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The 2017 reform to improve financial sustainability of national health insurance in Estonia: Analysis and first lessons on broadening the revenue base*

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ABSTRACT

In 2017, the Estonian government addressed the longstanding challenge of financial sustainability of the health system by expanding its revenue base. As a relatively low-spending country on health, Estonia relies predominantly on payroll contributions from the working population, which exposes the system to economic shocks and population ageing. In an effort to reduce these vulnerabilities, Estonia will gradually introduce a government transfer on behalf of pensioners, although long-term sustainability of the health system could still prove challenging as the overall health spending as a percentage of GDP is not expected to substantially increase. Estonia has rolled out the reform according to plan, but it has led to debate about the need to achieve universal population coverage (currently at about 95%). Moreover, the Estonian experience also holds important lessons for other countries looking to reform their health system. For example, policymakers should recognize that reforms require extensive preparation using consistent messaging over a long period of time, also to prevent prioritising short term and popular fixes over structural reforms. Additionally, collaboration between the health and financial ministries throughout the reform increases the buy-in for the reform and likelihood of adoption. Furthermore, health professionals play a significant role in advocacy, and seeking support from this group can smooth the path towards health system reform.

1. The purpose of the Estonian health insurance financing reform

The financial sustainability of Estonia's health insurance system was debated for a more than a decade, with the primary concern that relying solely on wage-based contributions to finance the system could undermine its financial sustainability. Before the reform, nearly half of the Estonian population was eligible for health insurance without contributing to the system. This raises the question of fairness, which WHO identifies as an essential element of long-term sustainability for health system financing [1]. Given the ageing population, many held concerns that the health insurance system would erode its financial sustainability in the longer term [2]. Moreover, during times of economic downturn, which Estonia has experienced at regular intervals since regaining independence in the early 1990s, the wage based system led to sharp drops in revenue. Overall, these factors risked a weakened support for a solidarity-based public health system and could have affected the system's political sustainability [3]. National and international studies recognized the need to broaden the revenue base for health insurance, but there had been no political commitment to tackle that issue until 2015. The debate was amplified by the structural deficit of the Estonian Health Insurance Fund's budget since 2013.

Although the reform does not change the core principles of the health financing system, it still constitutes a landmark change because it sets the system on a path towards a more diversified mix

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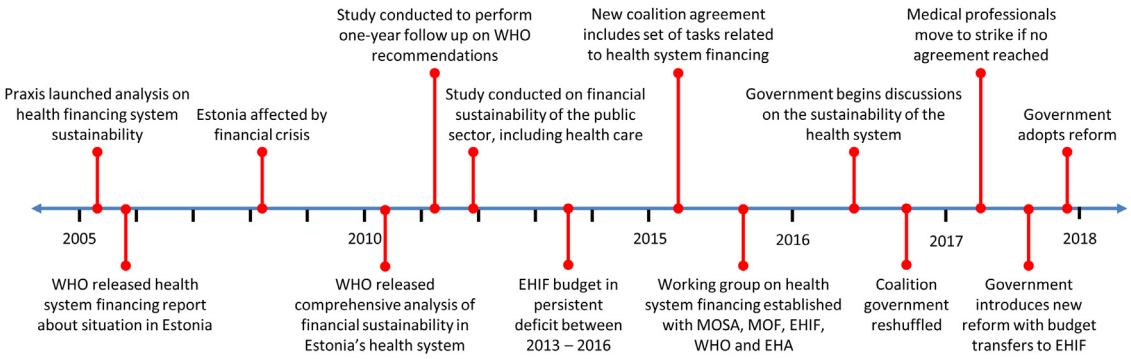

Fig. 1. Health policy process.

Source: Author's compilation

of revenue sources that includes general tax revenue. Indeed, the Estonian health insurance system has been rather exceptional in that it was solely based on wage-related contributions while other central and eastern European countries with national health insurance schemes increasingly moved towards including more funding from general tax revenue [4]. The Estonian experience provides valuable policy lessons for other countries looking to expand the revenue base or enact health financing reforms.

2. Political and economic background

Estonia is a high-income country with a mandatory health insurance system established in the early 1990s. Since then the country went through rapid social and economic changes, transitioned from a lower middle income country to a high income country, and energetically reformed its health system [4,5]. The level of health expenditure as a share of GDP is low in Estonia compared to EU and OECD averages. It was around 5% of GDP between 2001 and 2007 and then rose above 6% during and after the financial crisis, because the health sector contracted less than other economic sectors. The Estonian Health Insurance Fund (EHIF), an autonomous agency responsible for purchasing a broad range of health services, pools most public funds for health care. Prior to the reform, the EHIF covered only the insured population – between 94–96% of Estonians [6,7].

