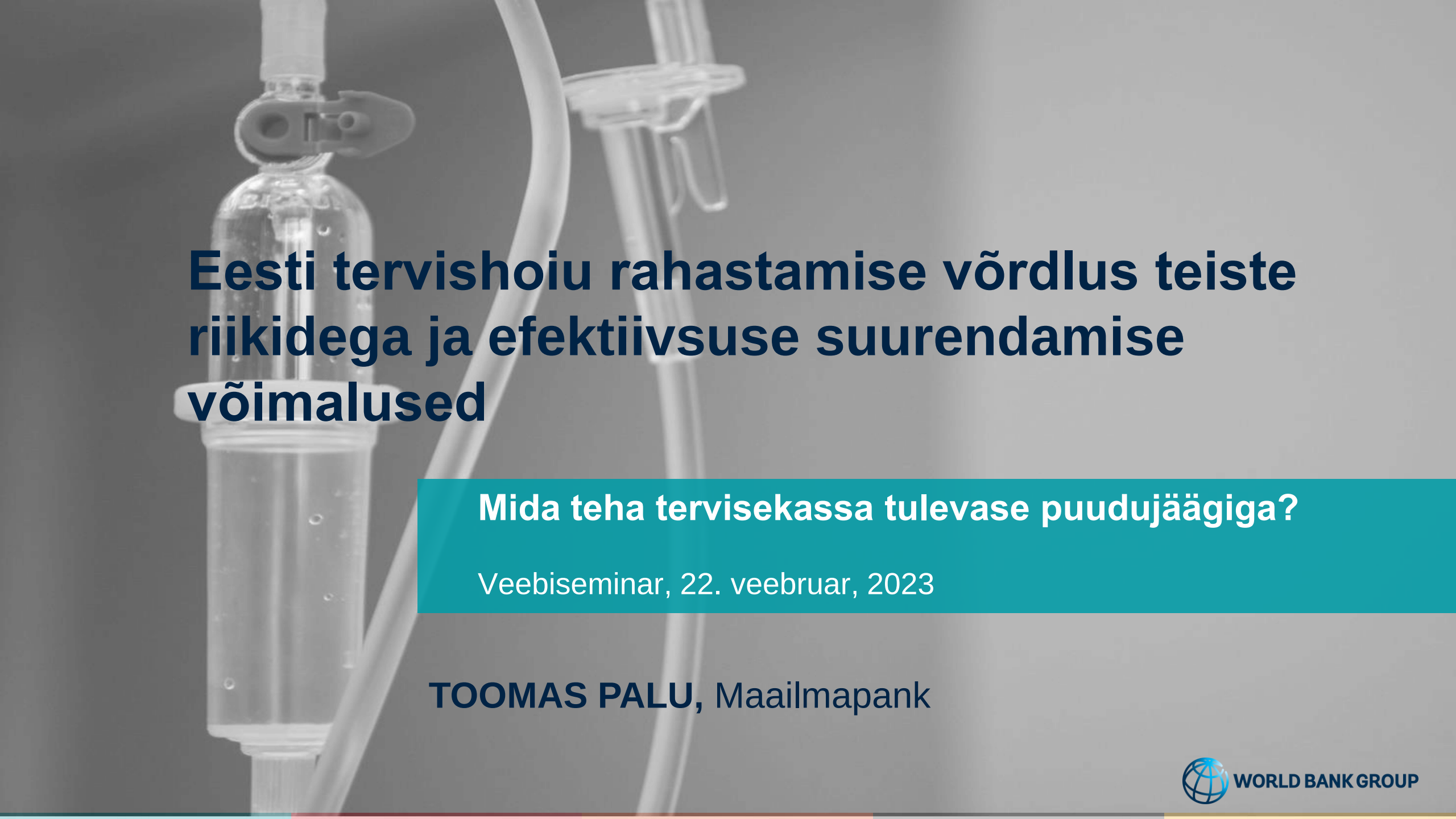

Eesti tervishoiu rahastamise võrdlus teiste riikidega ja efektiivsuse suurendamise võimalused

Mida teha tervisekassa tulevase puudujäägiga?

