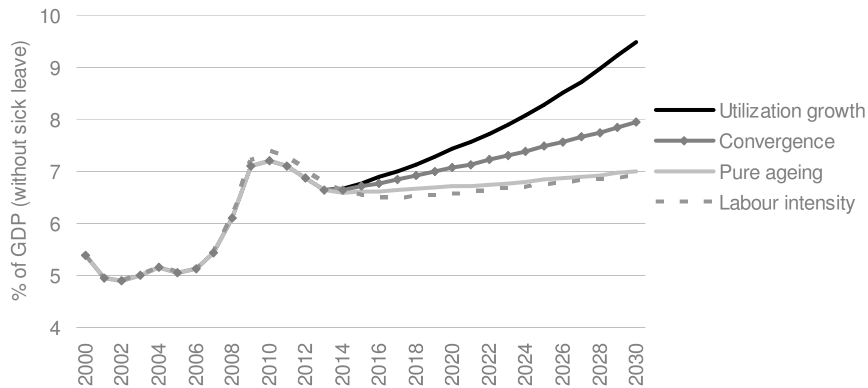
- financial protection & equity have declined due to rising OOPs for drugs
- the single-payer system works well but there is scope for efficiency gains
- via better investment controls, aligned incentives, more focus on primary care
- good governance requires tools to monitor performance against goals

Projections
expenditure & revenue

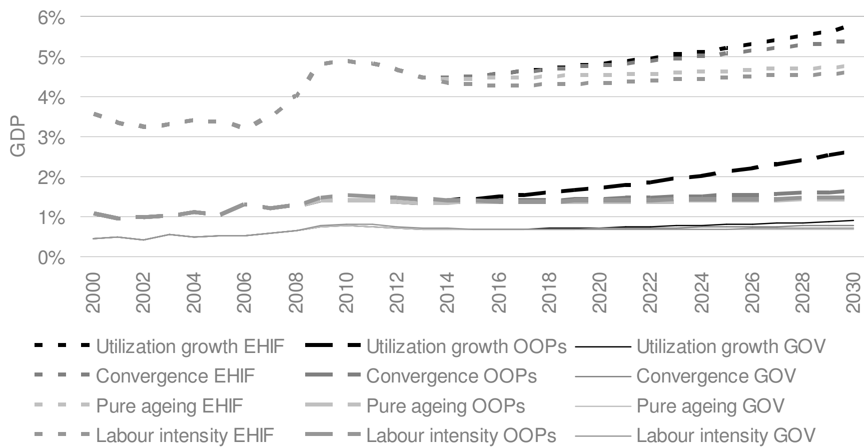
Projection methods

Input data:	population projections	*	age-related expenditure profiles	*	unit cost development	=	total expenditure
	↑		↑	↑	↑	↑	
Alternative scenarios:	**pure ageing**		**utilization growth**		**convergence**		**labour intensity**
	↑		↑		↑		↑
Population:	ageing		ageing		ageing		ageing
Health status:	constant		constant		constant		constant
Age + sex expenditure profiles:	constant		use increases based on past trends		constant + 0.8% general increase		constant
Unit cost development:	GDP per capita		GDP per capita		GDP per capita + 0.8% general increase		GDP per worker

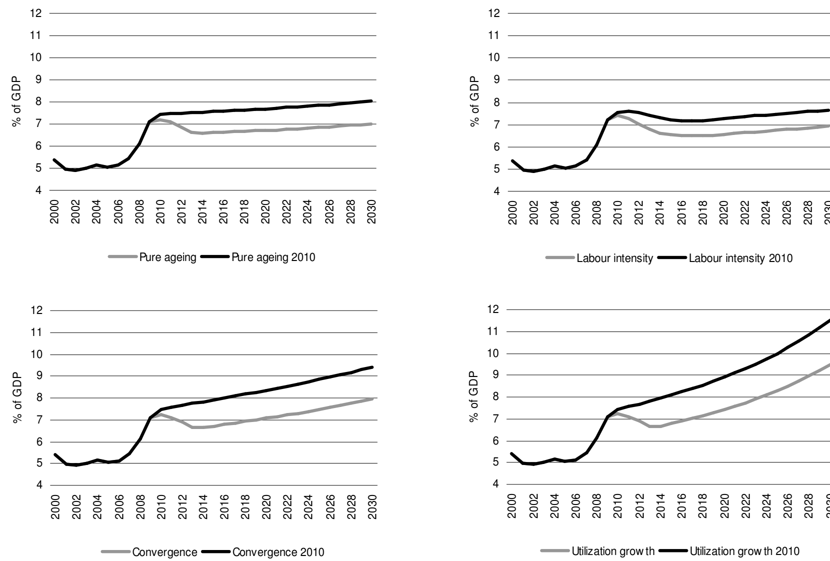
Increased utilisation leads to the highest spending growth



