WHO notes on the Memorandum[1] to the Cabinet of Ministers on the Analysis of additional funding for health and proposals for ensuring sustainability of health insurance in Estonia[2]

28 March, 2016.

Introduction

In 2010, the World Health Organization conducted a detailed analysis of the sustainability of the Estonian health financing system in close collaboration with the Ministry of Social Affairs and the Estonian Health Insurance Fund. The report was based on in-depth interviews with key stakeholders and a technical analysis of the health financing system including projections and lessons from international experience. Recommendations addressed both revenue and expenditure sides of financial sustainability with a strong emphasis on the message that the response to sustainability challenges should be driven by values and health policy objectives of Estonia. The current memorandum builds on the findings and recommendations of this report as well as the progress made since 2010 during and after the financial crisis and economic downturn.

Estonia has a robust health financing architecture with most of the key building blocks and processes in the right places, but the economic downturn put the system to a test and highlighted its vulnerability to economic cycles. Estonia's single payer system with strong governance structure and advanced provider payment systems is internationally recognized for its excellent performance, but there is some fragmentation in financing for vertical programs, emergency ambulance services and lack of coordination between providers and with social services. The almost exclusive reliance on social tax for raising revenues for the health insurance system makes the financing of the health sector extremely vulnerable to economic cycles and the current mechanism of accumulating reserves did not prove to be an effective mechanism to protect the health budget during times of economic downturn when need for services is likely to increase. The insurance function of public financing for health calls for a robust countercyclical mechanism in raising revenues and reliance on payroll tax works against this objective plus it may have adverse effects on the competitiveness of the labor market. Ageing population and diminishing labor-related income may necessitate increasing of social tax with its potential adverse effects on labor cost and the economy as a whole. In order to

[1] Draft version of the Memorandum as of February, 2016.

[2] This report was prepared by Tamás Evetovits, Senior Health Financing Specialist and Head of Office, WHO Barcelona Office for Health Systems Strengthening

address these challenges, diversification of revenue sources for health has been advised.

Policy responses to the financial crisis in Estonia led to significant reduction in public spending on health despite sufficient reserves available to cover the gap. Policy makers gave preference to fiscal balance which helped the country to meet Maastricht criteria and join the Eurozone. It may have also contributed to relatively quick recovery of the economy and in turn revenues through payroll tax started to increase again in 2011. In order to minimize adverse effects of the cuts, the country introduced efficiency enhancing measures: some of them offered temporary relief while others were more sustainable with long-term impact. The partial removal of temporary sick leave benefits from the responsibility of EHIF provided a one-time instrument to stabilize the financial situation of the health insurance fund. Central government budget for public health programs was severely cut highlighting vulnerability of a non-earmarked revenue source.

Relatively fast recovery helped to put the system back on a stable footing, but the fundamental sustainability challenges identified earlier remained and became even more severe due to interventions in response to the crisis. The Memorandum sets out clear directions for health financing policy starting with values and policy objectives enshrined in the WHO Tallinn Charter and in line with Health 2020 and the new Sustainable Development Goals. The concept of universal health coverage goes beyond a simple measure of insurance coverage for the whole population - which is still to be achieved in Estonia – and calls for strong financial protection against the cost of ill health and coverage of services of sufficient quality to be effective in treating and preventing diseases. There is no doubt that Estonia will need additional public funding to achieve these goals and sustainability of the health financing mechanisms is critical in that respect.

Good health at low cost? Yes, but!

Health outcomes and amenable mortality could be significantly improved by increasing health spending and improving services. Estonia performs well in international comparison only if we choose comparator countries at similar level of health expenditures. This means that at the current level of expenditure, the health outcomes are relatively good. However, Estonia could achieve much better health outcomes by spending more and better. Relevant comparator countries at similar or slightly higher level of economic development (e.g. Czech Republic, Portugal and Slovenia) have significantly better health outcomes when we look at mortality amenable to the performance of the health system itself i.e. it is not due to better diet or healthier life-style and other determinants of health. Efficiency is both about costs and outcomes. Estonia has a great potential to improve health outcomes in a cost-

effective manner which in this case means better health outcomes at higher, but still below average level of health spending in international comparison (Figure 1).