Veebiseminar, 22. veebruar, 2023

TOOMAS PALU, Maailmapank

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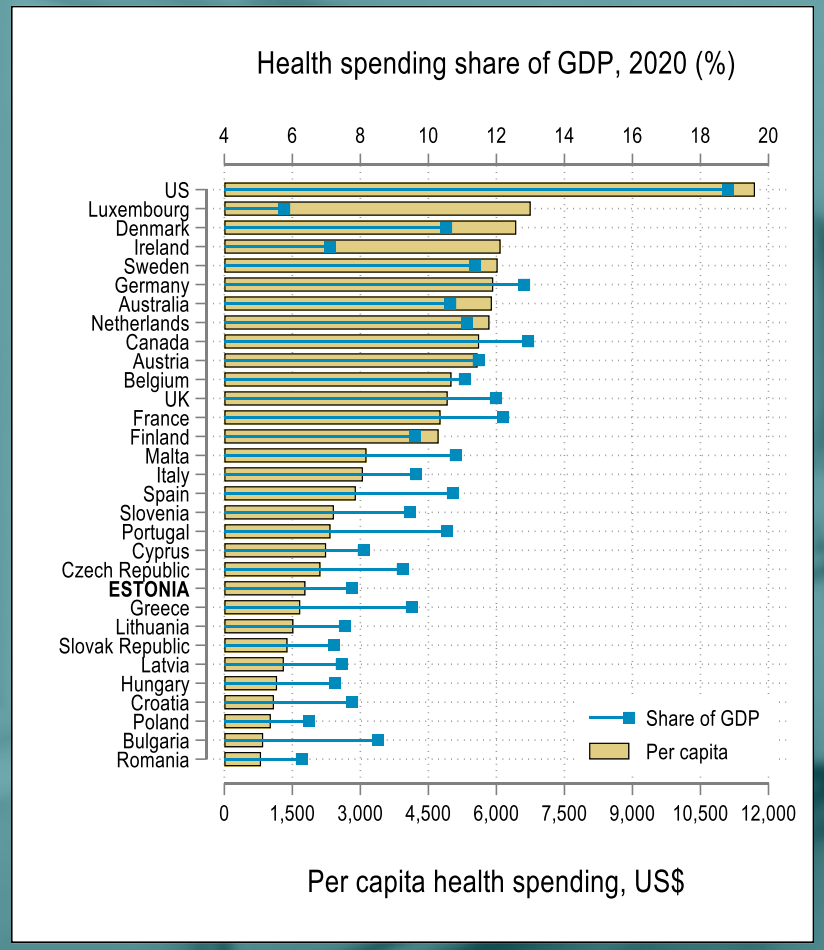
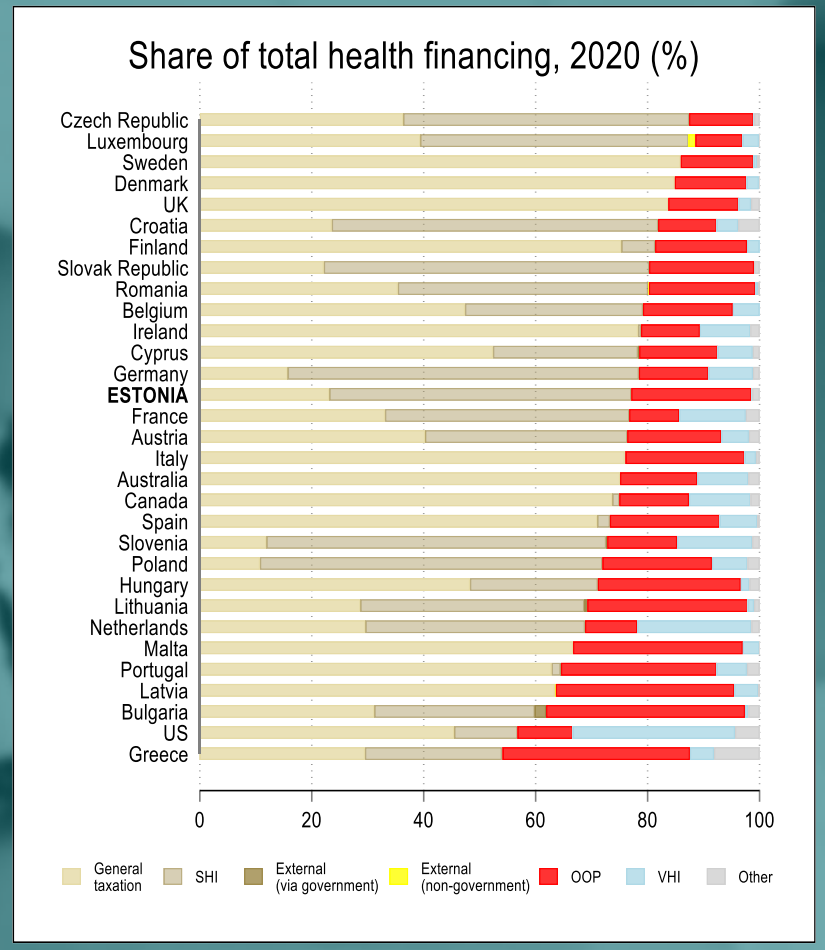
Health Financing in Estonia: Known View





- Estonia is one of the lowest spenders in health in Europe
  - per capita spending
  - as share of GDP
- Share of private OOP spending is high
  - above 15% threshold when catastrophic impact wanes
- Share of general taxation in THE among lowest in EU
- One of 3 countries in EU+ without VHI