Estonia's health system is mostly publicly financed through an earmarked payroll contribution of 13%. These revenues account for about two thirds of total health financing. Before the reform in 2018, the state budget funded some individual health services, accounting for around 10% of total health spending. These included services available to the whole population such as ambulance care, public health programmes and immunizations, as well as emergency care for the uninsured. The central government also contributed revenue to the health insurance budget for certain population groups (e.g., individuals on parental leave and caregivers of disabled people) but these groups form only a minor share (3.5%) of total insured population in 2016 [8]. The annual state budget defined the contribution for this group, but it could not be lower than the contribution rate calculated based on the previous years' minimum wage. Yet, additional revenues through that contribution were rather marginal. Children and pensioners were all eligible to the health insurance without any additional contribution made on the behalf of them. In total, 47% of all insured were covered with health insurance without any form of contributions in 2016, showing broad solidarity in the system [5].

About quarter of total health spending is financed from private sources (25.3% in 2017) [9], which is considerably above EU averages (20.6% in 2016) [10]. The majority consists of direct payments made by patients for medicines and dental care. As the share of public health expenditures has remained stable over the years, the increase in public spending has not curbed out of pocket expenditures [9].

3. Health policy processes

The heavy reliance on wage-related contributions and the relatively low level of public spending has been an object of political and public debate for over a decade, and Fig. 1 depicts an overview of this process. In 2005, the Praxis Centre for Policy Studies Foundation (Praxis) conducted an analysis on the health financing system, with key findings about sustainability concerns [11]. At the same time, a WHO report (2005) on the health financing system in Estonia recognized the need to broaden the revenue base [3]. A more comprehensive analysis by the WHO followed in 2010, commissioned by the Ministry of Social Affairs and prepared by a working group convened by the EHIF [2]. A report at the national level followed after one year [12]. These reports continued to demonstrate that the design of the EHIF's revenue base was not financially sustainable and the Estonian health insurance system should move away from solely relying on wage-related contributions. After the WHO reports, the Ministry of Finance commissioned a comprehensive study on the financial sustainability of the public sector, which among other areas included health care [13]. Yet, even though high-level meetings and open hearings in the Parliament were held and extensively discussed in the media, none of these reports made it on the political agenda of the political parties nor were they explicitly discussed at the government level.

One possible reason that Estonia took no political action earlier can be attributed to the significant impact of the 2008 financial crisis. The main measures that enabled Estonia to cope with the crisis included temporary reductions in the health services tariffs paid to health care providers and more importantly, a significant reform of the temporary sickness benefits scheme reducing expenditures by 7% of EHIF's total budget [14]. Reducing the sick leave benefits available to Estonians enabled EHIF reserves to remain mostly unused during the crisis period, even though the EHIF had accumulated considerable reserves as a lesson learned from the late 1990s crisis.

The EHIF's conservative policy of balanced budgets and low external debt also provides clues for why Estonia postponed action. During the financial crisis starting in 2008, the government's main goal was to ensure fiscal sustainability to support growth and to meet the Eurozone criteria to enable Estonia to adopt the euro in January 2011. The EHIF has thus prioritized budgeting practices where expenditures fit to the available revenues without using reserves. However, this practice changed for four years between 2013 and 2016 when EHIF's expenditures were higher than its revenues and consequently its budget was in a persistent deficit.

Health professionals had strongly negotiated for wage increases, including striking in 2012, which triggered Estonia to use the existing non-mandatory reserves in the EHIF's budget to satisfy these demands.

In 2015 after the elections, the new three-party government was established with the Reform Party, the Social Democrats and the Pro Patria and Res Publica Union. The first coalition agreement included a set of tasks to explore options for additional healthcare funding. This provided the necessary momentum to bring the technical and academic discussions and overall policy dialogue to the next level. In October 2015, the coalition established a working group to provide analysis and proposals under the leadership of the Ministry of Social Affairs (MOSA) in collaboration with the Ministry of Finance (MOF), the EHIF, the WHO and the Estonian Hospitals Association. Consequently, in July 2016, the government discussed the financial sustainability of the health system for the first time in a decade. While these discussions did not lead to any conclusion, in the fall of 2016, the coalition government was re-shuffled and the Centre Party replaced the Reform Party. This represented the first time after 18 years that the Reform Party was not part of the ruling coalition.

