



Health Financing in Estonia: Challenges and Recommendations

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Preamble: WHO framework for analyzing health systems and health financing

The World Health Organization (World Health Report 2000) has identified three generic goals that all health care systems should seek to achieve: improving the population health, the system's responsiveness, providing protection against the financial burden associated with medical expenditure while distributing the burden of funding in a fair way. A fourth goal, efficiency, is transversal to the previous ones: attaining them should be done in a way that gives the best result given the available resources.

A number of interdependent functions need to be performed for the system to achieve the above mentioned goals:

- service provision: personal and public health services need to be produced,
- resource generation: human and physical resources have to be created and developed,
- financing: funding and incentives must be organized, and
- stewardship: the whole system must be strategically managed and led.

Of these four functions, the present discussion focuses on health financing, which is at the core of the current debates in Estonia.

Kutzin (2001) proposed a framework to analyze health care financing arrangements that distinguishes three sub-functions:

- the collection of revenues that will ultimately be used to purchase health services,
- the pooling of these funds, in other words, the way the financial flows are organized, and
- purchasing of health services, which describes the interaction between the intermediaries who manage the prepaid/pooled funds and those who deliver the services.

Building on a detailed analysis of how these functions are organized in Estonia (*Health System Financing in Estonia*, 2005), the present document underlines the main challenges faced by the health financing system and proposes some suggestions for further improvements. These suggestions reflect WHO's overall vision of specific policy objectives for health financing. In particular, a health financing system should:

1. Promote access to care and protection against financial risk
2. Promote "solidarity" by
 - distributing the burden of funding the system relative to individual capacity to contribute;
 - distributing health care services and resources in relation to individual need;
3. Promote efficiency through explicit incentives and streamlined administrative arrangements
4. Be transparent and understandable

Health financing in Estonia

In 2003, total health expenditure in Estonia represented about 5.4% of GDP, a level comparable to that of other middle-income countries. However, 75% of this expenditure is public, a funding mix which is closer to that of richer countries. Indeed, lower and middle income countries tend to rely more heavily on out-of-pocket payments at the point of care, which greatly undermines their capacity to provide financial protection to their population.

Therefore, despite its income level, Estonia is in a good position to achieve one of the main objectives of a health care system: to protect citizens against the cost of care and to ensure that resources and services are distributed according to need.

Challenges and recommendations for improving financial protection for the population

The vast majority of the population, including children and the elderly, is covered by a public and compulsory health insurance scheme. The uninsured, which represent about 6% of the population, consist principally of low-income male adults who are either long term unemployed or who work in the informal sector. The government is responsible for funding emergency care for them but in the long run, it would be advisable to better integrate them in the system and to ensure that they can access care early, at the primary care level, and not necessarily in an emergency situation.

Even if health expenditure remains funded principally from public sources, the government share of total health spending has been declining over the past years. Unlike in many countries of the region, this decline is not a consequence of a collapse of the fiscal system and general public expenditure cuts. Rather, it appears that the government has been steadily prioritizing away from health. Since 1998, total public expenditure has been increasing roughly at the same pace as the GDP (about 30% in real terms between 1998 and 2003). Public sector health expenditure, on the other hand, has increased three times less in real terms (10% between 1998 and 2003). In other words, health expenditure has been representing a decreasing share of total public expenditure (from 13% in 1998 to about 11% in 2003). Different studies (e.g. Jesse et al. 2004, Suhrcke 2004) using a variety of health status measures show that Estonia's performance in terms of health is lagging behind that of other accessing countries. In particular, the HIV/AIDS epidemic is posing a challenge that largely remains to be addressed. This does not mean that more public funds should pour indiscriminately into the health system. Nevertheless, addressing these health issues will most likely require some specific priorities to be established and funded in a sustainable way while respecting global macro-economic constraints. The main challenge will be to use the funds in a way that improves overall population health and financial risk protection, in particular by establishing a set of incentives for all actors in the system that are aligned with these objectives.

In terms of total revenues raised for health, the main driving force behind the 26% real increase in the past five years has been out-of-pocket payments, which have nearly doubled in real terms. What really matters is not the funding mix per se, but rather the capacity of the system to limit financial barriers to the use of care and to avoid that the most vulnerable bear a disproportionate burden. A recent study (Habicht et al 2005) showed that in 2002, nearly 1.5% of the population fell under the poverty line due to out-of-pocket payments in health and that more than 7% of the population, concentrated amongst the low income groups, spent more than 20% of its non-

