Purchasing in Estonia

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Topics to be discussed:

- health care reforms in Estonia
- planning and pooling
- contract – with whom?
- process of the contracting
- quality developments and P4P attempts in Estonia

Estonia

2009:

Population 1 340 415

Insured persons 1 281 718

Active care hospitals 18 (+ 3 local hospitals)

FP-s (GP) 802

NHA in 2007:

Total Health Exp 5,4% of GDP

Per person 618 EUR

OOP 21,9%

Main reforms

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Health financing reform 1992

- Introduction of health insurance
- Autonomy to health care providers
- Contracts between EHIF and individual hospitals
- New payment methods for health services

Primary care reform

- Training in family medicine from 1993
- Autonomy and new contracting/financing model from 1998

Hospital reform

- Administrative closers 1994
- Masterplan and implementation from 2000

Acute care hospitals beds

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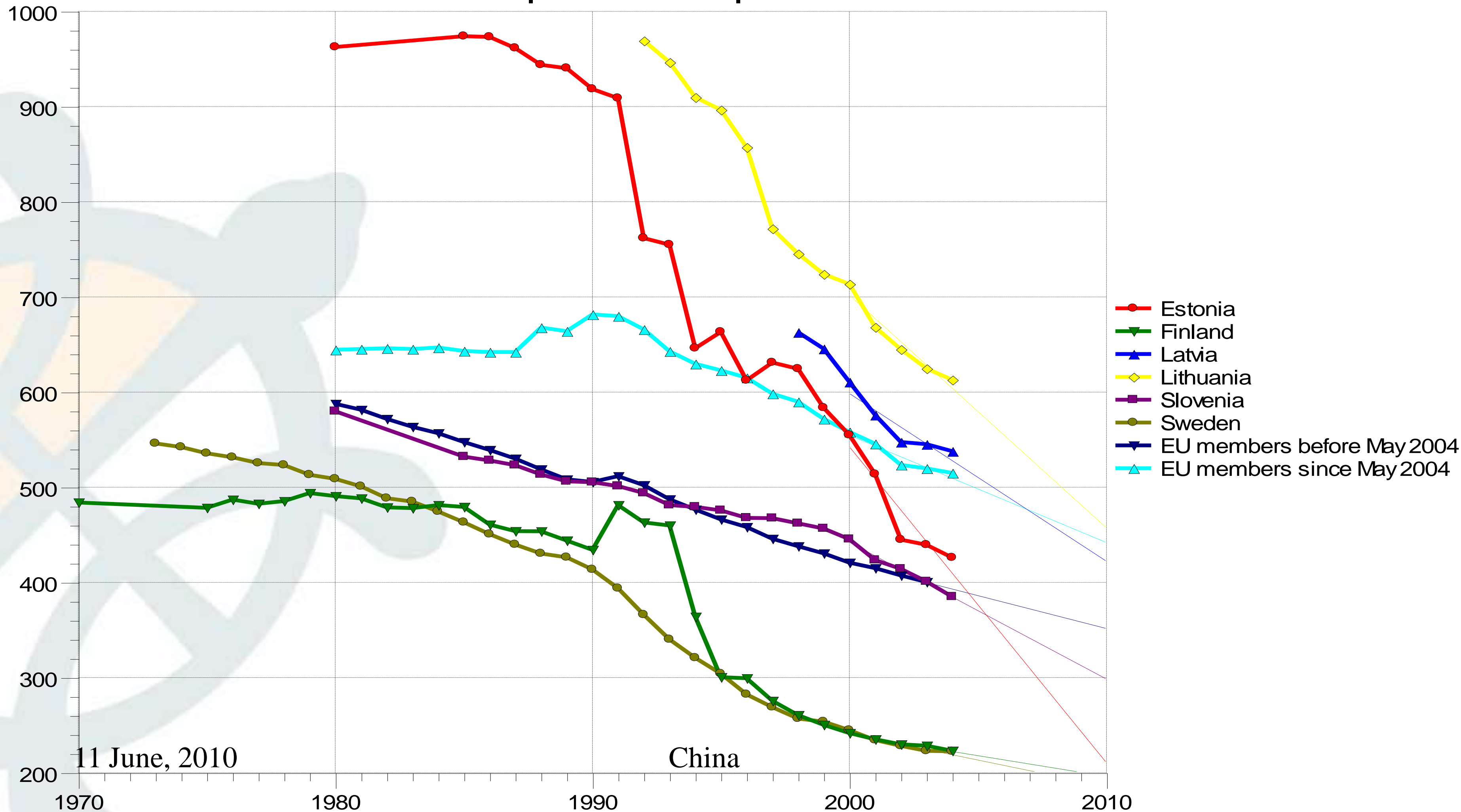