As discussions continued into 2017, health professionals released a statement that if the government was unable to make a decision on the long-term financial sustainability of the health insurance system, they would strike as they did previously in 2012. In April 2017, the government responded by introducing a new reform increasing the state budget transfers to the EHIF. This state budget allocation would be made on behalf of non-working pensioners. Along with the decision of additional funding, the government agreed that the EHIF would finance some of the services previously financed through the state budget in order to reduce fragmentation in the healthcare system. Parliament then discussed these decisions and adopted the package of legal amendments in early December 2017.

4. Content of reform

Starting from 2018, the EHIF's revenue base was gradually broadened to include a new type of revenue source calculated on the basis of the pension distributed to non-working pensioners. Only non-working pensioners are included in the state budget transfer because working pensioners already contribute through their employers' social tax. The transfer is calculated from the general state budget revenues using actual data of pensions from the Social Insurance Board. The reform agenda foresees a gradual increase of this transfer from 7% in 2018 up to 13% of the average state guaranteed pension in 2022. Therefore, by 2022, the transfer on behalf of pensioners will equal the 13% contribution rate from employees. With this decision, Estonia has diversified the revenue base to include an earmarked budget transfer for health insurance to complement its existing earmarked tax on wages for health insurance. When the reform was implemented in 2017, it was forecasted that by 2022 this new additional revenue source would contribute around 11% of the EHIF's budget and amount to around 200 million euros.

In parallel, Estonia has consolidated previously state-financed health expenditures under the EHIF's budget. With this consolidation, the EHIF will gradually become responsible for health services and functions that were previously financed and operated by the state. These include emergency care for the uninsured, ambulance care, HIV and drug dependency treatment, among other pharmaceuticals and services. For example, the EHIF is now able to centrally procure certain pharmaceuticals (e.g. ARV, TB medicines and vaccines). The reform also broadens the population served by the EHIF, which had historically only been responsible for insured persons, to the entire population of Estonia including the currently uninsured. The reform does not include any changes to the population coverage or benefit package and thus does not result in universal health coverage.

Of the predicted 200 million euro increase to the EHIF's budget by 2022, around 100 million will be additional funding to the EHIF to cover the cost of services taken over from the state. The EHIF can use the remaining funds at its discretion, for example to improve access.

This is not predicted to significantly increase the total public health care spending (about 0.2% of GDP by 2022) [5]. Arguably more importantly, an explicit formula-based revenue allocation to the EHIF's budget will replace the previously annually negotiated and potentially less stable budget allocations at the state level.

5. Stakeholders views on health financing reform

The main driver of the reform was the political commitment to tackle the health insurance financial sustainability issue. Historically, social democratic governments have prompted all radical health financing decisions, from introducing the health insurance system in 1992 to establishing the EHIF in 2001, and this reform follows the same pattern. Opposition parties, as defined as those not in the coalition government when parliament passed the reform in 2017, did not strongly resist the idea of introducing the additional transfer on behalf of the pensioners but they criticised consolidation of additional functions under the EHIF because these would also cover uninsured persons. For example, there was a concern that if EHIF finances services for the entire population and the system insures all Estonians, the population may have less incentive to contribute to the health insurance system by working in the formal economy and people could decide to work in the black market, leading to losses in tax revenue [15].

Fig. 2 maps the position of each key stakeholder group as well as the influence of the group. The powerful Estonian Medical Association (EMA) is the most prominent professional group representing doctors in Estonia and has been highly supportive of broadening the revenue base for the last decade. Their support was also crucial during the introduction of the health insurance system in the early 1990s [4]. The EMA's threat to go on strike unless the government acted played a key role in passing the reform. During the 2017 reform, the EMA demanded to keep all additional funding for the health system, especially for the hospitals. However, as the discussions continued the EMA finally accepted that part of the additional funding should go to the EHIF in order to cover services previously funded from the state budget. Still, the EMA did not publicly endorse the reform in the end because they opposed consolidating ambulance care under the EHIF [16].

Other health sector stakeholders, including the Estonian Nurses' Union and Estonian Hospital Association were supportive, and the latter favoured the idea of additional funding coming to the hospitals. Nurses' concerns mainly related to the EHIF's new functions, and they questioned the short time period without public consultation in preparing this fundamental change in the health sector. Understandably the Union of Estonian Medical Emergency represented the opposing position, as from their perspective, consolidation of ambulance care financing under the EHIF's budget would reduce their bargaining power for additional funding [15]. The Estonian Employers' Confederation opposed the reform package as it could make working in the informal economy more attractive.