Figure 1. International comparison of selected mortality data amenable to health system performance and per capita health expenditure (PPP adjusted, 2013)

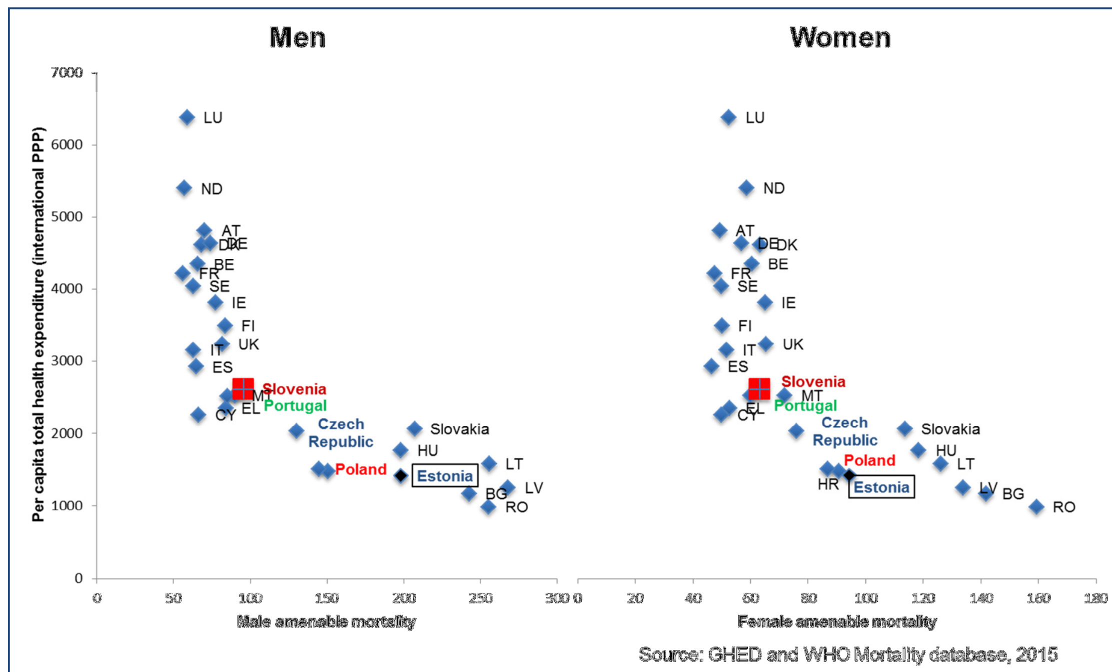
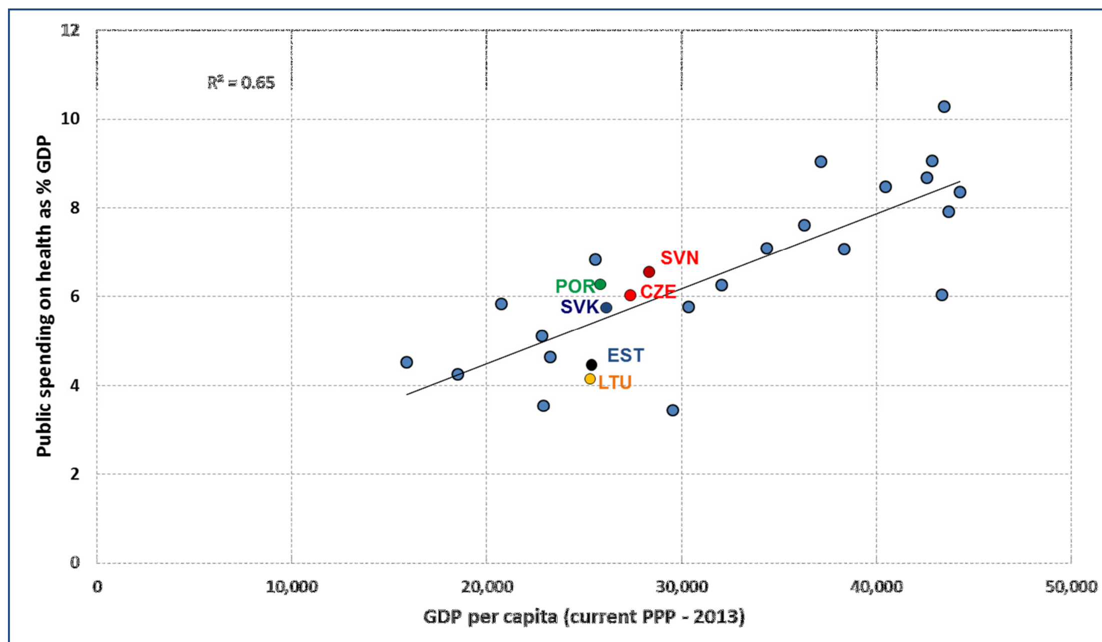


