POLIITIKAUURINGUTE KESKUS

PRAXIS

CENTER FOR POLICY STUDIES

Hospital Sector Reform in Estonia

Summary

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1. Country profile

The total population of Estonia is about 1.35 million and it has been declining steadily since 1991, mainly due to negative natural growth and emigration. By ethnic groups the population comprises 69% Estonians, 26% Russians and 5% other nationalities. Similar to countries across Europe, the Estonian population is aging. Estonia has a crude birth rate of 9.63, a crude death rate of 13.41, and a fertility rate of 1.37, which is lower than that required to maintain the current population level.

The average life expectancy decreased in the first half of the nineties, reaching its lowest point in 1994, when it was 61 for men and 73 for women. Since 1995 life expectancy has slowly increased and was respectively 66 for men and 77 for women in 2003, which remains however among the lowest in the EU (see figure 1).

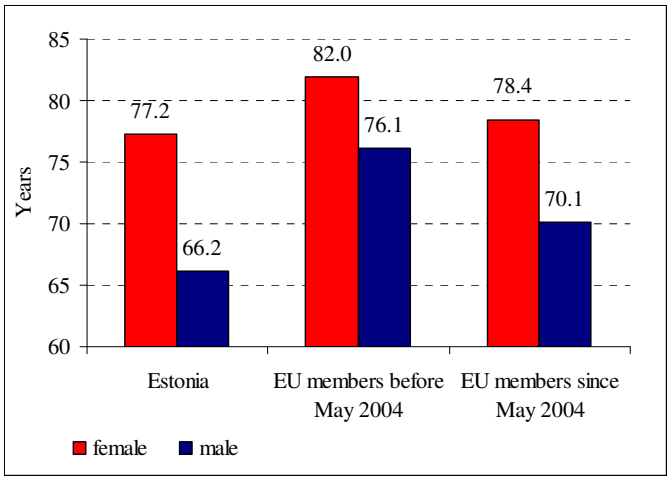

Figure 1. Average life expectancy in Estonia and EU in 2004.
Source: European Health for All Database, WHO/Europe

Radical economic reform in Estonia started in the late 1980s with the aim of restoring a market economy after the planned economy model under the Soviet Union. This was supported by the re-establishment of independence in Estonia in August 1991 and subsequent monetary reform, as a first step in modernizing the economy. The characteristic features of Estonian reform have been radical and rapid introduction of market-oriented institutions. Rapid growth has a positive impact on the convergence process – as a result, the country is witnessing a remarkable convergence in real terms with EU levels, with purchasing power parity per capita GDP increasing to 51% of the EU level in 2004 from 35% in 1995. The GDP per capita in 2004 had risen to the level of 14,555 international dollars.

2. Health reforms and the hospital sector in Estonia

The Estonian health system has undergone significant changes since independence in 1991. During the first wave, in the early nineties, the attempt in health sector reform was to move away from a Semashko-type health care system by decentralization and the introduction of market forces. The first radical change was to introduce a health insurance system, which was seen as the precondition for building a sustainable health system. As part of the plan to decentralize the health care system, the health insurance system was designed on a regional basis where 22 non-competing sickness funds were established. A contracting system between sickness funds and providers was introduced and fee-for-service payment mechanisms were adopted. In line with establishing the health insurance system, a purchaser-provider split was introduced. Providers were given more autonomy in terms of management decisions - making them more responsive to the introduced market mechanisms - including decisions about salary levels and investment. In practice, these reforms resulted in a total restructuring of the Semashko health system established during the Soviet era.

During the second half of the nineties the changes were more incremental, as part of which the legal environment for purchasers and providers was rearranged to increase efficiency and transparency. In 1997 the Ministry of Social Affairs fostered primary care reform to cover all of Estonia with primary care providers until 2003. An important milestone in hospital sector reform was the development of the Hospital Master Plan 2015 (hereafter referred to as HMP 2015) to make projections about future hospital capacity commissioned by the Ministry of Social Affairs (see below). According to the Health Care Services Organization Act enforced in 2001, all public hospitals had to be incorporated into private law as foundations or joint-stock companies. According to this change, all public hospitals began to act under private law, having full managerial rights over assets and access to financial markets, but at the same time giving them full residual claimant status. These changes were expected to foster the implementation of hospital sector reform and achieve the targets set in the Hospital Master Plan (see above). In addition, the Estonian Health Insurance Fund was established through special legislation as a public independent legal entity with seven regional departments and replaced the previous system of regional and central sickness funds. This fundamental change also enabled the clarification of the roles of central and regional departments and an increase in purchasing power.

