Cost control mechanisms in Estonian health insurance system

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Estonia at glance

Population: 1,34 million
ALE at birth 76 years (2010)
Health Expenditure (2010)
- 6.3 % of GDP
- Per person €677.5 (US$895)
- Public expenditure 78.9 %
- Social health insurance 68.2%

Social health insurance coverage 95-96% of population
Estonian Health Insurance Fund (EHIF)

single payer, public law, public ownership

Hospitals (acute care, nursing care)

Family physicians (primary health care)

Other providers

Health care provider
private law, public or private ownership
Collection of Funds and Purchasing Services

EHIF expenditures form 86.4% of total public health expenditures and 65.0% of total health expenditures (in 2009)

- Main source of EHIF revenues (about 99%) is a social health insurance tax (13% payroll tax)
- About 5% of population is uninsured

EHIF purchases most of health care to insured, except ambulance care

- The collected funds are pooled centrally
- Pharmaceutical reimbursements and temporary sick leave benefits are administered centrally
- Health care services funds are allocated among four EHIF regions based on capitation
Purchasing process of EHIF

- EHIF’s annual budget
- Capitation based allocations to EHIF regions
- Selection of partners
- Negotiations about contract volumes (regional basis)
- Changes in health service prices and benefit package
- Annual capped cost and volume contracts; 5-year framework contracts for strategic hospitals, 3-year for others
- Adjustments of contract if necessary
- Quarterly contract, queue and budget monitoring and utilisation review

Pooling in EHIF:
EHIF’s 4-year budget planning principles and EHIF’s 4-year development plan

Planning by specialities (running and next year perspective)
Pooling in EHIF

EHIF’s 4-year budget planning principles and EHIF’s 4-year development plan

EHIF’s annual budget

Capitation based allocations to EHIF regions

Planning by specialities (running and next year perspective)

BUDGET PLANNING
Budget planning

4-year budget planning principles
- Bases on MoF forecast on health insurance tax revenues
- Gives the forecast of the financial sustainability in 4-year perspective
- Sets priorities for expenditure side (expenditures are seen rather need than revenue driven)
- Basis for annual budget

Establishment of the annual budget
- Priorities according to EHIF’s development plan
- Has to be balanced, EHIF is not allowed to take obligations without budget to cover
- Budget for health care services: cases x average cost = amount
- Basis for contracting with service providers
EHIF reserves policy

**BY LAW**

Solvency reserve
- 6% of total budget To balance macroeconomic risks
- Needs government approval

Risk reserve
- 2% of health insurance budget to balance the risks of health insurance obligations
- Needs EHIF’s supervisory board approval

**EHIF „INITIATIVE“**

Surplus
- Difference between forecasted revenues and expenditures
- Needs EHIF’s supervisory board approval (<30% of total surplus, <7% of previous period’s health care services budget)
EHIF revenues, expenditures and reserves

Source: EHIF, www.haigekassa.ee
Long term sustainability

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

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

Sarah Thomas, Andres Võrk, Truman Holli, Lis Siitova, Toomas Eeestri and Tarmo Holli


Utilization growth scenario
Convergence scenario
Pure ageing scenario
Social tax revenue
EHIF expenditure

Gap between revenue and expenditure in 2030 as % of GDP

0.4 1.0 1.4

Eesti Haigekassa
Sotsiaalministeerium
EHIF revenues

- Covered by state or other schemes: 5%; 687 euros per person
- Non-contributing insured persons: 49%; 0 euros per person
- Employed insured persons: 46%; 1200 euros per person

Source: EHIF, www.haigekassa.ee
## EHIF’s budget in 2012

<table>
<thead>
<tr>
<th>Type of expenditures</th>
<th>Budget (plan, million euro)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention programs</td>
<td>7</td>
<td>1%</td>
</tr>
<tr>
<td>Primary care</td>
<td>72</td>
<td>9%</td>
</tr>
<tr>
<td>Specialist care</td>
<td>448</td>
<td>57%</td>
</tr>
<tr>
<td>Long-term care</td>
<td>17</td>
<td>2%</td>
</tr>
<tr>
<td>Dental care</td>
<td>19</td>
<td>2%</td>
</tr>
<tr>
<td>Health promotion</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Pharmaceuticals (out-patient)</td>
<td>102</td>
<td>13%</td>
</tr>
<tr>
<td>Temporary sick leave benefits</td>
<td>88</td>
<td>11%</td>
</tr>
<tr>
<td>Other monetary benefits</td>
<td>9</td>
<td>1%</td>
</tr>
<tr>
<td>Other expenditures</td>
<td>16</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Health insurance expenditures in total</strong></td>
<td><strong>779</strong></td>
<td><strong>99%</strong></td>
</tr>
<tr>
<td>EHIF administrative costs</td>
<td>8,0</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Expenditures in total</strong></td>
<td><strong>787</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*Source: EHIF, www.haigekassa.ee*
CONTRACTING, TARIFF SETTING

Annual capped cost and volume contracts; 5-year framework contracts for strategic hospitals, 3-year for others

Quarterly contract, queue and budget monitoring and utilisation review

Selection of partners

Negotiations about contract volumes (regional basis)

Framework contract conditions negotiated and agreed among EHIF and Estonian Hospital Union or Estonian Society of Family Physicians

Changes in health service prices and benefit package

Adjustments of contract if necessary

Negotiations about contract volumes (regional basis)
Contracting and tariff setting

EHIF is not required to enter into a contract with all providers

Financial part of the contract is negotiated annually
- Cost and volumes by specialties and by care types as outpatient, daycare, inpatient are negotiated
- Contract is agreed by quarters to ensure stability of care provision over the year
- Services provided over the contract volume are covered on certain conditions but only 30% of costs

Health care service prices and benefit package is approved by Government
- Tariffs are same to all providers
- Mix of payment methods is used (DRG, FFS, capitation, P4P)
- In addition to cost-effectiveness analysis budget impact analysis has to be done for all changes in prices and benefit package -> no changes if there are no funds to cover that
Lessons learned from Estonia

You can’t spend money you don’t have
  – Full responsibility over spending
  – Longer perspective budget strategy
  – Mandatory reserves and ability to retain revenues that are not spent

Control your expenditures
  – Careful contract planning and monitoring with regular negotiations with providers
  – Payment methods that support efficiency
  – Transparent but regulated pricing
  – IT systems are essential to support planning and monitoring process

But, long term sustainability is a bit more than just controlling your expenditures...
Thank you for your attention!