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Expenditure "controlled" by the EHIF (covered by contracts):

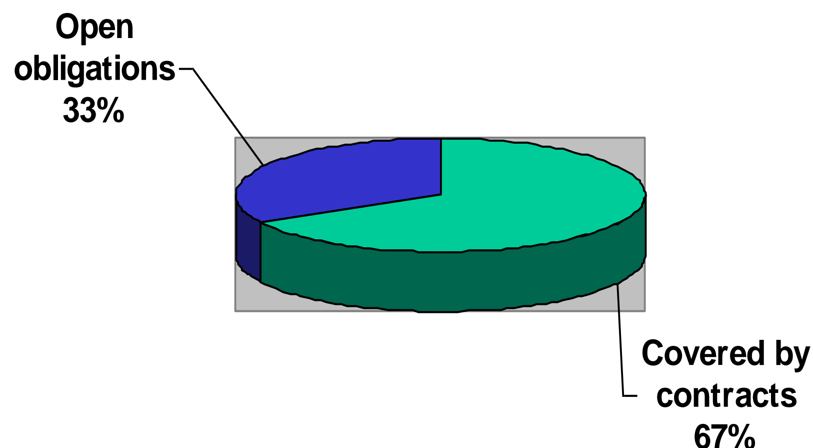
- Health services
- Health promotion costs

Open obligations

- Pharmaceuticals
- Sick-leave benefits

(for incapacity for work)