subsistence income on health. Comparing 1995, 2001 and 2002, the study also shows that the situation has worsened over time and that the main source of the problem seems to be outpatient expenditures on medicines by lower-income elderly persons. Since then, the co-payment policy has been changed, and while measures to provide additional protection for pharmaceutical expenditures have been put in place, their effectiveness has not yet been measured. Worryingly, however, the average level of out-of-pocket payments increased even further (from €48 per household member in 2002 to €72 in 2003). In other words, we believe that there is sufficient cause for concern, particularly with regard to the trend, and that this issue should be brought to the attention of Estonian policy makers. While the solution to the problem of improving financial protection for the poor will not come just from increasing government health spending, it is likely that the success of reforms to improve financial protection, e.g. targeted exemptions from co-payment, will have to be supported by increased public spending in order to “purchase” this extra protection for the poor. In general, it would be useful to closely monitor the impact of out-of-pocket payments on individuals, particularly if the funding mix is going to shift further in favor of private funding.

To conclude on the issue of private payments, we would like to state that relying on voluntary insurance to improve the distribution of the burden of private payments in the population is not a good solution. First of all, experience shows that development of a private insurance market is a very slow process. Second, and more importantly, private insurance is predominantly taken up by richer individuals and, unless it is heavily regulated, people who are in bad health face important barriers to accessing it. In other words, unregulated private insurance is not a good tool for improving the equity of funding in a health care system. When considering whether private insurance take-up should be encouraged and the market regulated, which means using public resources to try to overcome these limitations, attention should be paid to whether alternative uses of public funds may provide a more efficient approach to achieving these objectives.

Estonian Health Insurance Fund: the main pooling institution in the system

Most public revenues for health are pooled in the Estonian Health Insurance Fund which is responsible for purchasing care on behalf of the insured population. The EHIF is an independent public agency which operates under strict financial rules and is obliged to constitute financial reserves to be able to meet its obligations every year. The expenditures of the health insurance fund result from a mix of open-ended and legal obligations (such as reimbursing drugs, paying sick leave, and constituting reserves) and other commitments, which mostly pertain to the funding of health care services. The level of funding available for that last category essentially depends on the amount left once other obligations have been met. This system has made it possible for the EHIF to mitigate the impact of the 2000 macro-economic crisis, but it also partly explains why public health expenditure remained stable afterwards: the reconstitution of reserves was a priority for the Fund. In essence, the EHIF has played a key role in keeping government health expenditure under control in Estonia while concurrently avoiding the accumulation of deficits over time. This is an accomplishment that very few countries have managed to put in place. The down-side, of course, is that the Fund can be viewed as “responsible” for rationing or keeping prices down, a position that is probably politically difficult to sustain, particularly in situations where providers are putting pressure on the Government to obtain higher remuneration.

The bulk of the EHIF revenues come from earmarked contributions levied on the working population. Given the scope of health insurance, and the fact that large categories of the population are insured statutorily (e.g. children, elderly persons) without a defined source of funds for these groups, a very large redistribution is taking place from those who work to those who do not. In fact, half of the insured are considered “non-contributing”, which means that they are in fact benefiting from this implicit redistribution.

This raises a first question as relying solely on wage-based contributions may create some distortions and undermine the financial fairness of the system. Labor is the main source of households’ income in Estonia (66% in 2003). But as the economy grows, income sources tend to differentiate, and typically the income of higher-income persons tends to be decreasingly based on wages. The fact that everyone over 65 is exempted from contribution regardless of their actual income level may also not be fair. In other words, it would be interesting to estimate and monitor at intervals whether there is some degree of correlation between what people earn and what they contribute, no matter where their income comes from. This fundamental reason why this is important, and it holds for other issues than health insurance, is that the way revenues are raised has an impact on a system’s political sustainability. In the long run, the perception that a small category of people pays for everyone else can only weaken support for the public system. Given the way the EHIF is funded, this question is almost certain to arise sooner than later.

It is interesting to point that Estonia is somewhat an exception in this respect, “in spirit” at least. In many countries, explicit provisions are made for some institution (Pension Fund, Unemployment Fund or general government budget revenues) to contribute on behalf of the “non-contributing insured” (Normand and Busse 2002; Busse et al 2004). Such an arrangement sends a signal that the burden is more broadly shared and that the responsibility of funding for those who are not in a position to do so is collectively assumed. In Estonia, the Government does contribute on behalf of 4% of the population, but it is the exception rather than the rule. Looking at this from a more pragmatic perspective, it is important to remind ourselves that having a “social insurance system” does in no way imply that it should solely be funded by wage-based contributions, even if historically these instruments have been used simultaneously. In Western Europe, for example, Germany and the Netherlands are the only countries in which more than 60% of total health spending comes from wage-related contributions (Busse et al 2004). In other words, it is possible to disconnect the debate on labor cost from that on the level of public resources that flow into a social insurance fund. If more public resources are needed, whether to address specific diseases, to better protect some people from high expenditure, to provide full EHIF coverage for the uninsured, or to fund the access of an ageing population, it does not mean that contribution rates have to increase.

