**Second Annual UHC Financing Forum: Greater Efficiency for Better Health and Financial Protection**

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**Panel discussion: Making way for UHC by tackling wasteful spending on health: Results from the OECD study and interactive discussion**

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Why publicly and openly address the issues of waste and fraud?

Two broad comments:

While health care issues are always intimate to particular national settings, the health care is always high on the people's agenda. And I am aware of no country where (irrespective of particular political setting) people are not concerned with whether and how care is provided. As a consequence, the issues of fairness and accessibility are essential. Therefore, public authorities need to tackle fraud and waste preemptively to ensure health care policy credibility over medium and long term.

The second point is the question of political economy in a broader sense – does explicit political recognition that there are issues of fraud and waste in health care to be addresses in sustained manner, does meaningful transparency in health care support general development over medium and long term? And my personal answer is definite yes.

On more specific issues:

It is true that addressing fraud and waste may help health care authorities in the quest for additional public funds from MOF and from the society in general. However, one should bear in mind that in inter-departmental turf wars, transparency is only one factor of success. One could even say that one can never be transparent enough.

The overwhelming case to address waste and fraud is, such, important in itself so as to provide better health care irrespective of level of income of a country concerned. Because fraudulent inefficiencies reduce the overall amount of resources directly used to provide care. And wasteful inefficiencies may support over-provision of care in some (and, consequently under-provision of care in other) instances. But in both cases, the patient is in receiving end.

Addressing waste in Estonian health care

We have probably addressed the usual suspects like (a) the use of reference prices in compensation of medicines, (b) activity-based costing methodology in setting primary care and hospital prices, incl. DRGs; (c) clear delineation of purchaser-provider relationship with fairly well detailed financial contracts; (d) systematic and transparent methodology for costing of (average) prices per treatment case for every contract

So our indeed our main focus should be on further and more sophisticated ways to address inefficiencies in service delivery (and in some specific instances, to address plain insurance fraud).

In this context, I would emphasize importance of following measures:

(a) Better understanding of and to focus on implementation of value-based (or patient-centered) approach:

a. Systematic promotion of treatment protocols and quality measurement
b. Much better understanding of actual treatment costs on hospital level (patient-based as opposed to department-based silo-approach)
c. Much better understanding of treatment of chronical illnesses and multimorbidities on primary care level
d. Possible introduction of bundled and/or broader treatment episode based contracting and output/outcome-based QBS on primary level.

(b) Qualitatively much better use of big data

a. We have full electronic repository of prescriptions, sick leave claims and, most importantly, of hospital invoices.
b. Systematic (and impact based) analysis and assessment of treatment costs to ensure appropriate volumes and amounts for budgeting and contracting.
c. More systematic analysis of variation in hospital treatment costs and practices.
d. More systematic inquiries into suspicious variations in claims

(c) More systematic and coercive monitoring of non-core benefits, such as sick leave benefits and some minor items in insurance portfolio subject to cash-based compensation.