CONFERENCE "THE FUTURE OF SOCIAL HEALTH INSURANCE: REDEFINING SOLIDARITY AND RESPONSIBILITY?"

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From passive to strategic purchasers. What instruments are needed to increase accountability and set longer-term health objectives?

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Estonian health care system: providers, purchasers and EHIF

1. All Estonian service providers, incl. family physicians and hospitals are governed by private law and are independent legal entities in public or private ownership.

2. Estonian Health Insurance Fund (EHIF) as the sole provider of universal health insurance is the biggest purchaser of services (appr. 70% of total market size). Other purchasers include central government, domestic and foreign households and, to a lesser extent, employers and private health insurance providers.

3. EHIF insurance covers family doctors services, out-patient and in-patient hospital care, dental care for children, pharmaceuticals reimbursement, EU/third country care and sick leave benefits.

4. EHIF business volume is 900 million euros and all employees, children, students, retirees and registered unemployed are individually enrolled automatically EHIF is financed by individualized 13% payroll tax that is automatically transferred to EHIF.

EHIF purchasing practices: primary care (GP) level and specialized health care

1. EHIF enters into yearly contracts with GPs and specialized health care providers.

2. Family physicians' contracts are based on (i) a capitation fee, (ii) basic allowance per practice, (iii) distance allowance and (iiii) FFS for analyses and other primary level services beyond the basic package. Additionally, there is a performance based part (appr. 3-4% of capitation payment). Family physicians' contract is not related to number of visits.

3. EHIF has 19 strategic hospitals as permanent contracting parties. Additionally, EHIF tenders approximately 20% of out-patient elective services and 5% of in-patient services for other providers.

4. Specialized medical care' contracts are based on payment per case of treatment. Case of treatment consists of several different services. FFS-based payment is applied for cases in out-patient care and combined FFS/DRG payment (weights 30/70) is applied for cases in in-patient and surgical day-care.

5. EHIF maintains single central and uniform price list of health care services that is reviewed annually (prices are calculated using ABC methodology, thereby effectively averaging costs across service providers)..

6. EHIF negotiates with every hospital yearly contract, agreeing thereby number of cases, average price of a case and total binding monetary amount of a yearly contract. Strategic hospitals are reimbursed for cases over the agreed limit using a coefficient 0,7 (out-patient services) and 0,3 (in-patient services). The binding limit for the total sum of all contracts is EHIF's yearly budget (binding macro ceiling) that is set by EHIF's Supervisory Board.

7. Specialties and number of cases in a hospital's contract with EHIF depends on the type of hospital (regional, central or local), estimated demand for services and past performance (volume and waiting time). An average price of a case of treatment varies across hospitals.

Discussion: strengths and weaknesses of strategic purchasing

1. The key strength of the current system is its ability to plan and control the costs of EHIF and to support financial soundness, also taking into account waiting times.

2. Moreover, the current system supports both introduction of new methods of treatment in hospitals (by increasing average cost of case if new services are added to central price list) and using existing methods of treatment in cost effective manner (by reducing average cost of case if, e.g. price of some inputs declines and price of service correspondingly declines in central price list).

3. The main weaknesses of the current system are considered as follows: (i) excessive focus on number of cases and not necessarily on comprehensive treatment of a patient, (ii) no explicit connection between the quality of outcome and monetary amount of a contract in specialist hospital care; (iii) no explicit connection between waiting times and monetary amount of a contract. Requirements related to quality and waiting times are included in general conditions of a contract, but not in a monetary part.

Outlook: future developments

Short term

1. Ensure efficient use of ABC methodology for costing of services to avoid protracted structural deviations from actual cost base.

2. Stronger emphasis on comprehensiveness of insurance package, incl. interconnectedness of primary and specialist level, nursing care and supporting self-care.

3. Further strengthening of primary care (family physicians and nurses):

- Increase earmarked FFS component for analyses, special treatments, e-consultations and purchases of specialist services, e.g. physiotherapy. In general, to push services, analyses and other activities downstream as much as feasible.

- Provide more incentives for care coordination of individual patients, incl. by developing and gradually increasing the pay for performance component.

4. More focused specialized medical care:

- Modeling demand for services and translate demand into yearly contracts

- Increasing use of out-patient and day surgery services as far as feasible
- Support further up-streaming of higher resource and technology intensive in-patient services to regional/central hospitals; support networking between hospitals.

5. Implications of the EU patients' rights directive

Medium to long term

1. Further focus on individualized and coordinated approach to patients, co-ordinated by family physicians.
2. Focus on quality of treatment (measured quality indicators) and access (waiting times) in contacts with hospitals (instead of number of cases), including in monetary part of the contract.
3. Introduce DRG-based budgeting (e.g., in day surgery) and consider episode-based financing.