Other agencies pool public revenues, in particular the Ministry of Social Affairs and municipalities (see Health System Financing in Estonia, 2005 for more details), but they play a much smaller role than the EHIF which is responsible for 87% of public expenditure on health. Municipalities’ expenditures actually represent a very small share of total health expenditure (1% in 2003). This situation results from a combination of factors: their responsibilities are somewhat loosely defined, and their capacity and willingness to actually address them appears limited. Although this may not be amongst the top priorities, clarifying the situation and injecting some accountability at this level would be useful in the long run.

In any case, a critical and positive feature of the current health financing system in Estonia is the fact that a single agency, namely the EHIF, is pooling most public resources. Having a single broad pool helps to achieve a number of important objectives.

1. First, it promotes equity and solidarity by disconnecting who pays (and how much they pay) from who benefits from available services (and the extent to which they use needed services). In systems where independent funds are responsible for covering separate segments of the population, setting up a redistribution system across pools has proven to be both difficult and costly. As noted above, this separation does still exist for the uninsured, whose care is funded mainly by the central government budget and to a lesser degree by municipalities. The State budget transfers for the uninsured are actually administered by the EHIF but in a separate pool than the revenues for the rest of the population. Pooling these revenues together on behalf of the entire population would facilitate an even greater degree of equity and solidarity in the health financing system, particularly if the benefit package of the uninsured was to become identical to that of the whole population, as we believe would be advisable. On the same subject, at the moment, it seems that the resources allocated to providers for the care they deliver to the uninsured are not high enough to cover their cost, and that some degree of cross-subsidization is taking place at the provider level. If this is true, then we would recommend that funding be adjusted as the providers should not be bearing the financial risk of treating the uninsured.
2. Having a single pool for the population also creates a good purchasing environment.
 - a. In the above mentioned situation where separate insurers cover separate segments of the population, it also means that each insurer has to purchase care for its own population. Putting aside the issue of equity, a specific and complex regulatory framework is needed to promote an environment for the multiple purchasing organizations to establish coherent remuneration schemes that give proper incentives for the providers. And perhaps more simply, the presence of multiple payers dilutes purchasing power relative to what could be achieved, and is currently being achieved, by a single agency such as the EHIF in Estonia.
 - b. A single pool also facilitates the allocation of resources according to need. When separate organizations are responsible for allocating funds to different segments of the health care system (either parallel systems or different categories of providers), they tend to compete with each other for resources and also try to shift responsibility for paying for care to the other organizations. And again, experience shows that mechanisms for reallocation across segments are difficult to implement effectively. This type of fragmentation is limited in Estonia as the EHIF is purchasing most of the care, with the exception of ambulance care. Clearly, some efforts are also made to direct resources according to need. Most resources are allocated among regions on the basis of crude capitations, but the Fund's regional branches have some capacity to further adjust the allocation between types of care so as to better fit the population's needs. We believe that further attention should be given in the future to improving the scope and methods for strategic allocation based on more detailed need assessments at the sub-regional level. This strategic allocation is meant to have several dimensions and it might translate into prioritizing specific geographic areas but also specific types of care to better respond to the needs of a given population (i.e. given outpatient specialties). Lastly, it should also take into account the priorities established for the whole system (for instance encouraging primary versus specialized care, or outpatient versus inpatient surgery).
 - c. Finally, if different organizations are responsible for funding parts of health care facility costs (e.g. salaries, capital costs...) it also limits the purchasers' capacity to set up coherent remuneration schemes. By the same token, it reduces the provider's capacity to combine inputs in an efficient way and to provide cost-effective care. The recent inclusion of capital costs in the prices paid to health facilities is a good, albeit

perhaps politically difficult, step in that direction. A big challenge in the coming years will be to integrate external funding from EU Structural Funds into the system in a transparent way that is coherent, on the one hand, with the priorities established at a global level, particularly in the National Master Plan and on the other, with the consequences of the integrating capital costs in the prices paid to hospitals by the EHIF. Another area where fragmentation is still an issue, as in many countries, is public health. Funding is coming from the Central budget, the EHIF, the municipalities and international sources, for instance the Global Fund to Fight AIDS, Tuberculosis and Malaria and it seems that even if all the funds remain not pooled, responsibilities could be clarified.

