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Strategic purchasing reform in Estonia: Reducing inequalities in access while improving care concentration and quality☆

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ABSTRACT

As of 2014, the Estonian Health Insurance Fund has adopted new purchasing procedures and criteria, which it now has started to implement in specialist care. Main changes include (1) redefined access criteria based on population need rather than historical supply, which aim to achieve more equal access of providers and specialties; (2) stricter definition and use of optimal workload criteria to increase the concentration of specialist care (3) better consideration of patient movement; and (4) an increased emphasis on quality to foster quality improvement. The new criteria were first used in the contract cycle that started in 2014 and resulted in fewer contracted providers for a similar volume of care compared to the previous contract cycle. This implies that provision of specialized care has become concentrated at fewer providers. It is too early to draw firm conclusions on the impact on care quality or on actors, but the process has sparked debate on the role of selective contracting and the role of public and private providers in Estonian health care. Lastly, the Estonian experience may hold important lessons for other countries looking to overcome inequalities in access while concentrating care and improving care quality.

1. Introduction

The Health Insurance Act stipulates that the Estonian Health Insurance Fund (EHIF), the core purchaser of health services in Estonia, is not obliged to contract all health care providers operating in Estonia. Since 2002 the EHIF has developed a transparent contracting process and introduced criteria for selecting the best providers in terms of quality and cost [1]. Health care providers are contracted for at least three-years. The last contract cycle for inpatient and outpatient specialist as well as nursing care ended in the first quarter of 2014. This provided an opportunity to revise the selective contracting criteria so that they would better respond to changes in the health care delivery system and population needs, but also to further prioritize providers with a higher quality of care. The changes needed to address the increasing role of family medicine based primary care with a gradual increase of gatekeeping and coordinating prevention and care [2]; the concentration of higher level specialist care; and an increased capacity of the Hospital Network Development Plan (HNDP) hospitals due to the EU structural funds investments. Unsurprisingly, these developments have had significant repercussions for the EHIF's strategic purchasing policy.

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Strategic purchasing, or active purchasing, in contrast to passive purchasing (e.g., use of historical budgets), can be seen as the main instrument for promoting efficiency in the use of health funds [3]. It should promote quality and efficiency by among others examining actual health needs and their regional variations, the interventions and services that best meet these needs, and how these interventions and services should be purchased or provided while taking into account the availability of providers and their quality [4]. Today, many countries are grappling with these issues and seek to develop the expertise and systems to implement an effective strategic purchasing policy [5].

This paper aims to describe the main changes in purchasing of specialist inpatient and outpatient care in Estonia. Moreover, it examines its results so far and its impact on stakeholders. In the conclusion we focus on the long-term impact of this new contracting policy and some lessons for other countries.

2. The purchasing process in Estonia

Selective contracting was introduced in 2002 to ensure timely and geographical access to care in locations and specialties where HNDP hospitals, which are not selectively contracted, have limited capacity and long waiting times exist. Furthermore, it was intended to introduce more competition into health care provision, increase choice, improve service quality and allow contracting of private providers. The process applies a set of defined criteria in line with the Administrative Procedure Act and the Health Insurance Act. Selected providers receive contracts for a minimum period of three years.

At the beginning of each year the EHIF negotiates capped cost and volume contracts with hospitals [1]. The contract's framework covers medium-term conditions for five years for HNDP hospitals [6] and at least three years for other selected providers. The EHIF only contracts providers that are licensed by the Health Board. The EHIF is required to contract all HNDP hospitals (19 state- or municipality-owned acute care hospitals working under private law). The negotiation process determines the volume of care these hospitals are allowed to provide in a certain location. HNDP hospitals provide outpatient and inpatient specialist care but also nursing care and some also dental care [7]. The rationale behind this is that these hospitals need to be contracted to guarantee geographical access to a minimum level of specialist care and 24/7 emergency care. The HNDP 2015 has its origins in the Hospital Master Plan (HMP) commissioned by the Ministry of Social Affairs (MoSA) with financial support from the World Bank. It was prepared by Swedish consultants and aimed to plan an efficient future hospital network. In 2003, the government eventually adopted it as the HNDP. Among others, it categorized hospitals into regional, central, general and local according to the range of services provided and required that a hospital should be within 60 min travel time by car (70 km) [1].

In 2013 the EHIF had contracts with 167 specialist care providers in total, including 19 HNDP hospitals, which means that 148 have been selectively contracted. In dental care the number of selected providers is 338 and in nursing care 60. However, in terms of turnover, selected providers account for a relatively small share (8%) of the specialist care budget. In contrast, this share is much higher in dental care (88%) and nursing care (46%). These shares have been stable since the early 2000s.[1]

The new contract cycle for specialist care providers started in April 2014 and will last for four years and one quarter. The formal selection process started in late 2013 and covers important innovations in geographical access criteria, which are used for planning and selective contracting, and a stronger emphasis on quality criteria in contracting. The new criteria were published about 2 month before launching the selection process, which means that there was little time for stakeholders to adapt to the new situation.

2.1. New geographical accessibility criteria

According to the Health Insurance Act, access to health care services has to be equal in all regions of Estonia. This principle is the basis for the EHIF when defining its purchasing policy and its contracting process. Access to care is monitored in two dimensions: timely access and geographical access. Timely access is measured with the time an individual has to wait to receive necessary care, which is reported monthly by providers to EHIF. Geographical accessibility, meaning which services should be available in which location, had not been explicitly defined until recently. Some elements of the latter are reflected in the ministerial level decree on requirements on hospital types, which sets minimum and maximum levels of specialties that have to be available by hospital types [1]. However, these requirements are set for the provider rather than its geographical area and have not been systematically revised since the mid 2000s. Therefore, the EHIF had to develop own geographical accessibility criteria to be used for annual contract planning and also as a basis for selective contracting.

Geographical accessibility criteria were first defined for outpatient specialist care. It was assumed that service provision of good quality could be achieved if doctors perform a certain minimum amount of services in their provision area. The areas were defined as counties (15 in total), because historically each county had at least one strategic hospital. The minimum workload per one county was then defined as the amount of services and the corresponding number of full time equivalent specialists needed to deliver these services. The assumption is that one full-time equivalent doctor works 225 days per year, 7 h per day and that one appointment with a patient lasts on average 20 min. Furthermore, to best utilize limited human resources, defining a minimum workload per location should avoid fragmentation of their working time over different locations. Moreover, to provide outpatient specialist care of good quality there is need for high-tech equipment and access to supportive medical services such as laboratories and radiology. It is assumed that this can be

[1] This data comes from (unpublished) EHIF internal information to which the first author has exclusive access