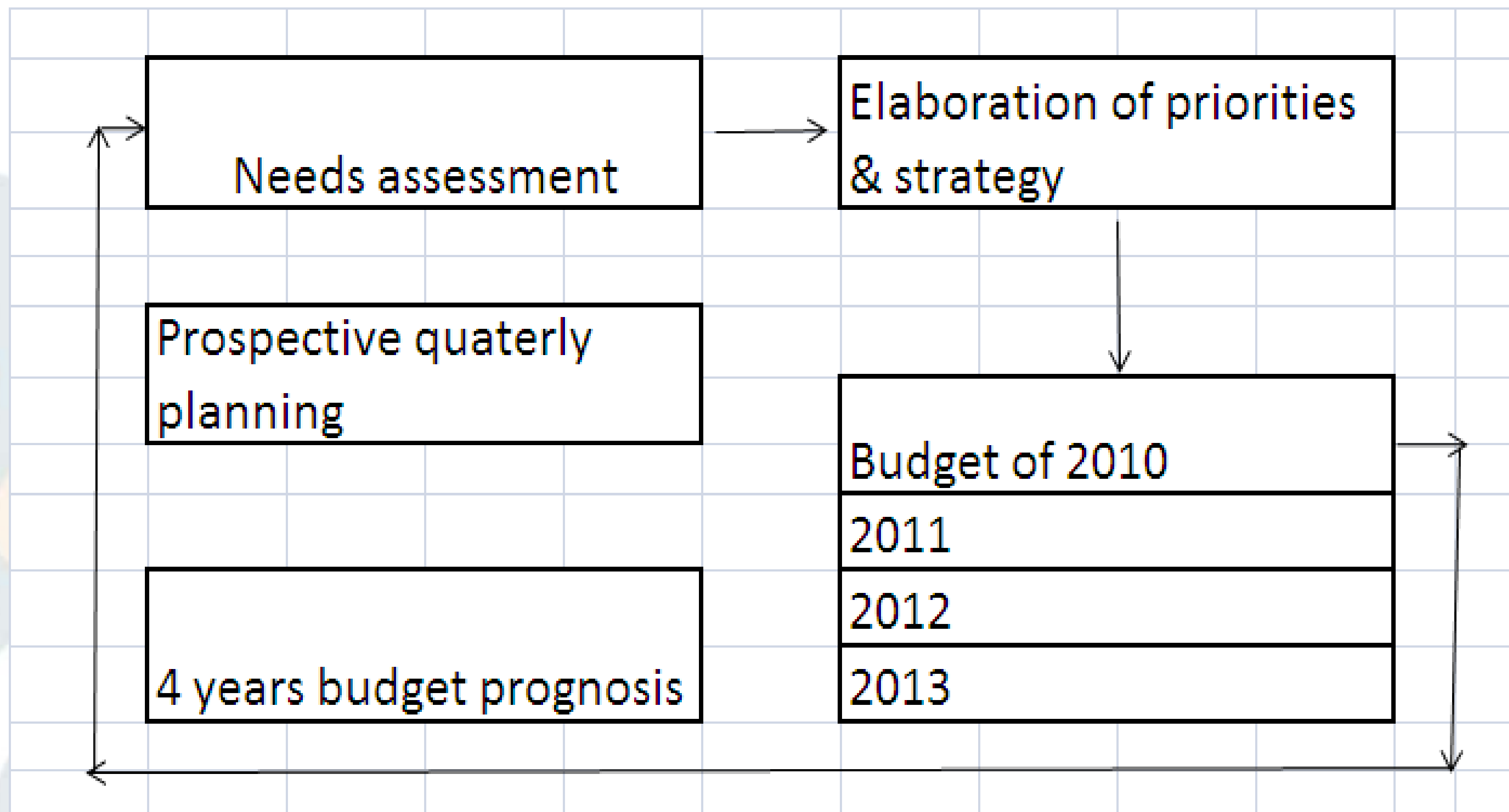
- Other cash benefits



Proactive strategic purchasing

- Which services to purchase
  - Needs assessment & planning
- How to purchase
  - Type of contract and provider payment method
- From whom to purchase
  - Effective provider,
  - selection of providers

Planning circle



Stages of the planning process cont

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Health care needs assessment – starting point of the planning

- For all budget sections
- Number of cases
- Estonia nationally and by regional branches

Our tools in needs assessment:

- Utility data (number of cases, waiting lists)
- Comparative analysis (by regional branches&average in Estonia)
- Development plans of specialities
- “Corporate view” from purchasing staff

Stages of the planning process cont

Establishment of the budget

- Determination of priorities & pooling resources
- Planning cases to ensure the access
- Budget: cases and amounts per specialities and per type of care
- Closed sub-budgets (PHC, specialized and long-term care, dental care, prevention-promotion)
- Verify budget with assessed needs (if needs exceed budget – establishing maximum-waiting times by EHIF´s supervisory board)

Pooling of ressources

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Main source of EHIF revenues is a social tax (about 97% in 2009)

EHIF purchases most of health services to insured (exc ambulance care)

- The collected funds are pooled centrally and allocated among 4 EHIF regions per capita without need-adjustments
- Reimbursement of drugs and sick leave benefits - administered centrally