6. Preliminary and expected outcomes

One year into the reform, planning is in line with the initial scope and timeline. The EHIF will continue to take over additional ser-

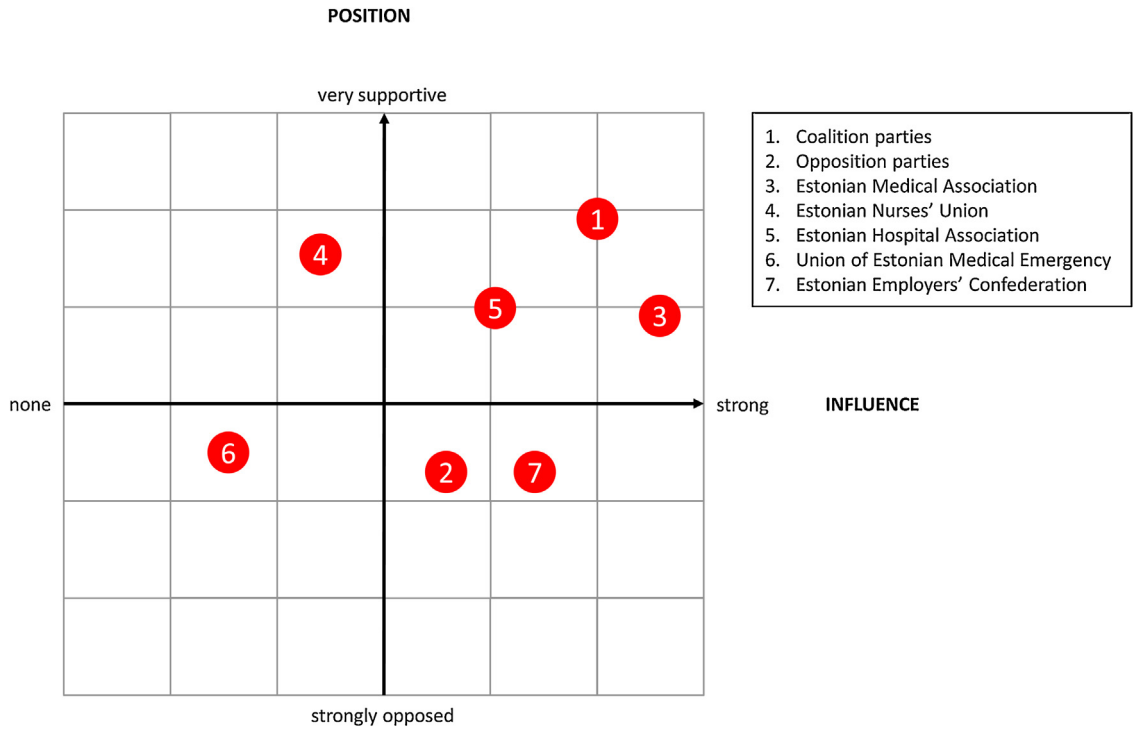

Fig. 2. Stakeholder's views on health financing reform.

Source: Author's compilation

vices and the state budget transfer will continue to increase until the reform concludes in 2022. In 2019, the state budget transfer will increase from 7% to 10% and EHIF will begin to reimburse emergency care for uninsured and centrally procured drugs (as for Tuberculosis, HIV/AIDS) and vaccines. In 2018, the EHIF used extra funding on efforts to improve access to specialist care by reducing waiting times to cataract surgery and endoprosthesis as well as increasing the volume of inpatient care. However, there is no system to monitor the use and outcomes of the additional funding. Additionally, due to the favourable economic environment, the EHIF revenues from the social tax are already increasing more than 10% annually, resulting in a very positive outlook for the 2019 budget [6].

The payroll tax will continue to be the predominant financing mechanism of the Estonian health system, ensuring redistribution of resources from higher-income groups to lower-income [17]. However, the growing state contributions on behalf of the non-working pensioners funded from general revenues could have some re-distributional effect over the next years and as larger reliance on indirect taxes or additional contributions from the central government may lead to more regressive health care financing and equity concerns [18].