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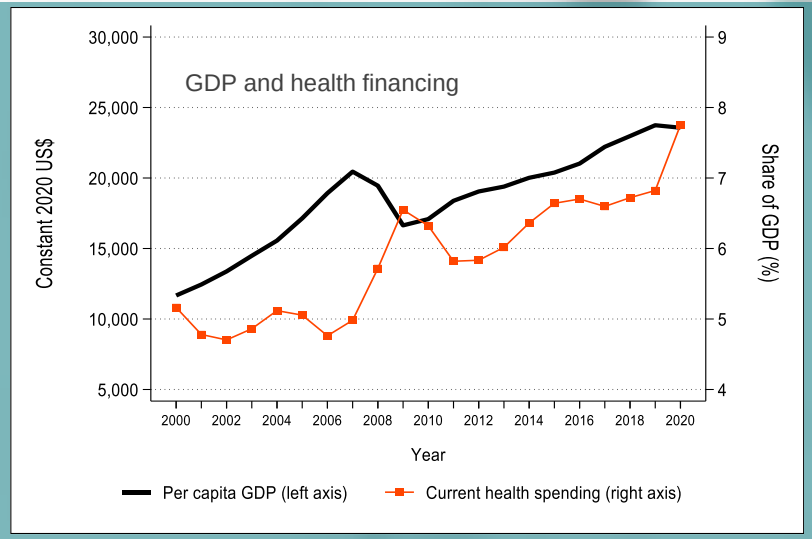
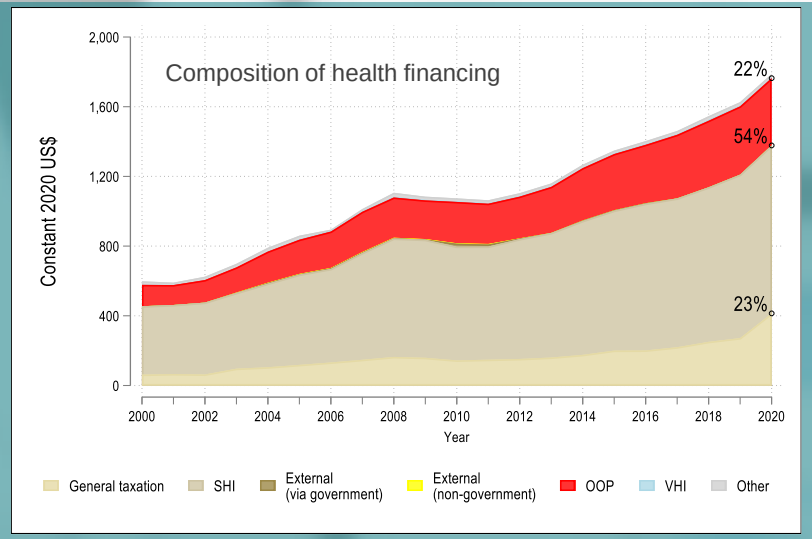
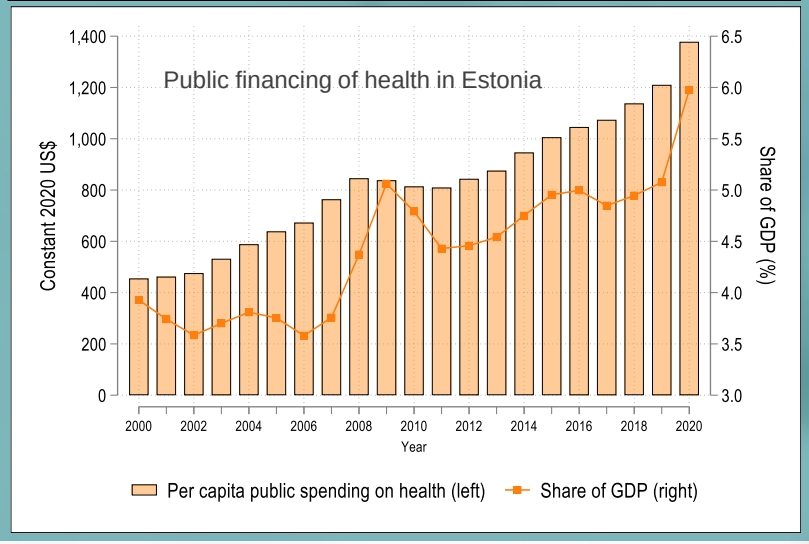
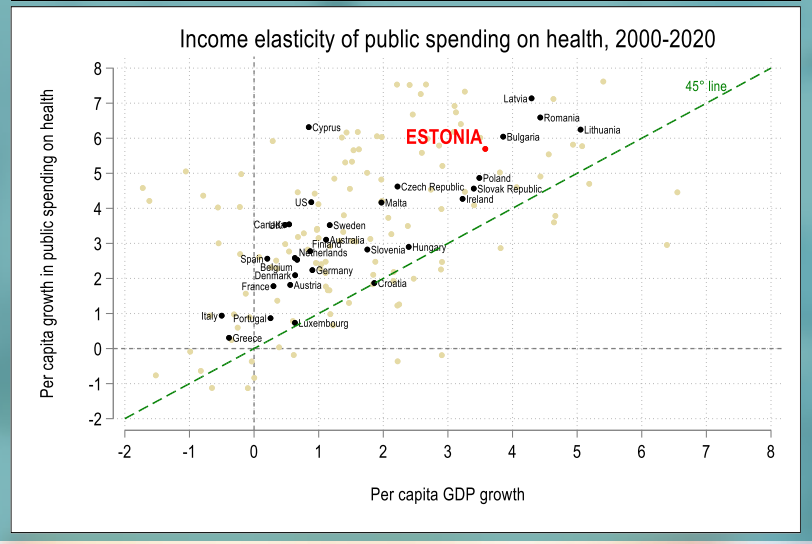
Health Financing in Estonia: Another View

