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Estonian Health Insurance Fund

Primary care reforms, DRGs and move to single payor

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Background

Population 1 340 415 (2009)

GDP per capita 10 342€ (2009)

ALE at birth 75 years (2009)

Health Expenditure (2009)

- 7.0 % of GDP
- Per person €724.5
- Public expenditure 75.3 %

Social health insurance covers 95-96% of population

Health system reforms

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1990	Reform
Centralised state budget financing Considerable gap in availability of new medical technology and pharmaceuticals	Social health insurance
Polyclinics	Transformation of primary care into family medicine
Hospital centered health care system	Hospital closures and mergers, new governance structures

History of Health Insurance System

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Three phases since 1991

- Regional non-competing sickness funds (22 in total)
- Regional sickness funds coordinated by central sickness fund (since 1994)
- One Estonian Health Insurance Fund (EHIF) with regional departments (since 2001), where number of regional departments has been reduced to 4

EHIF is public legal body established by law

Objectives of health insurance system and EHIF

"*Health insurance is based on the solidarity of and limited cost-sharing by insured persons and on the principle that services are provided according to the needs of insured persons, that treatment is equally available in all regions and that health insurance funds are used for their intended purpose*" (Health Insurance Act, issued 2002)

"*… to ensure the payment of health insurance benefits pursuant to the Health Insurance Act, other legislation and health insurance expenditures prescribed in the budget of the health insurance fund*" (Estonian Health Insurance Fund Act, issued 2001)

Purchaser-provider split

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EHIF

public law , public ownership


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Contract

Health care provider

private law, public or private ownership

- **Hospitals (acute care, nursing care)**
- **Family physisians (primary health care)**
- **Other providers**

PRIMARY CARE REFORM

Primary health care reform milestones since end of 80s

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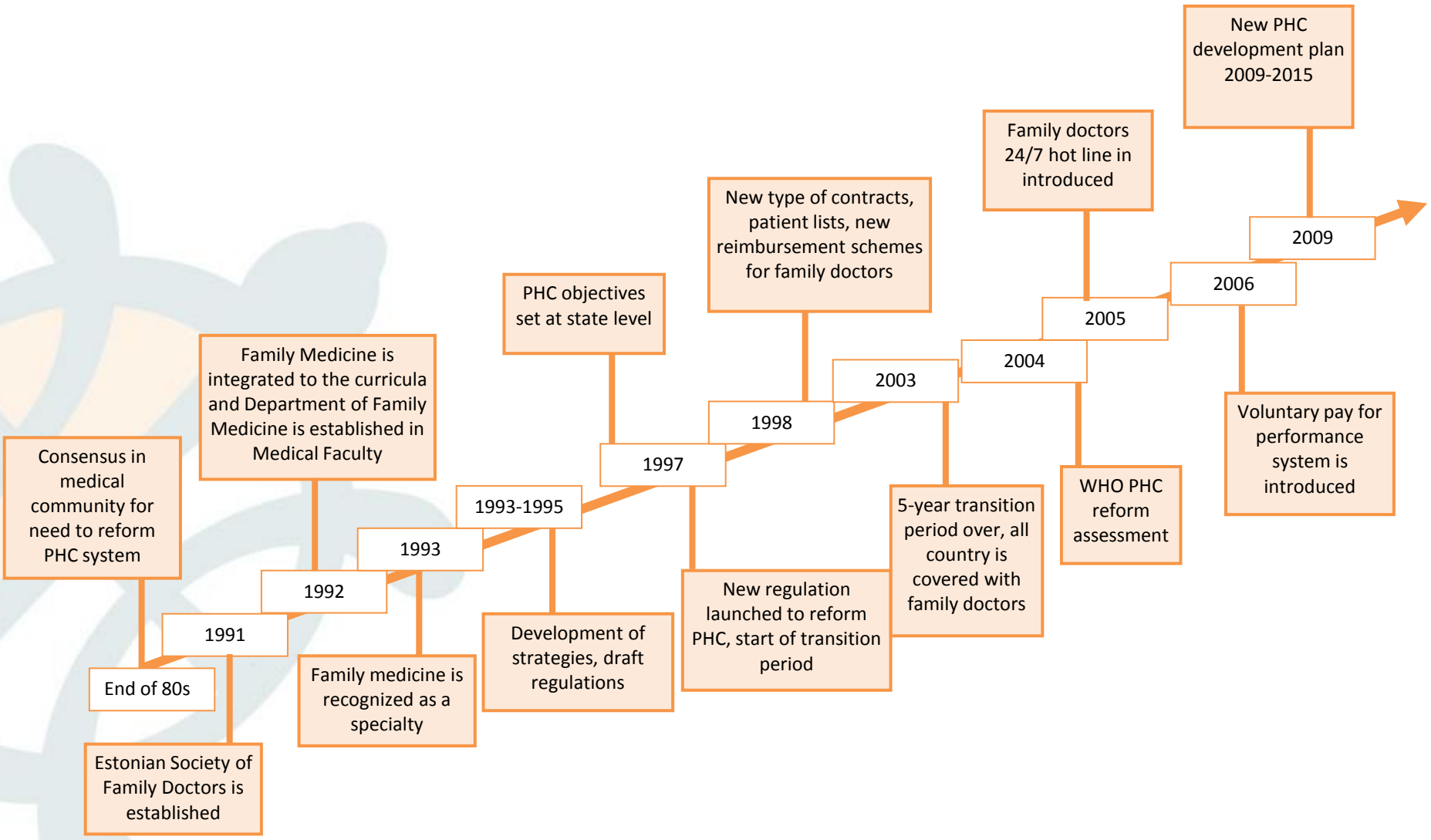