One spillover of the reform is that it has led to some initial public discussions on the general design and fairness of insurance coverage as well as possibilities to move to universal population coverage. Universal health coverage includes dimensions of population, service, and cost, and gaps in the insured population in Estonia have led to debate about population coverage. In 2018, a MOSA-funded study provided new evidence on gaps in Estonian health insurance coverage [19]. The study found considerable gaps in the health insurance coverage among the Estonian working age population (between 19–65 years). As of November 2017, only 86% of the working age population were insured. However, most uninsured have had insurance at some point in time: only 27,000 of the 120,000 uninsured in Estonia had no health insurance at all during the last 11 years. The study suggests the current system is not flexible enough to consider various forms of employment, so that individuals without a permanent full-time position have potentially unstable insurance coverage. Fine-tuning the current system could expand health insurance coverage by up to 1% of the population, but more public funding will be needed to achieve universal or near-universal population coverage. However, there is currently no political appetite for any further system-wide reforms.

7. Key lessons learned

The first lesson that could be learned from the Estonian experience is that a health policy reform agenda requires extensive preparation and consistent messaging over a long period of time. In the case of this reform, the financial sustainability continued to be the most analysed and discussed topic in the country's health sector for over a decade. Evidence-based studies from national and internal organizations created a common understanding and language about the situation in the health sector, framed key messages, helped take away persistent and common misconceptions, and enabled the public to understand the challenges faced by the health sector. Continued discussions with only one prominent solution carrying consensus– introducing state budget funded transfers on the behalf of pensioners – ensured broad acceptance for the reform design.

A second important lesson is that the Ministry of Health and Ministry of Finance should work closely together to design the reform. The MOSA and MOF conducted several joint studies, often with support from credible international partners (e.g. WHO), on the financial sustainability of the health sector. This has enabled dialogue informed by evidence and consensus building on potential solutions. Although the two ministries advocated different approaches to increase revenues for the EHIF, joint working groups provided the forum to discuss these differences and explore international experiences and evidence.

Third, it is important to use the right momentum to secure political commitment and enact reform. In the Estonian experience, the

government's decision to focus on reforming the health insurance system was supported by a favourable economic environment in addition to the Minister of Health position held by the social democrat party. This combination created the fiscal and political space to discuss increasing the state budget transfer.

Fourth, governments enacting health reform should seek support from health professionals and recognise the significance of their role in advocacy. In this reform, health professionals often spoke publicly on behalf of patients to ensure access to care and better financial protection. This shifted the advocacy of health professionals for the first time away from increasing their salaries towards increased public funding for the health sector. This received very strong public support as long waiting times due to the limited funding have been a longstanding concern among the public.

Fifth, policymakers should design reforms in such a way that they offer something for different stakeholders as part of a broader reform package. In the case of Estonia, the key reform objective to diversify the health insurance revenue base could not have been accomplished by increasing the health sector budget alone due to lacking political support. Therefore, policymakers found an opportunity to combine broadening the revenue base, as favoured by the MOSA with the consolidation of existing health expenditures as favoured by the MOF in order to move forward. The Ministry of Finance welcomed this compromise as it reduces existing fragmentation in the purchasing function and enables increased administrative efficiency in the heath sector.

Lastly, the public and politicians require a level of understanding about the gaps and issues in existing financing and explicit plans about how the health care system could best utilize additional funds. Without this, policymakers will prioritise short-term solutions and lose larger opportunities for structural reform. In the Estonian context, health policy advocates supported redesigning the service model, but no accompanying plan was available for a wider audience to support this idea. Therefore, hospitals will receive additional funding to maintain access to care and shorten the waiting times in some clinical areas such as cataract surgery and endoprothesis. Thus, the initial idea to use the additional funding to support structural reforms in the service delivery and move towards better care integration may have been overruled by a "business as usual" approach.

8. Conclusions

Estonia's latest reform to diversify the health insurance revenue base is in line with reforms other countries have made over the last decades that aim to ensure sustainability of the system. Estonia achieved the key objective of the reform to increase the revenue base of the health insurance system by consolidating previously state budget funded services under the EHIF. This not only widens the EHIF's role in Estonia's health sector but has also prompted recent discussions about achieving full universal health coverage for its population. Over the time, it will be possible to evaluate whether pooling resources, consolidating health delivery functions and strengthening the purchasers' role in the health system will improve access to services and medicines, ensure better financial protection, facilitate continuity of care and ensure efficient use of resources. Continuously monitoring and studying if Estonia is moving forward towards universal health coverage, including improving financial protection, is essential.

The financial sustainability of the Estonian health system will be an ongoing concern, as this reform arguably does not bring enough additional funds to support an ageing population and the increasing prevalence of chronic diseases. It is difficult to estimate the revenue increase of the EHIF and the change to the health sector's share of GDP. Still, the first step to diversify the EHIF's revenue base is complete and it has opened the door to continue discussing the optimal level of public financing for the health system in the future.

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