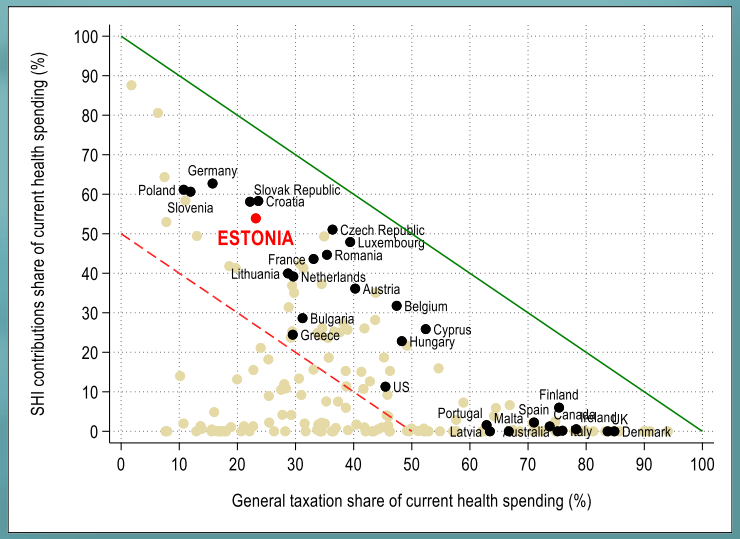




- Estonia health financing has been resilient to shocks
- Public health spending has been growing at faster pace, catching up with EU average
- Growth of OOPs as share of THE is worrisome
- Estonia no longer a Bismarckian dinosaur







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Determinants of Public Financing for Health*

Health's share X Public spending share of GDP X GDP = Public spending on health = Domestic + SHI + External

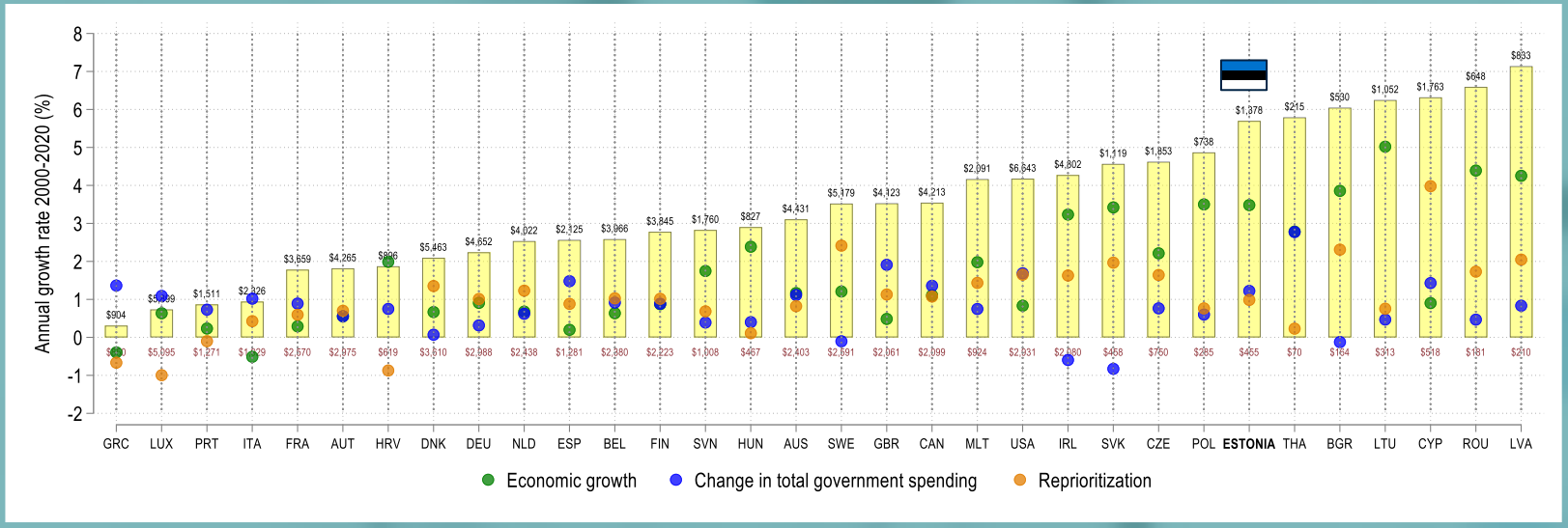
- Health's share: Priority to health
- Public spending share of GDP: Revenues, Grants, Deficit
- GDP: Size of economy
- Domestic + SHI + External: Composition of public spending on health