In a nutshell, the fragmentation of the pooling and purchasing arrangements in health financing systems, which was a predominant characteristic in Semashko health systems, is harmful. By setting up a single fund for nearly the entire population and systematically developing its purchasing and accountability mechanisms over time, Estonia has both created the conditions and implemented specific mechanisms for the health financing system to contribute to improved performance of the overall health system. Maintaining a coherent system in that respect or even further reducing fragmentation should remain a priority.

Still, reducing fragmentation is not a political objective *per se*, but a means to the several ends listed above. The on-going challenges for the government become to ensure:

- First, that the level of resources granted is compatible with the missions assigned,
- Second, that whoever has some autonomy to divide up the given budget, does so in a way that contributes to the overall systems goals: improvement of the population's health in a cost-effective manner that respects standards of quality, and protects the population against potentially impoverishing levels of health care costs.

In other words, more autonomy has to come with improved management capacity on the one side and more sophisticated monitoring and supervision on the other. In cases where some degree of fragmentation remains, then effective coordination has to be put in place.

Strategic purchasing of health services in Estonia

In terms of purchasing care, Estonia has put in place a contractual framework and payment methods that combine a variety of incentives adapted to each type of provider. The contractual process is clearly designed: following the regional needs assessment, providers are selected. This does not so much translate into selective contracting as into adjustments of the contracted volumes per provider. In this process, some degree of price competition has been introduced recently. In addition, standard contract conditions that are meant to ensure access to the population are included in the contracts, and their actual degree of achievement is meant to be monitored during the execution. This framework applies for outpatient and inpatient care provided to the insured. In areas such as ambulance care, care for the uninsured and public health, it seems that purchasing and allocation could be more strategic.

The payment method for each type of provider has become increasingly sophisticated over time. The principles that govern these changes appear logical and consistent. The trend is to rely on payment methods (e.g. prepayment rather than reimbursement) that contain incentives to better combine inputs while trying to cap the overall cost.

Like in the most developed countries, the “next frontier” will be to find better ways of rewarding the provision of better outcomes, in terms of health but also quality of care and responsiveness to clients. Particular challenges in this respect will be to improve client orientation and the coordination of providers for chronic disease management. These objectives go beyond the area of health financing alone, but health financing tools can be used to promote them.

As in many countries, the changes in the payment mechanisms over time probably reflect improvements in the capacity of all actors to react to incentives and monitor their consequences, as well as the development of information systems (which has been consistently pursued in Estonia). Some changes were also made to offset or counterbalance given limitations of the prior remuneration scheme that had become obvious over time. As a result, payment methods for most providers are mixed, which can be a good feature so long as it remains transparent and the result of a coherent implementation. For instance, currently, GP practices receive:

- a capitation that is now adjusted for age,
- some fee-for-services as an incentive to provide additional care at the primary care level, but, in order to limit the impact on volumes, a limit is set on the proportion of the practices’ income that fee-for-service can represent
- lump sum payments for investment costs or specific practice characteristics: distance to hospital and diploma in family medicine. The justification for that latter payment is however gone now as, since 2003, having a diploma in family medicine is a precondition for having a contract with the insurance fund. But the next step is under discussion and should bring about a higher focus on performance and quality of care, in the form of quality bonuses for family doctors.

Hospitals are paid by a combination of per diem with some time limits introduced to moderate the length of stay, and fees for services with capped volumes. Capital costs were recently included in the prices and the current concern is that the average length of stay is stable and might even increase in reaction to the recent changes. DRGs are currently being introduced which should in theory counterbalance these incentives.

All in all, there is no canonical model for purchasing care and remunerating providers. Mechanisms for this have to be constantly adapted and improved over time (Grignon et al. 2002, Figueras, Robinson, and Jakubowski, forthcoming), a lesson that appears to have been learned in Estonia.

The main problem with respect to provider payments in Estonia might be one that cannot be solved to everyone’s satisfaction: rarely will providers agree that they are paid enough or purchasers believe that they should not be getting more for their money. Decisions on the level of remuneration are political and too often taken under pressure. Ideally, changes in the level of remuneration should be negotiated in exchange for improvements, in terms of management or quality or scope of services. They should also remain in line with the development of the overall economy so as not to create large distortions among different sectors or compromise the health system’s attempts to reach important objectives such as equity in access and funding.

Conclusion

In conclusion, we believe that the institutional structure of the health financing system in Estonia is fundamentally sound, and that the performance of the system has been enhanced over time. As a result, the health financing system in Estonia has many positive features that make it a leader among transitional countries. It provides good financial protection for the vast majority of the population, its organization is fairly simple, and there are clear incentives and accountability mechanisms in place. Although in this report we identify several areas for improvement, our intention is to encourage both greater investment in health and further development of existing systems and mechanisms. In our view, there is no need for a radical reform of the system.

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