PHC payment methods

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- Capitation (age adjusted)
- Basic allowance (lump sum payment)
- FFS based additional fund to cover the agreed list of diagnostic services
  - 27%-32% of FP-s capitation budget
  - Paid according to submitted bills retrospectively
  - Defined list of more than 50 services and 50 tests (analyses)
  - All referrals to specialists are paid by the Health Insurance separately and directly to specialist care provider
- Some additional payments for FPs in remote areas
- Quality bonus system

PHC payment reform

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Very **simple calculations** at the very beginning

- Previous financing was translated into new payment without detailed costing
- Equal for everybody in 1998, age-weighted since 1999 (3 groups: <2y; 2-70y, >70y) and altered since 2012 (5 groups: <3y; 3-7y; 7-49y; 50-69y; >70y)

Relatively **higher prices** compared to other types of care to support reform progress

- Ensured support of family physicians!

Monthly **basic allowance** to enable investments to equipment

- Provides incentive to merge single practices to small group practices

Partial fund holding to support enhancement of more comprehensive care at PHC level

- Agreement what are PHC activities, has been extended over time

Success factors of payment reform

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Payment reform was part of PHC reform

- Learning from other countries experiences
- Clear reform targets accepted by stakeholders

New contractual relationships with FPs and health insurance fund provided strong financial incentive

Simple approach to change payment system

Development of health insurance ICT system in parallel

- Since 2001 all invoices data is electronically available, data quality has been increased step-by-step
- Providers have been responsible for their own ICT systems
- Enables savings, transparency and increased data quality

HOSPITAL SECTOR REFORM

The major steps in hospital sector before 2000

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Hospitals' licensing (1994-95)

-small hospitals (mainly in rural areas) with less than 50 beds were reorganized or closed

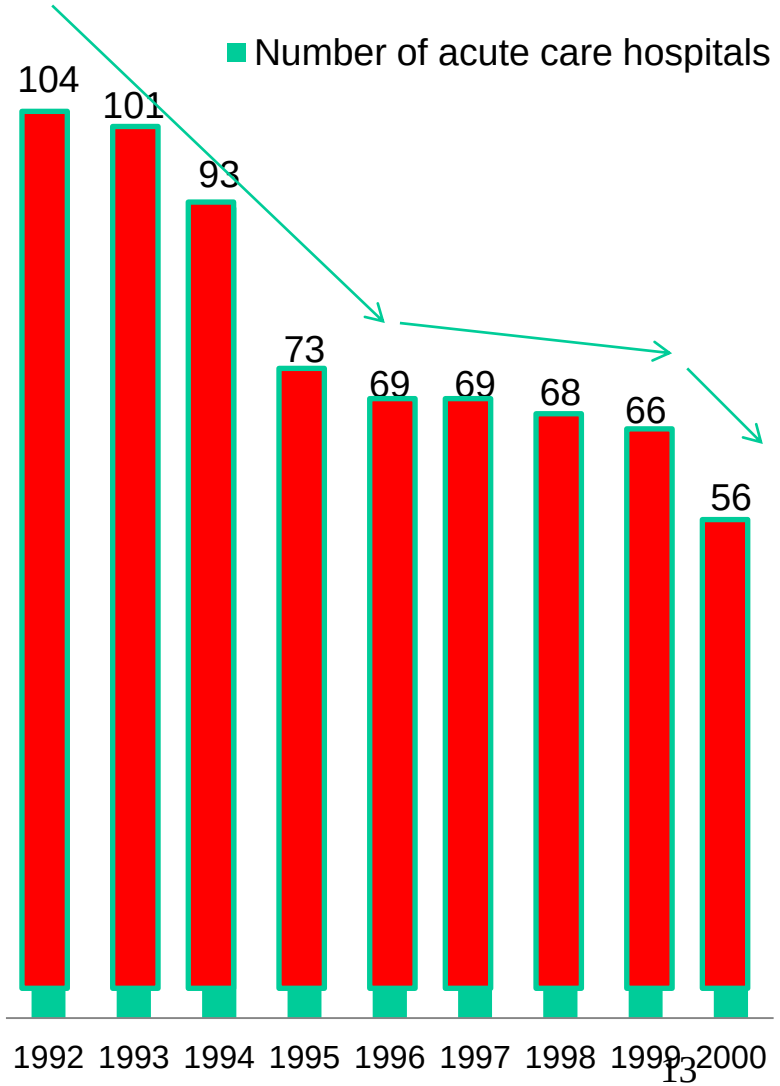
-most of hospitals were given to municipalities