EHIF´s costs and revenues 2001-2010

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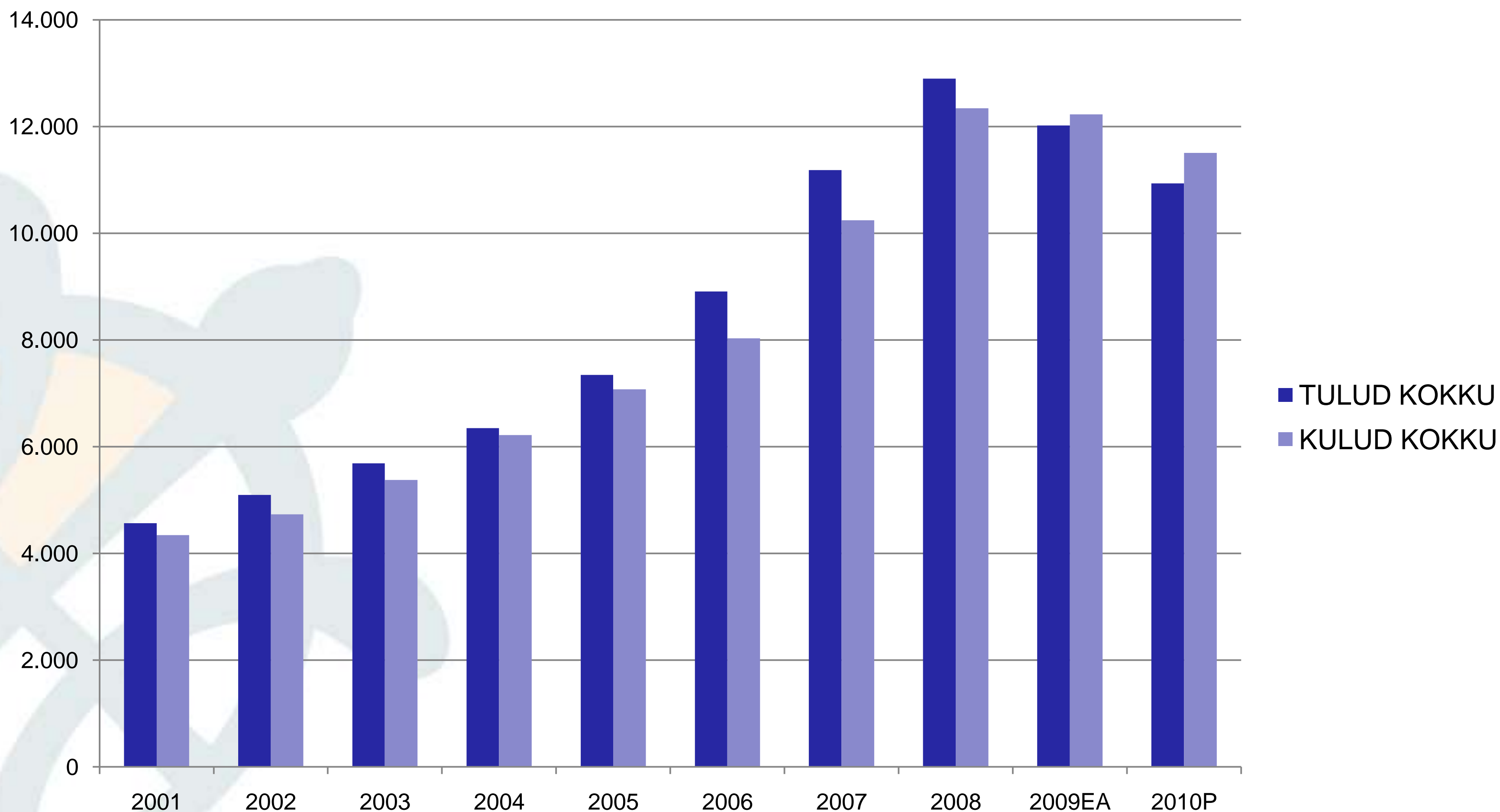
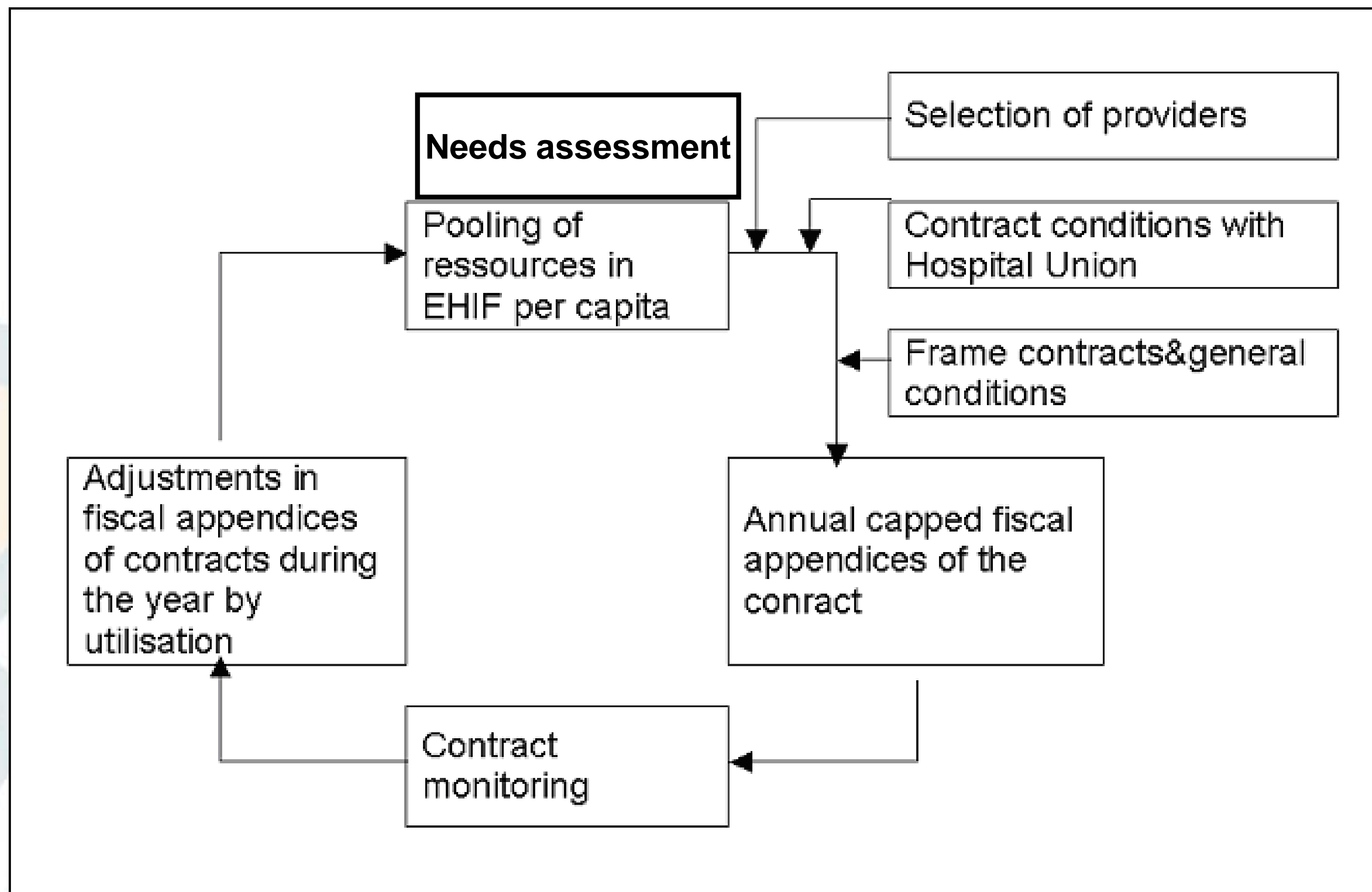