As mentioned above, the hospital sector reform was re-initiated in the late nineties, when the Ministry of Social Affairs commissioned the development of the HMP 2015 to make projections about future hospital capacity. The criteria used for planning hospital capacity included sufficient population pools to support minimum service volumes for quality and efficiency, the development of medical technology, demographic and epidemiological projections and the requirement that a hospital should be no further away than 60 minutes travel time by car (70 km). The plan suggested that the number of acute inpatient beds be reduced by two thirds and that acute inpatient care be concentrated in 15 larger hospitals, decreasing the total number of hospitals, through mergers and other types of restructuring, by three quarters (from 68 to 15) by 2015.

In spite of negative publicity surrounding the HMP 2015, the Ministry has since used it as the basis for further discussions and it has been an important trigger for further changes within the hospital sector. The principles set out in HMP 2015 were taken as a basis and further described in the Health Services Organization Act, which was adopted in 2001. In addition, development plans by counties and by areas of expertise were developed in 2001, which was the first time that county doctors and specialist associations explicitly formulated their long-term plans. Based on these documents and HMP 2015 the Ministry produced a revised HMP 2015. After a series of consultations and some compromise, the extract of the revised HMP 2015 was approved as government regulation in April 2003. This version envisaged 19 hospitals (rather than 15 as suggested in the earlier version of the master plan) being eligible for long-term contracts with the health insurance fund and state investment.

According to the revised HMP 2015, the drivers of hospital network reform in Estonia were the overcapacity of acute care hospital beds, low bed occupation rates, low proportion of day-care, too high an average length of stay in acute inpatient care and for some areas of expertise too small a service area to maintain competency. The objectives listed therein were: (1) to ensure access to high quality medical care; (2) to optimize the costs for the establishment and functioning of the hospital network; and (3) to ensure the sustainability of the hospital network. To measure the achievement of these objectives, measurable targets were set:

- to decrease ALOS in acute care from 6.7 in 2001 to 4.6 in 2015;
- to decrease acute care beds from 6500 in 2001 to 3200 in 2015;
- to increase the bed occupancy rate in acute care from 67% in 2001 to 83% in 2015.

The accomplishment of these targets has so far been quite successful (see figure 2 below). The revised HMP 2015 recommends that the number of acute hospitals and beds be further reduced to 19 acute hospitals and 3200 acute beds (see figure 2A). In 1990, Estonia had about 120 hospitals with about 14,000 acute care beds. Since then, the number of hospitals and the number of beds have fallen dramatically. By 1998 the number of acute care beds had fallen to about 8600 and by 2003 to about 6000. The reduction of acute beds in the mid-nineties was related to the establishment of a hospital licensing system where small hospitals providing predominantly long-term care lost their acute care status and became nursing homes. Other hospitals have been turned into primary care centers providing ambulatory care. In recent years, the reduction in the number of acute beds has been due to hospital mergers.