-now providing long-term care as nursing homes or some are turned to out-patient centers

Establishment of Tartu University Hospital (from 1998)

-16 hospitals, centers and outpatient clinic reorganized and merged to one hospital

-triggered changes in capital area



Implementation of Estonian Hospital Masterplan 2015

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Aimed to

- Reduce the share of inpatient care
- Increase the share of outpatient care, day-care and nursing care
- Concentrate the more sophisticated and expensive specialist care to fewer hospitals

Updating the HMP (2002/2003)

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The original HMP 2015 was reassessed, updated and approved by Government

Hospital Network Development Plan (HNDP) stipulates 19 active care hospitals that are eligible for:

- long-term (5 year) contracts with the EHIF
- state-supported capital investment

The HNDP and specialist association development plans were used as a basis for:

- developing criteria for hospital licensing
- regulating the types of services that hospitals at different levels are allowed to provide

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IMPLEMENTATION OF DRG SYSTEM

Situation before introducing DRGs (2000/2001)

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The average cost per case increased rapidly and volume inflation growth was fast

- increase by more than 30% between 01.2000 and 09.2002

Not efficient use of bed-days

- high ALOS (9,9 days in 1999)

Access to care low

- long queues and waiting times

FFS and *per diem* rates were the main payment methods for in-patient care

- perverse incentives for providers

HMP was in initial phase

- still the extensive over-capacity in hospital sector

Need for additional incentives for rising efficiency

DRGs was seen as a tool to:

-gain the efficiency and contain cost in terms of fixed budget of EHIF

-decrease the volume inflation

-increase the further transparency of hospital output

Main steps in implementation

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- Selecting appropriate DRG system
- Grouping historical data, analyzing and providing feedback to providers
- Translation of terminology and preparation of guidelines
- IT-solutions
- Implementation of classification for surgical procedures (NCSP) and training
- Price calculation/development of cost-weights

Selection of DRG system

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Three alternative was considered

- Australian AR-DRG (Australian Refined Diagnosis Related Groups)
- NordDRG
- Estonia's own case-based system

Various criteria were used to evaluate the available systems

- Technical solutions
- Availability of technical support
- Use of primary classifications
- Cost of the system
- …

Technical solutions

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From the mid 1990s – the development of electronic solution began

End of 1990s – local insurance funds had electronic databases

By 2000 – Estonia was covered with one database, data were collected through electronic channels

Central NordDRG batch-grouper in EHIF's server

Gradual implementation

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2002 – the full implementation of the DRGs as a financing tool was seen to be too risky

2003 – DRGs as a grouping tool

2004 – DRGs as a financing tool....

.... but, DRGs were/are used in combination with the FFS and *per diem* rate, i.e. only a proportion of each case is reimbursed by on the basis of DRG price

Lessons learned from the DRG implementation process

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- DRGs are not for punishing providers and there is need to find win-win solutions
- If sure that DRGs are important for the health system, don't be stuck on methodological and classification problems
- Involve partners and provide training, but don't be disappointed if there is no interest
- Docs don't like coding

Source: Overview of Estonian experiences with DRG system. Estonian Health Insurance Fund, Tallinn 2009.

... additional remarks

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- DRGs is an important instrument and incentive, but other incentives are equally important
- DRGs do not meet all policy objectives neither solve all problems in health care
- DRGs can provide more flexibility to providers but depends on individual hospital management
- DRGs have impact to the hospital network but have different effects on individual hospitals
- Bundle payments call for additional focus on quality and tools to observe the variation