Figure 2. Public spending on health as a percent of GDP in EU countries by level of economic development. (PPP adjusted, 2013)



Public expenditure on health is far below the EU trend line and many comparator countries of similar economic development. Estonia could spend more on health by increasing the share of health within public financing to at least 15% of total government expenditure and by increasing fiscal space through increased taxation (Figures 3). Both options are within the decision rights of the government and reflect public policy priorities. Figure 4 provides data on how OECD countries allowed the health sector to gain a greater share of government spending over time at the expense of other sectors. As Figure 2 suggests the EU trend line cuts across between 5-6% of GDP for public spending on health and several relevant comparator countries spend even more than 6% of GDP on health through public sources. While not all that spending may be efficient, it is clear that with good policies in place additional public spending can exponentially improve health outcomes in Estonia (see trend line on Figure 1 as well).

Figure 3. Accounting for public spending on health

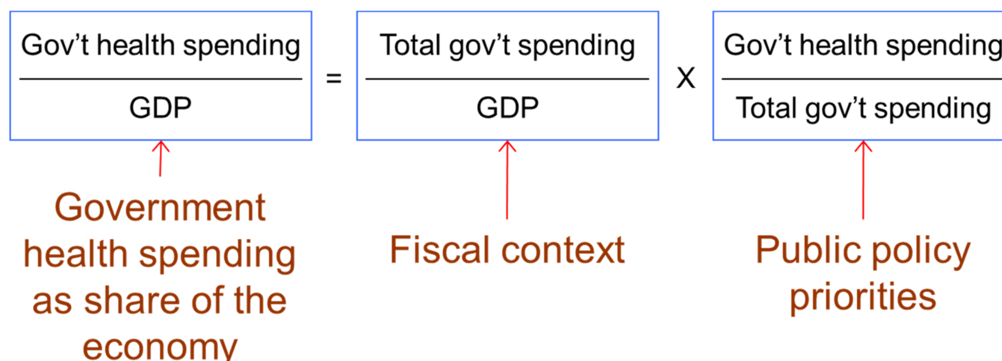
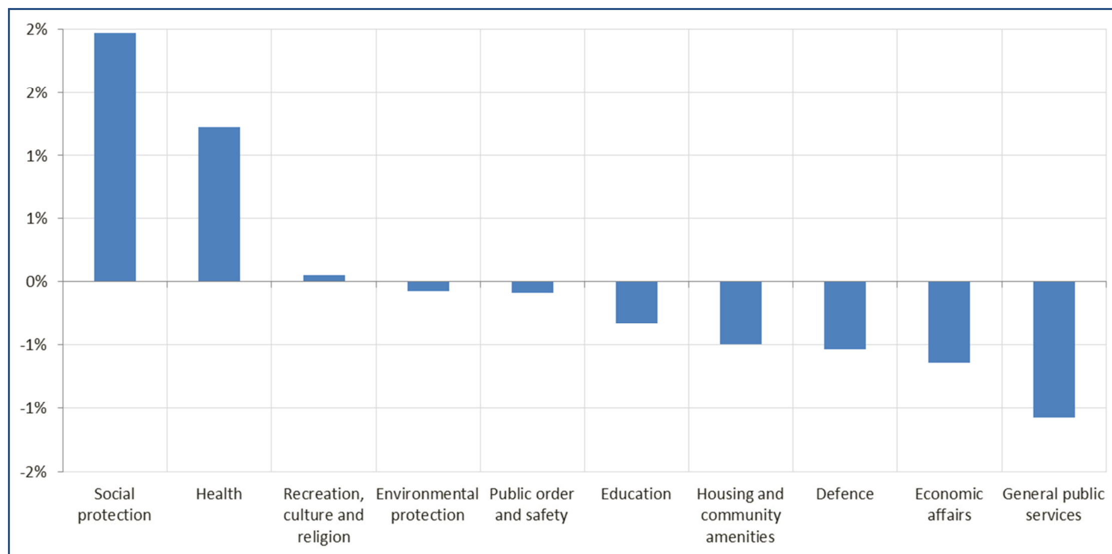


Figure 4. Change in the structure of general government expenditures on average in OECD countries by function (2001 to 2011). OECD National Accounts Statistics