Contracting

- main tool for “communication” between providers and EHIF
- as well as for cost control on system level

Contracting circle



Contract – with whom?

EHIF isn´t required to contract all providers

Provider can be offered a contract:

- a hospital specified in the Hospital Masterplan through negotiations since 2003
- through selection of providers (limited competition)
- GP – have to compete, competition is organized by county governor in cooperation with EHIF

Selection of providers

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Aims of selective contracting

- Mild market competition to improve quality (where many providers)
- Service provision in remote areas that are less attractive for hospitals or to guarantee access

Amount of services for competitive selection

- Mainly outpatient services & dental care&nursing care
- The extent of the budget that remains after negotiations with hospitals specified in the HMP (ca 15% of cases)

Tendering is open for all providers (excl HMP hospitals) – defined number of expected cases on speciality in a certain area

The terms of the contract

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The frame contract and general conditions are concluded:

- with a hospital specified in the Hospital Masterplan – for 5 years
- through selection of providers – for 3 years

Every year negotiations about fiscal appendices of the contract with each provider:

- the amount of obligations (the minimum volume of health services provided);
- average price of the case

Basic principles: access to services

Guarantee access to agreed services during the time the entire contract is valid

Define management of queues and increase transparency of long queues

Define maximum waiting times in contracts

- emergency - no delay
- elective - outpatient specialist 6 weeks; in-patient – up to 8 months (exc)

Lepingu nr:	6057104	
Lisa nr:	3-05-2	
Eesti Haigekassa:	Tartu osakond	
Lepingu kuupäev:	22.03.2004	
Lepingu muudatuse kuupäev:	17.03.2005	
Tervishoiuteenuse osutaja:	Viljandi Haigla SA	
Periood:	01.01.2005 - 31.12.2005	

	I kvartal 05							
	Ambulatoorne		Päevaravi		Statsionaarne		Kokku I kvartal 05	
	Ravijuhud *	Summa	Ravijuhud *	Summa	Ravijuhud *	Summa	Ravijuhud *	Summa
	arv	krooni	arv	krooni	arv	krooni	arv	krooni
Kogusumma	13 052	4 086 752	260	735 102	1 849	14 084 983	15 161	18 906 838
▽ **Eriarstiabi**	13 052	4 086 752	260	735 102	1 845	12 689 323	**15 157**	**17 511 178**
▽ **Kirurgia**	2 173	804 940	55	289 230	466	3 783 920	**2 694**	**4 878 090**
▷ üldkirurgia	2 173	804 940	55	289 230	466	3 783 920	**2 694**	**4 878 090**
▷ **Otorinolarüngoloogia**	981	215 626	52	187 166			**1 033**	**402 792**
▷ **Neuroloogia**	831	308 391					**831**	**308 391**
▽ **Oftamoloogia**	1 015	211 350					**1 015**	**211 350**
Muu oftalmoloogia	1 015	211 350					**1 015**	**211 350**
▽ **Sünnitusabi ja günekol**	2 684	956 243	135	249 608	261	1 415 410	**3 080**	**2 621 261**
▷ Muu sünnitusabi ja güneko	2 684	956 243	135	249 608	143	606 930	**2 962**	**1 812 782**
▷ Sünnitused					118	808 479	**118**	**808 479**
▷ **Pulmonoloogia**	253	63 262			20	261 180	**273**	**324 442**
▷ **Dermatoveneroloogia**	1 172	195 681					**1 172**	**195 681**
▷ **Pediaatria**	299	49 503			233	517 387	**532**	**566 891**
▷ **Psühhiaatria**	1 225	212 880			250	2 932 875	**1 475**	**3 145 755**
▽ **Sisehaigused**	2 127	818 165	18	9 098	540	3 408 362	**2 685**	**4 235 625**
▷ reumatoloogia	57	17 834					**57**	**17 834**
▷ endokrinoloogia	329	111 493					**329**	**111 493**
▷ gastroenteroloogia	95	38 200					**95**	**38 200**
▷ kardioloogia	871	439 587					**871**	**439 587**
▷ sisehaigused	775	211 052	18	9 098	540	3 408 362	**1 333**	**3 628 512**
▷ **Esmane järelravi**					25	133 925	**25**	**133 925**
▷ **Taastusravi**	223	221 185			50	236 265	**273**	**457 450**
▷ **Klassifitseerimata mitte**	69	29 525					**69**	**29 525**
▷ **Valvekulud**					4	1 395 660	**4**	**1 395 660**
▷ **Eriarstiabi reserv**								

Structure of EHIF cost-volume contract (I quarter)

I quarter									
Speciality	Out-patient cases	Sum	Day-care cases	Sum	In-patient cases	Sum	Total cases	Sum	Total
Cardiology	100	1000	10	1000	100	10000	210	12000	12000
General Surgery	100	1000	10	1000	100	10000	210	12000	12000
...									
...									
Contract reserve (up to 15%)							10	2000	2000
Total	200	2000	20	2000	200	20000	420	26000	26000