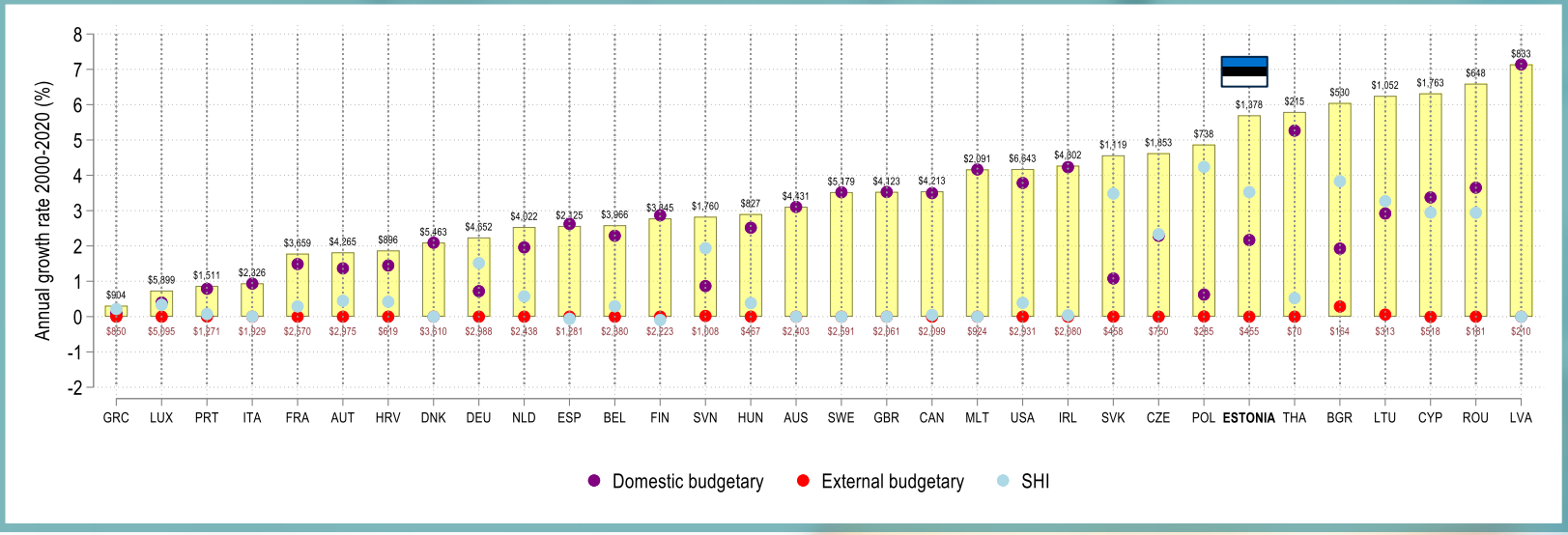
*Tandon formula

2000	2010	2020
11% X 36% X US$11,584 = US$455	12% X 40% X US$16,988 = US$814	13% X 45% X US$23,605 = US$1,378
Revenues 36% + Deficit 0.1%	Revenues 40% + Surplus 0.2%	Revenues 39% + Deficit 6%

Size of economy matters, but so does overall revenue effort, willingness/ability to borrow, and priority to health

Composition of Health Expenditure Growth





- Estonia has among fastest growth rates of public expenditure on health
- Most from economic growth but reprioritization of health also important
- SHI the main driver but budget contribution also paying role

Footnotes:

- *OECD data suggests that public expenditure growth rate accelerated further 2020-2021*
- *the best performer has relied completely on general budget allocation*

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Options for More Money for Health

- Change narrative – from health as recurrent discretionary spending to investment into human capital
- Resilient health system adds 1.4% of GDP on average health care costs in OECD countries compared to pre-pandemic normal
- Global trend to diversify away from SHI contributions as public revenue source for health
  - Cost of labor, gig economy, demographic changes impacting cost and revenues
  - Hard earmarking increasingly controversial
- Health taxes as an option for increasing Government revenues
  - Can contribute up to 2% of GDP (in Estonia currently around 1.2%)
  - Can be linked to soft earmarks for health
- Prioritizing health in budgets
  - Formula based allocations linked to costs for predictability and adequacy
- Reassess boundaries between private and public spending
- One silver bullet unlikely, combination of multiple measures
- Realize efficiency gains – More Health for Money