Financial protection and unmet need

Estonia performs relatively poor in some key metrics for universal health coverage: unmet need and financial protection. According to the EU-SILC survey data unmet need for health services is higher than EU average and Estonia is among the poorly performing 25% of the EU member states. Depending on socio-economic status, between 7-11% of the population reported that they did not seek care or delayed utilization due to financial and other barriers to access care when they had a perceived need for health services (Figure 5). Similarly, financial protection could be significantly improved by increasing public spending and introducing policies that protect the poor better. Ongoing monitoring of financial protection by WHO suggests that the incidence of catastrophic and impoverishing health expenditure by households has been on the decline prior to 2010, but it is stagnating since then and the trend is at risk of a reversal for some population groups. Estonia performs poorly in international comparison and many comparator countries provide better protection against the cost of ill health for their population. Improving financial protection should be in the focus of a new health financing strategy.

Out-of-pocket expenditure on health by the Estonian population is higher than EU and OECD averages and increasing. The level of out-of-pocket payments (OOPs) is closely related to measures of financial protection. Estonia could significantly improve financial protection by reducing overall level of OOPs and by improving policies that protect the poor better through exemptions from co-payment and by increasing the scope of coverage especially for prescription drugs and dental care. International comparative analysis suggests that in countries where the level of OOPs is kept below 15% of total health expenditure, financial protection measures tend to be excellent especially when specific pro-poor policies are in place. The share of OOPs between 15-30% of total expenditure calls for strong pro-poor policies in order to achieve good financial protection. In the absence of effective pro-poor policies, the level of OOPs shall be kept below 15% of total expenditure in order to secure financial protection.

Figure 5. Unmet need for a medical examination for financial or other reasons by income groups in the European Union, EU-SILC data for 2013

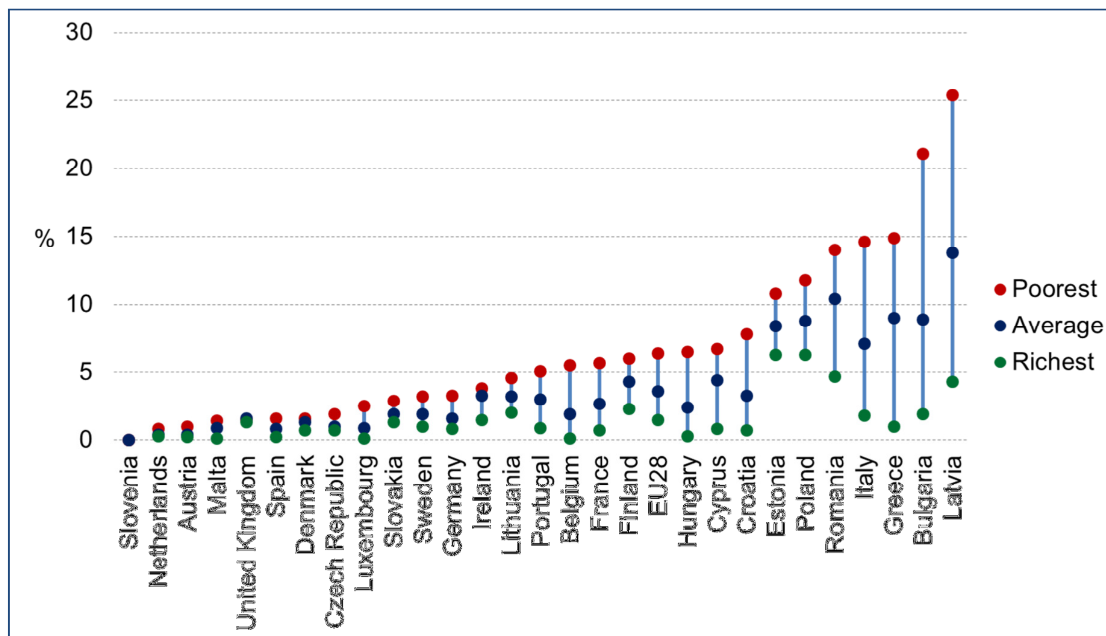
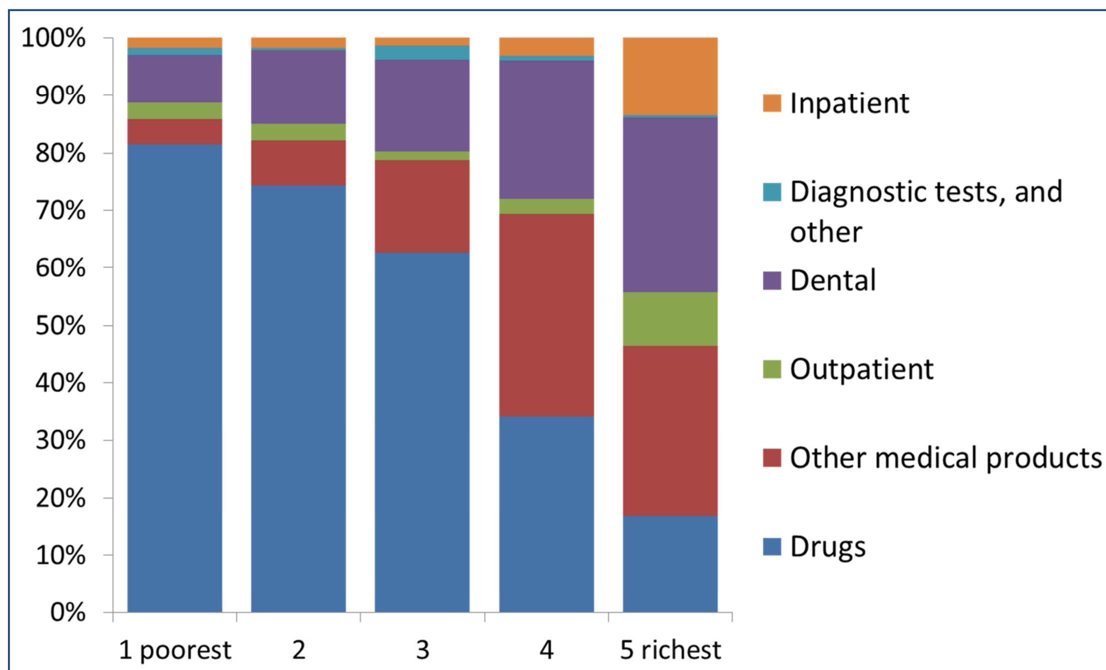