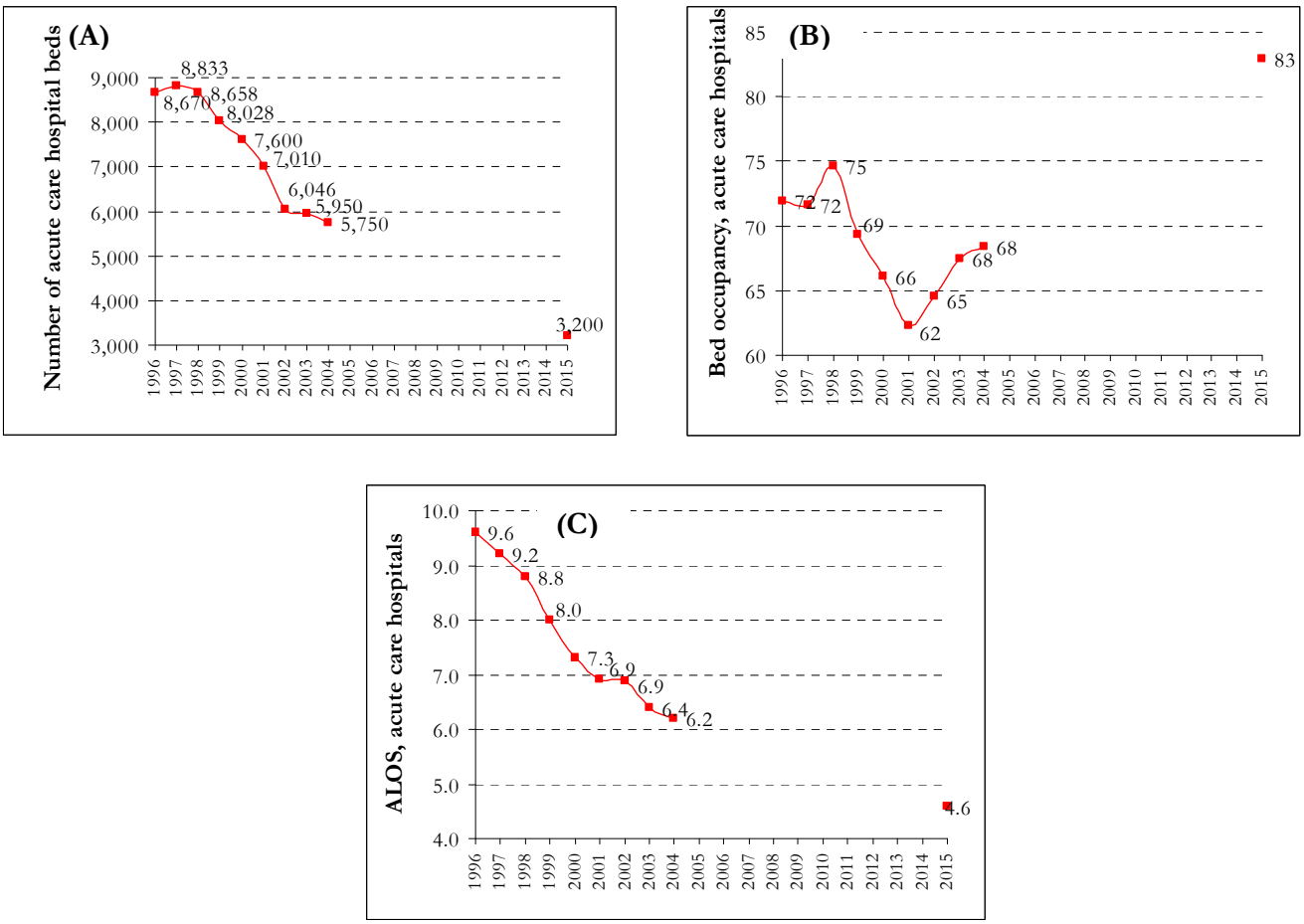

Figure 2. Performance of Estonian hospital sector core targets set in revised HMP 2015.
Source: European Health for All Database, WHO/Europe

3. Main results of postal surveys among hospital management and supervisory board members and interviews with key shareholders

To obtain some insight into how hospital sector reform has influenced hospital management, we conducted two postal surveys – one for hospital managers and another for supervisory board members.

The questionnaire for the postal survey for hospital managers was prepared in close collaboration with Estonian and Bulgarian research teams and to a large extent these surveys have the same content, so as to ensure comparability between the two countries. Questionnaires were sent to all 50 hospitals in Estonia, using one reminder after the initial letter. These were personalized questionnaires and were addressed to the members' management boards, and therefore the number of questionnaires was higher than the

number of hospitals – 83. In total, 46 completed questionnaires were received, which makes a response rate of 55%.

As hospital sector governance is an important issue on the health sector agenda, an additional postal survey for hospitals' supervisory board members was prepared. This questionnaire included around half of the questions as were used for management board members, so as to enable a comparison of the attitudes and opinions of hospital managers and governors. Questionnaires were sent to the members of six regional and central hospital supervisory boards. In total, 39 questionnaires were sent out in June 2006. Compared to management boards, the response rate was very low – only 13 completed questionnaires were received, producing a response rate of just 33%. The low rate may be related to the timing of the survey (mid-summer) on the one hand, but this may also reflect the passivity of hospital supervisory boards.

3.1. Assessment of hospital sector reforms

Hospital managers and supervisory board members were asked whether state policy in the field of health care has clearly defined strategic objectives in carrying out hospital reform. Most respondents, both hospital managers and supervisory board members, disagreed with the statement (see figure 3A). However, the responses varied by hospital types in the case of hospital managers as managers of general hospitals (smaller county level acute care hospitals) tend to be more critical, as 100% of respondents think that the strategic objectives for the hospital sector are not clearly defined.