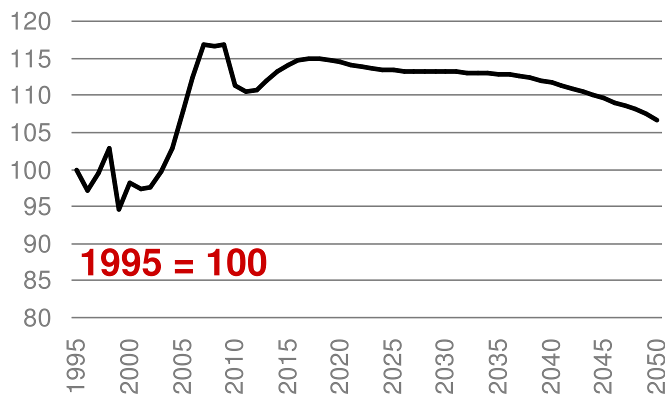
Increased utilisation doubles OOPs as % of GDP



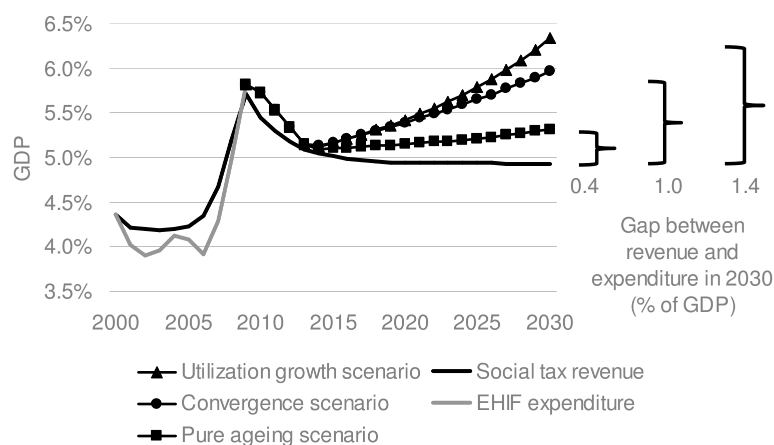
What if costs rise in 2010?



Social tax revenue per capita as a % of average wage



Projected revenue-expenditure gap for EHIF



Summary of projections

- technology & utilisation have a much larger effect on spending than ageing
- OOPs could double as % of GDP
- the public revenue-expenditure gap in 2030 could be large (0.5–1.7% of GDP)
- the gap could be bigger if health care prices rise before 2014 (1.3–3.0% of GDP), depleting EHIF reserves by 2013

Options for change

The social tax

- raise it
- lower it
- cap it
- split it
- apply it to dividends
- apply it to pensions
- government contributions for pensioners

Coverage changes

- lowering the breadth, scope and depth of public coverage
- creates greater opportunity for private finance
- is there a role for more private pre-payment (PHI or MSAs)?

EU evidence on PHI

- unlikely to protect poorer, older, less healthy people
- unlikely to relieve pressure on EHIF
- unlikely to enhance efficiency
- adds regulatory and administrative complexity and costs

Report recommendations

Selection criteria

- based on **assessment** of health financing policy
- significant **stakeholder** support
- reflects **values**
- **politically** feasible

Broaden the public revenue base

To bridge the gap and reduce reliance on employment the **government** should:

- make contributions to EHIF **on behalf of pensioners**
- apply the social tax to **dividends** from capital investment

Options for funding government contributions for pensioners

Options	Tax increase required to raise 0.4% of GDP by 2030
Health social tax paid by government for pensioners	Social tax 6% (if pensions remain around 9% of GDP)
13% of health social tax on gross pensions	
13% of health social tax on gross dividends	
Increase in VAT	From 20% to 21%
Increase in taxes on alcohol	About 30% increase from Jan 2010
Increase in taxes on tobacco	About 50% increase
Increase in social tax rate	From 13% to 14%
Increase in income tax rate	About 1%

Limit patient spending

To enhance financial protection & transparency the **MOSA** & **EHIF** should work together to:

- simplify **user charges** policy, improve its **targeting** (exempt poor & high users) and strengthen **protection** by capping OOPs
- encourage **rational** drug use by **enforcing** generic prescribing, introducing generic **substitution** & **educating** the public

Further improve purchasing

To enhance quality & efficiency the **MOSA** & **EHIF** should work together to:

- **control investment** in infrastructure and equipment
- secure better investment in **public health**
- **strengthen primary care**
- **align incentives** across the health system

Maintain good governance

To enhance transparency & accountability:

- EHIF should invest in better **monitoring of provider activity**
- the **MOSA** should provide **policy direction** for the whole health system
- the effective **single-payer system** should remain

Conclusions

- health financing policy faces challenges, but there are many levers to address them
- financial sustainability rests on political decisions
- the cost of doing nothing is high
- what sort of health system does Estonia want?