Figure 6. Out-of-pocket spending by households experiencing catastrophic and impoverishing expenditures by type of health service and income quintile. Average of 2000-2007, 2010-2012 data (unpublished WHO analysis by A. Vörk, 2015)



Improved coverage of prescription medicines and dental care would results in better financial protection and lower unmet need. Private spending on drugs (prescription and over-the-counter) is the most frequent cause of catastrophic and impoverishing levels of expenditure by households. Lack of coverage for dental care leads to high levels of private expenditure by the more affluent population groups while the poorer segments of the population simply do not seek dental care due to its high cost. Inclusion of dental care in the publicly funded benefit package would improve both financial protection and health outcomes for all segments of the population. At the same time, greater coverage of the cost of prescription medicines for the poorer population groups is the key to have better financial protection indicators (Figure 6).

Sustainable financing of health insurance

Insurance is primarily a function and the government is the ultimate insurer. While there is a remarkable institutional setup for providing health insurance for the Estonian population through EHIF, it is the government which bears ultimate financial responsibility for meeting the health needs of the population and covering its costs.

The insurance function of public financing calls for some form of counter-cyclical spending on health as needs for services do not decline during economic downturns, certainly not at the rate of decline of tax revenues. Because of the nature of the insurance function, the health sector needs stable and predictable revenues. Pro-cyclical health spending makes it difficult to meet health policy objectives and maintain good health system performance. Counter-cyclical revenue for health is more likely to secure access to services according to need and helps contain expenditure growth during economic prosperity.

Several European countries use explicit formula–based approaches to ensure stable and counter-cyclical revenues for health. Lithuania and Slovakia provide relevant examples for Estonia as these countries rely extensively on wage related health insurance contributions, but also use government budget transfers to cover the economically not active population groups and do so in a counter-cyclical manner. In Lithuania, the government's contribution to the health insurance budget is calculated by using average salary two years prior to the actual fiscal year and is paid on behalf of pensioners, children, unemployed and other economically non-active groups of the population (Figure 7). As a result, the revenue flow to the health insurance fund is more stable and resilient to economic fluctuations, the revenue base is broader than if it was only based on wage tax, and the significant share of general tax revenues for health lowers the cost of labor, which may have beneficial impact of competitiveness of the economy.