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More Health for Money: Efficiency Gains

What Efficiency IS

Doing the right things…

…In the right places

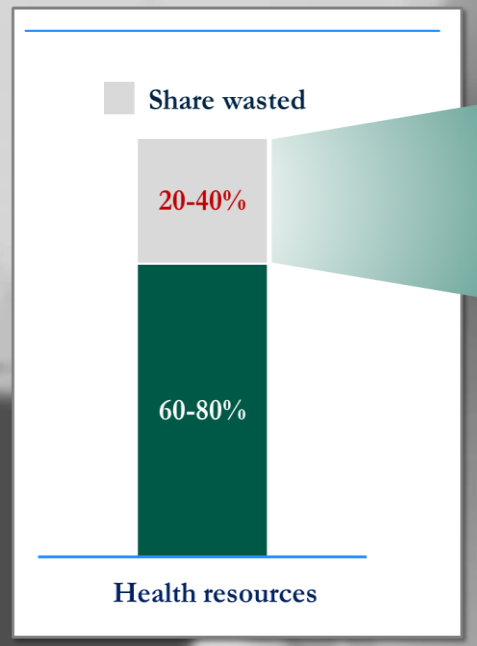
…In the right way

What Efficiency is NOT

- ✗ Balancing revenues and expenditures
- ✗ Cutting budgets

These measures can actually reduce efficiency…

The 3 R's: a comprehensive, action-oriented approach to efficiency



Allocative efficiency
- public health, PHC, specialist and hospital care

Technical efficiency
- Review incentive framework – DRGs, value-based care
- Procurement efficiencies
- More targeted approaches for financial protection
- Secondary prevention, chronic disease management
  - Ambulatory Care Sensitive Conditions (ACSC)

	Diabetes	Hypertension	Heart failure	COPD and Bronchiectasis	Asthma	Total (five conditions)
Admissions/discharges	800 303	665 396	1 749 384	1 109 865	328 976	**4 653 924**
% of all admissions	1.0%	0.8%	2.1%	1.3%	0.4%	**5.6%**
Average LOS (days)	8.5	6.9	9.5	8.9	6.6	**8.1** (avg.)
Total bed days	6 794 572	4 597 886	16 619 148	9 855 601	2 177 821	**37 603 706**
Proportion of all bed days	1.1%	0.7%	2.7%	1.6%	0.4%	**6.5%**