Contract monitoring & utilisation review

Capped Cost-and-volume contracts with providers

- caps are applied for every quarter
- development of the prospective cumulative monitoring
- monitoring volumes (measured in cases per specialty)
- monitoring costs (average cost per case in specialty)

“Overproduction”

Marginal pricing for supplemental services

- uses marginal cost/marginal price concept (since last year 30% of list´s price)
- applied to cover services that were produced over the agreed contract amount of HMP hospitals

Contract monitoring & utilisation review

Negotiations with providers during the year
- about contract amounts
- about average cost per case
- access

These negotiations may result
in amendments of the contract **due to the access problems**

Risk management in EHIF

Hospital contract level

- hospitals can reallocate up to 5% among different specialities inside a contract
- typical hospital contract has additional unallocated reserve up to 15% of total contract amount for reallocation among specialities inside the contract (but in coordination with EHIF)

Regional EHIF department level

- up to 3% of budget remains uncommitted in the beginning of the year

EHIF level (past – costly cases, now centralized planning of endoprosthesis and cataracts)

Risk management in EHIF cont

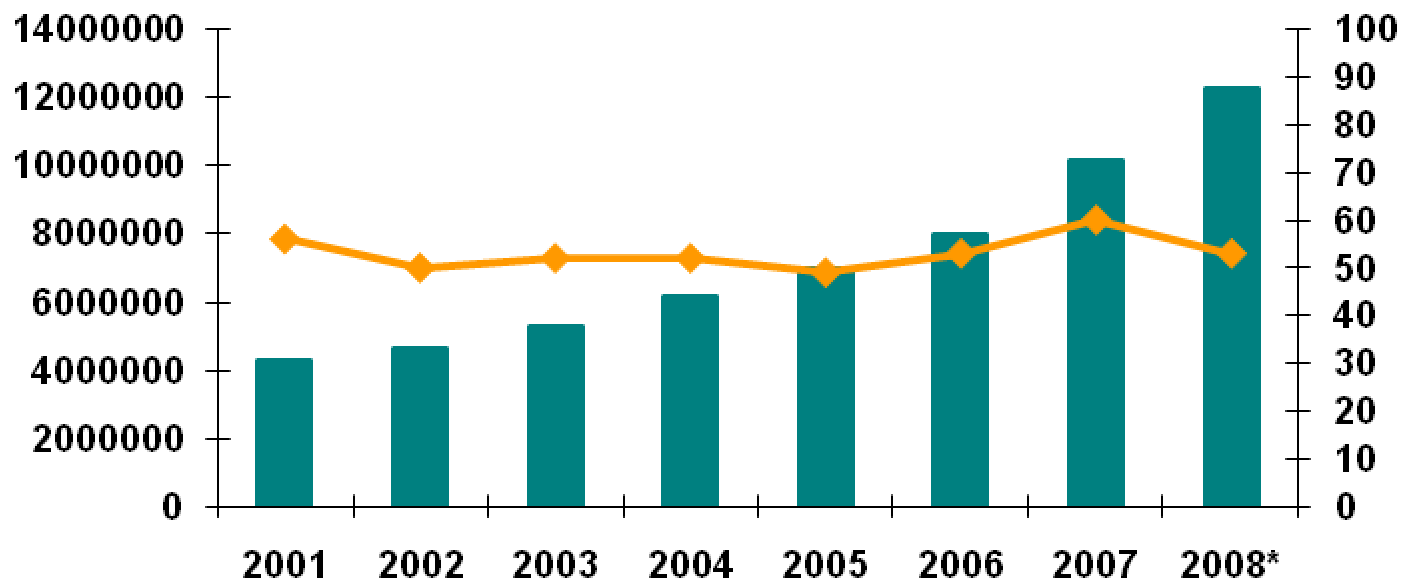
Legal reserve

- For the reduction of the risk which macroeconomic changes may cause to the health insurance system
- Since January 2005 6% from the EHIF´s budget (up to then 8%)

Cash reserves

- Can be used by management board for financing the expenditure of EHIF in the case of temporary cash squeeze
- Up to 2% from EHIF´s budget

Satisfaction with access and costs of EHIF



Thank You!

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