Figure 7. Lithuania's formula-based budget transfers (red) ensure stable revenue flow to the health insurance fund during times of declining payroll tax revenue Source: Kacevicius and Karanikolos (2015)

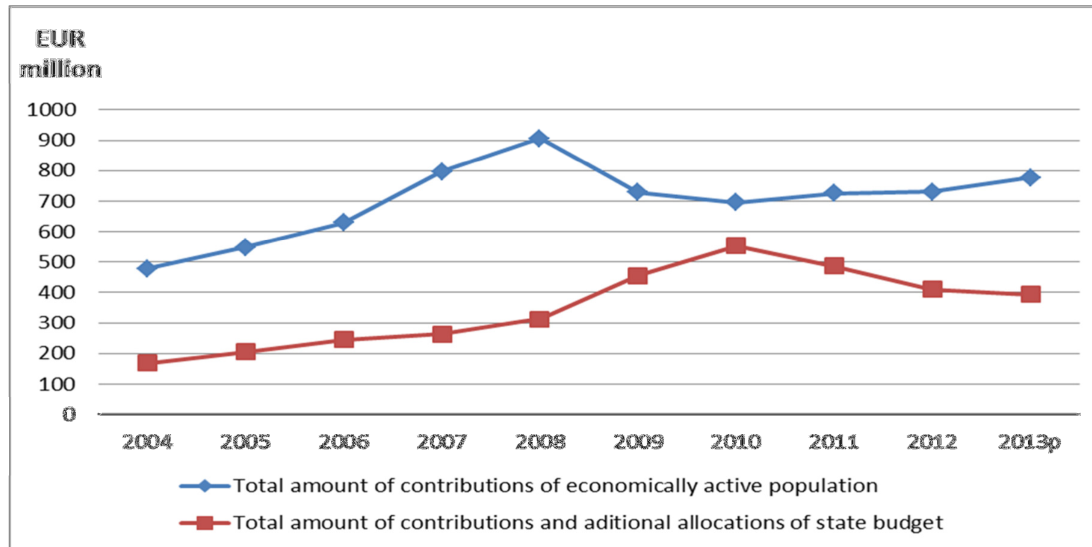
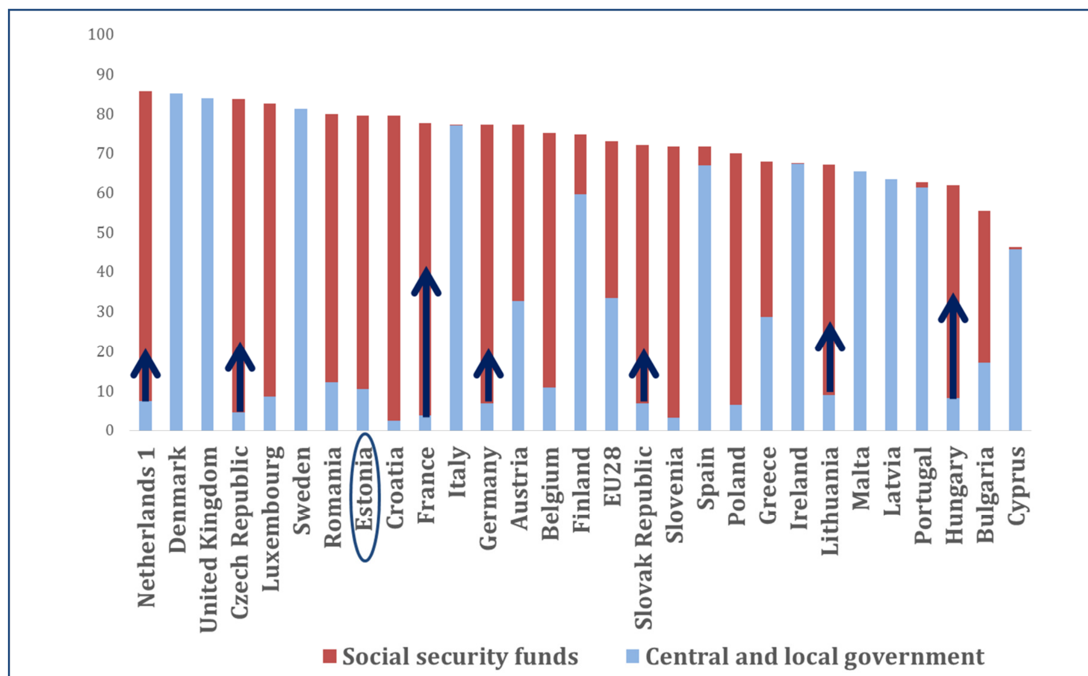


Figure 8. Increasing number of countries with 'social insurance systems' (red bars) have mixed sources of revenues through central government budget transfers



Most European countries which traditionally relied on wage related revenue collection moved to mixed sources of funding with increasing levels of central government budget transfers to the health insurance system. Figure 8 indicates the approximate magnitude of these government budget transfers in countries where social security funds play a key role in covering the cost of health care. In addition to Lithuania, the Czech Republic, France, Germany, Hungary, The Netherlands and Slovakia have significantly increased these allocations in recent years. In France and Hungary, general tax revenues now account for about 50% of the total health insurance budget.