EU countries, 2015. OECD, 2017

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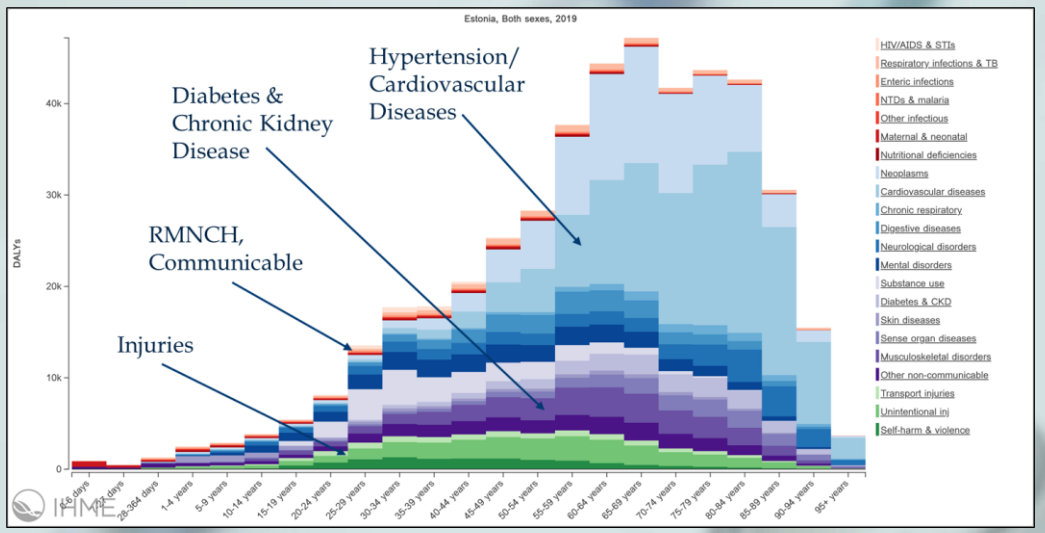
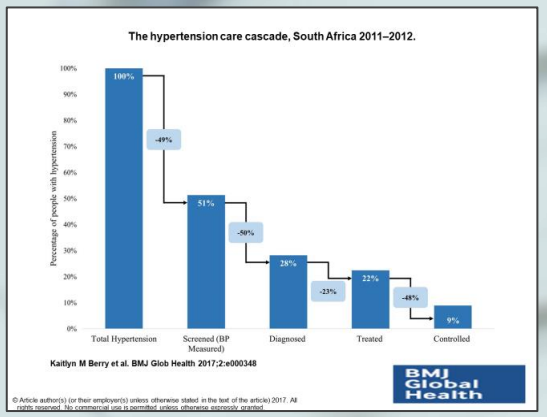
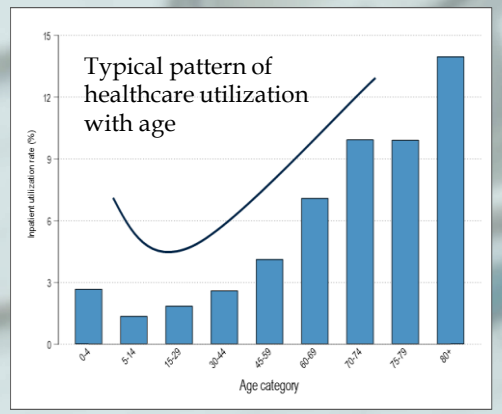
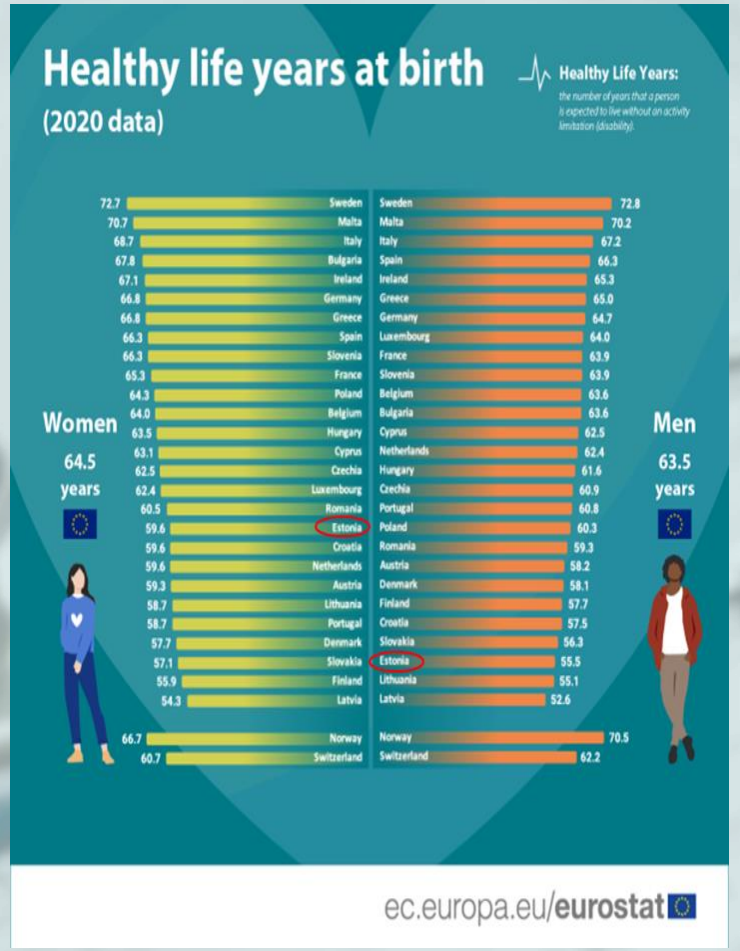
Disease Burden and ACSC