Calculation of government budget transfers for the economically inactive populations groups should be based on average salary. Using average salary (as opposed to minimum wage or state pension) as the basis for the calculation of government budget transfers reflects economic reality of the country and it is a proxy to economic growth and increasing demand for health care. Given that pensioners are relatively high cost and high frequency users of the health system, average salary based calculation is a better reflection of the actual cost of treating this major population group. Budget transfers on behalf of the unemployed addresses the need for counter-cyclical revenues, while transfers on behalf of the pensioners directly address the revenue side challenge due to changes in demography. Although ageing population means higher cost of health care, ageing itself is much more of a revenue side problem in the current system of health financing in Estonia.

Source of tax revenue for increased budget allocations to the health insurance system is primarily a taxation policy question which should carefully consider equity and efficiency aspects of different forms of taxation. While sin taxes may have a role in raising more government revenues and reducing unhealthy behavior/consumption, earmarking that revenue for health does not address the root cause of the sustainability challenge and is certainly not a solution to problems created by change on demography. On the other hand, sin taxes enjoy wide population support and have the attraction of influencing healthier behavior and consumption as well as production of goods. The disadvantage of sin taxes is in their regressive nature which means that they pose a greater burden on the poor than the rich. For a more progressive taxation policy, Estonia may also consider taxing dividends and other sources of income on capital. Enforcing collection from non-contributing groups who otherwise should participate in the mandatory health insurance system may also yield additional revenues, enhance solidarity and fairness while reducing the number of uninsured. Hungary provides a good example of how to address this enforcement challenge without denying access to care and through involvement the tax authorities in collecting unpaid health insurance contributions.

Policy scenarios and projections of expenditures and revenues of the health insurance fund

Several policy scenarios are considered in the projections of revenues and expenditures for EHIF, but there is no explicit scenario for reducing OOPs and securing universal population coverage. While important policy scenarios are discussed in the Memorandum, there is no explicit commitment to significantly reduce OOPs and address lack of universal population coverage. Between 6-8% of the population do not have insurance coverage and there has been limited effort by the Government in the past 5 years to address this problem despite widespread agreement among stakeholders that this needs to be resolved in line with the Tallinn Charter, Health 2020 and commitments to move towards universal health coverage. Since health insurance is mandatory in Estonia, there is no justification for maintaining the share of uninsured at this level. Information technology allows for tracking uninsured population groups if not earlier then at the point of seeking health care. Provision of services for the uninsured currently costs the system more than 7 million EUR per year for treatment at emergency departments and in primary care. Contact with the health system by the uninsured allows access to personal data which can be used for verification of insurance status and checking reasons for non-compliance with payment of contributions. EHIF can check and correct administrative mistakes, if any, or alert the tax agency for enforcement of collection of insurance contribution unless the uninsured falls in one of the categories for exemptions. Estonia could and should do better in securing insurance coverage for its total population. An explicit policy scenario for universal population coverage is missing from this strategic document.

Inclusion of dental care in the benefit package is an important step in the right direction. This policy scenario will reduce unmet need and OOPs at the same time for the whole population, but it is not enough to significantly reduce financial access barriers for the poorer segments of the population who will continue to face the burden of high cost-sharing of medicines. In order to improve financial protection in Estonia, cost-sharing for prescription drugs needs to be reduced for all or at least for the poor and for people with chronic conditions with high level of expenditure on medicines. It is feasible for Estonia to reduce OOPs to below 20% of total health expenditure in the medium term and even aim for less than 15% in the longer term. An explicit policy scenario for reducing OOPs is missing from this strategic document.

There is no doubt that the current financing system is unsustainable therefore diversification of revenues and more public sources for health are both needed. The Estonian Health Insurance Fund has a deficit and it is already using its reserves. Projections take a misleading approach to estimating ‘sustainability’ by

indicating the year in which all reserves would be exhausted. Reserves are meant to be used when revenues fall short due to unforeseen circumstances like an economic downturn or a sudden increase in demand for health services due to an outbreak, to name one example. If reserves are planned to be used for covering the cost of the different policy scenarios, then it is an indication of an unsustainable system of raising revenues for health. Instead of this approach, the scenarios should estimate the annual additional funding needed to meet the objectives and consider revenue side measures to fill the gap in a sustainable manner. Conceptually, it is important to distinguish sustainability of the current revenue collection system for health to meet existing commitments and the additional financing needed for improving coverage and reducing burden on the sick. If the system is using reserves to balance the budget on an annual basis, then the system is not sustainable. The projection model should address the root causes of unsustainable financing i.e. ageing and exclusive reliance on labor related revenue source.

Combinations of policy scenarios are missing in the projection model. It is very realistic to consider different combinations of policy scenarios and their cost consequences. Ultimately, the policy makers will have to prioritize between optional scenarios and contrast them with those that are harder to influence (ageing, increased demand, wage increase etc.). The document could be more helpful to this decision making process if some likely combinations of the different scenarios were also calculated and projected.

Given that EHIF was not allowed to make full use of the accumulated excess reserves during the years of the financial crisis, these excess reserves could now be used for covering the initial cost of additional benefits. Instead of counting with the reserves as a source of ‘revenue’ for a few more years which gives a false impression about the magnitude of the sustainability challenges, the reserves could now be used for implementing more policy scenarios than what would otherwise be fiscally feasible in 2017. Some of the cuts implemented during the crisis call for a policy revision as they were not pure efficiency gains, but reductions of benefits. Also, the pressure to increase wages to the level that prevents valuable workforce leaving the sector is imminent and it is probably less costly to keep well-trained workforce at home, then to deal with the potential future cost of a human resource crisis in the health sector. Several European countries experience this unfortunate labor market development adversely affecting the health sector. The current version of the Memorandum seems to underestimate the magnitude of this threat and the additional funding needs.

Removal of cash benefits for temporary incapacity to work from the responsibilities of EHIF is in line with international practice, but it does not address the sustainability challenge on the longer term. This is another example for a one-time intervention that provides temporary relief for the imbalance of

revenues and expenditures like it was used the same way during the crisis, but it is important to note that these benefits have impact on care seeking behavior and on health, therefore this policy should be revisited while keeping the budget to cover the cost outside of the responsibilities of EHIF. In fact, the partial removal of this benefit from the EHIF budget served as the single most important factor in keeping the EHIF budget relatively balanced in the absence of unconditional access to reserves. This also means that this buffer will not be available in future cases of financial imbalance. The system has been using up its options for counter-cyclical spending on health services.

Demand for more and improved health services will continue to increase at a rate higher than GDP growth. The most alarming scenario discussed in the Memorandum is the one that reflects cost of meeting increased demand for health services. According to this estimate, there is already a gap between currently available resources and projected expenditures to meet increasing demand. If we add the very realistic scenario of wage increase in the health sector then the combined projection becomes the most alarming scenario even without adding any of the very much justified benefits like dental care or the missing scenario of reducing OOPs. As discussed above, the full removal of temporary incapacity of work benefits may help to fill the gap between baseline and demand scenarios, but for the additional policy scenarios significant fresh sources of revenue is needed. For the initial, transition period the use of excess reserves can fill the gap until additional revenues for health become available. The practice of using EHIF's reserves to balance the government budget should not continue as the financial crisis is over and this fiscal policy cannot be justified during times of economic prosperity. It carries the risk of undermining trust in the institutional design of the Estonian health insurance system.

Cost pressure may somewhat be mitigated by revisiting the hospital masterplan and introducing more coordination and integration between levels of care. Estonia has developed a robust system of health insurance and introduced major restructuring of the delivery system during the past decade. The Estonian Health Insurance Fund implemented sophisticated provider payment reforms with documented success. The next step in the further modernization of service delivery and financing of health care providers is to introduce reforms that remove organizational barriers to more coordinated care across settings and over time. This may call for new financial incentives for provider of primary and secondary levels of health services. Hospitals will have to reduce avoidable admissions and primary care needs to be strengthened to effectively deal with primary care sensitive conditions. This calls for more coordination between levels and better incentives for moving service delivery closer to the community. The main objective of this kind of transformation of the delivery system is to improve health outcomes by providing better access and higher quality care using lower cost service delivery modalities.

While the potential savings are modest, the improved efficiency of using available resources provides the rationale for such modernization. Hospitals can play a major role in this direction of service delivery redesign and the first step is to revisit the hospital masterplan together with developing a strategy to strengthen primary care and care coordination/integration in the Estonian health system.

Figure 9. Key messages