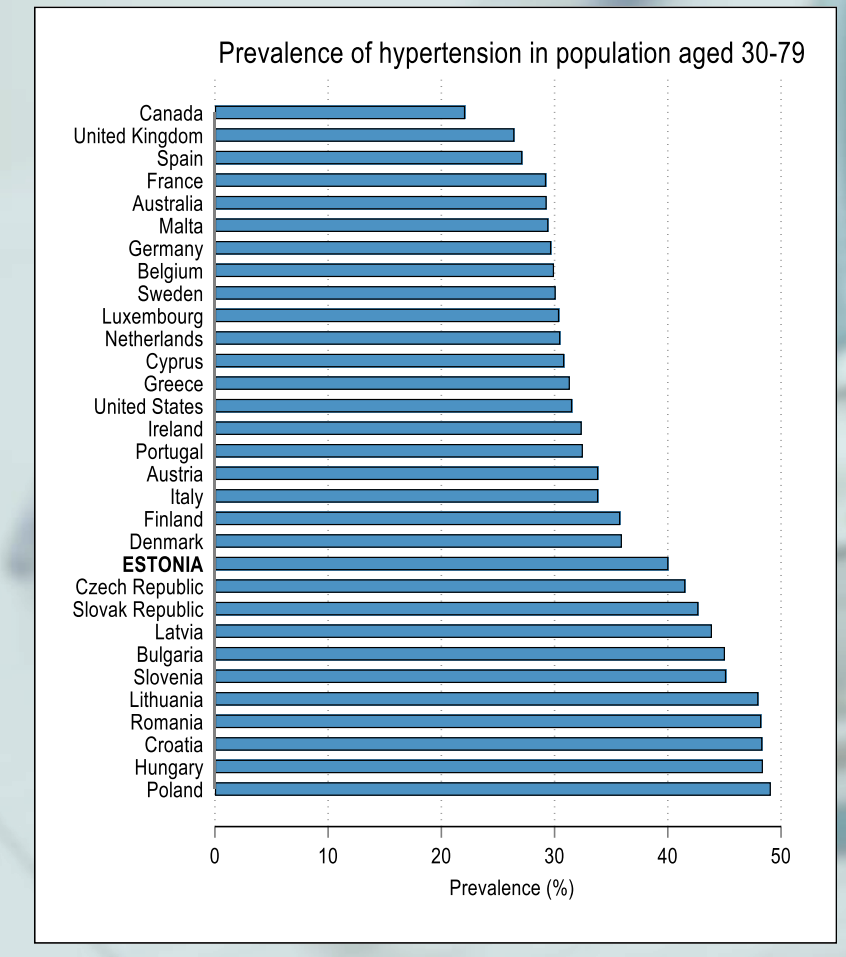


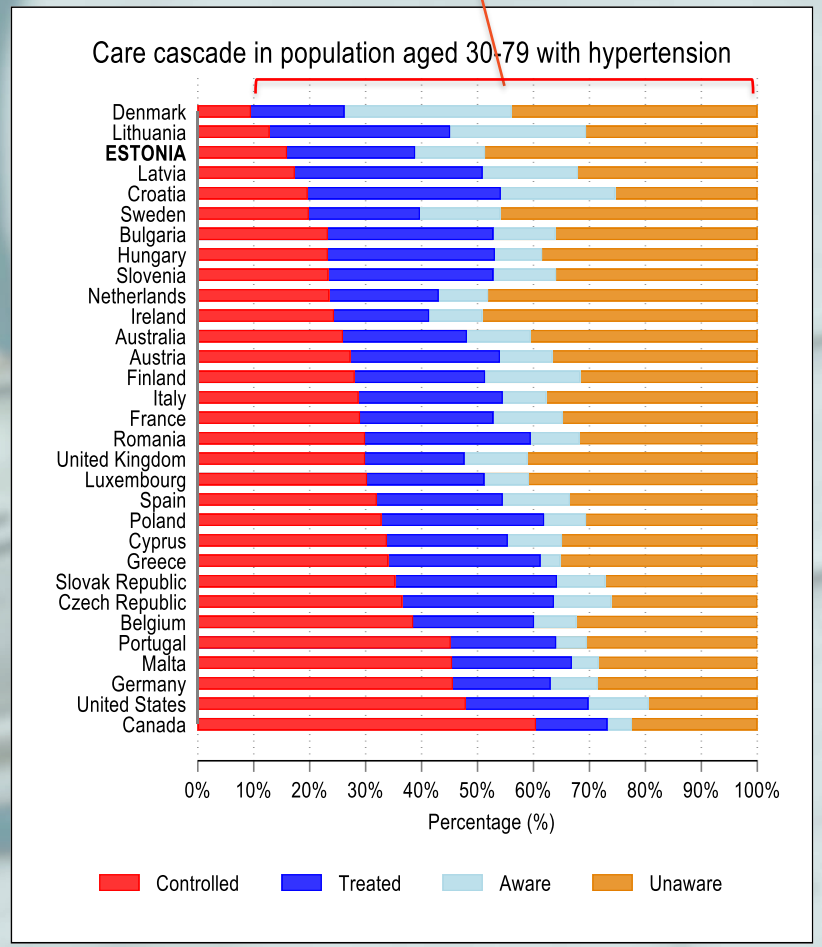
- Disease burden increases early in productive lives
- NCDs is a driver of health care costs
- Need to manage disease burden with efficiency and efficacy
  - Primary prevention
  - Secondary prevention and chronic case management
  - ASCS treatment cascade

IHME, Eurostat, BMJGH

Managing Disease Burden Better

Risk factors: age, excessive salt consumption, high saturated/trans fat diet, physical inactivity, low intake of fruits/vegetables, overweight/obesity, family history





Health promoting public policy

- Whole-of-government approach
- Health in All Policies

Secondary prevention and chronic case management

- Maximize performance of treatment cascade
- Minimize ACSCs in hospitals

Enablers

- Behavioral sciences
- Technology

Lancet, 2021

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Tänud!
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