The second statement about hospital sector reforms and health policy in general was whether the hospital sector is a priority in the government's health policy agenda. More than half of respondents considered the hospital sector not to be a priority area (see figure 3B). Managers of central and regional hospitals were most pessimistic, with 87% of respondents sharing this opinion.

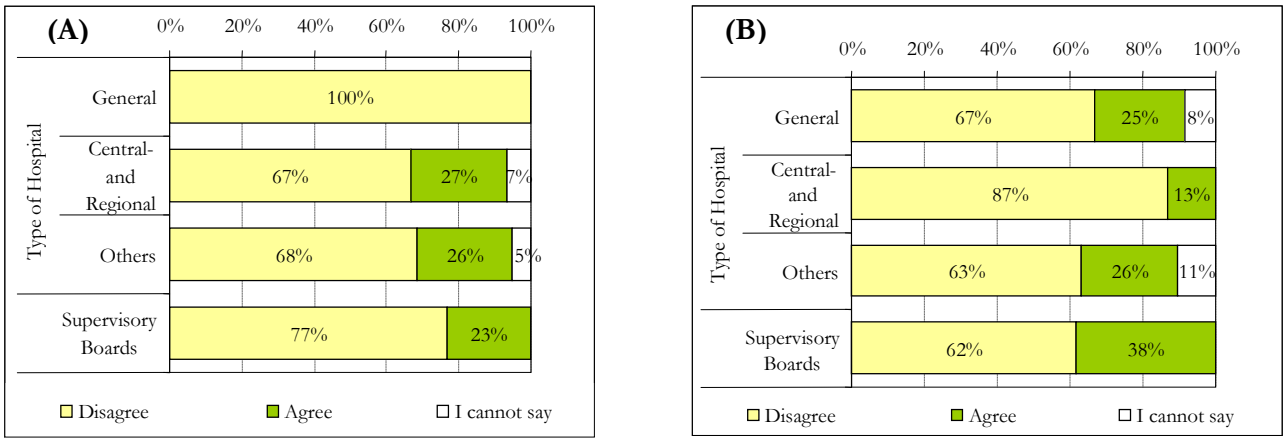

Figure 3. Assessment of hospital sector reform: (A) state policy in the field of health care has clearly defined strategic objectives in carrying out hospital reform; (B) the hospital sector is a priority in the government's health policy agenda.

Hospital management and supervisory board members were also asked to name the most important positive steps in hospital sector reform that have been taken during the last 10 years. This was an open-ended question (similar responses were grouped during the analysis), but in spite of this the response rate was high – 59% in the case of managers and 100% in the case of supervisory board members. The three most frequently mentioned positive aspects from managers were: the establishment of the health insurance system (including contracting) and a specific revenue base (mentioned by 26%); requirements for hospital types (26%); and the development of the Hospital Master Plan (26%). The three most frequent positive characteristics of hospital sector reform mentioned by supervisory board members were: the development of the Hospital Master Plan (38%); capital investment and renovation of buildings (31%); and the optimization of the hospital network (23%).

Secondly, respondents were asked to name the most important negative steps in hospital sector reform that have been taken during the last 10 years. Here the response rate was even higher – 80% in the case of managers and 100% in the case of supervisory board members. The three most frequently mentioned negative aspects from managers were: the health financing system, including shortage of resources (43%); no clear agreement on long-term objectives in the hospital sector (22%); and in third place there were five aspects: closure of hospitals/departments (19%); politicizing of hospital management (19%); poor development of long-term care (19%); over-centralization (monopolies) (19%); and poor accountability of owners (19%). The three most frequent negative characteristics mentioned by supervisory board members were: poor implementation of the Hospital Master Plan (46%); no clear agreement on long-term objectives in the hospital sector (38%); and hospitals acting under private law (31%).

3.2. Autonomy and market mechanisms

Hospital managers and supervisory board members were asked whether hospital managers have sufficient autonomy. The majority of respondents felt that their hospital management board has sufficient autonomy in everyday decision-making (see figure 4) and in the case of supervisory board members 100% of respondents agreed with this. It was among the managers of general hospitals that most respondents could be found who considered their autonomy insufficient.

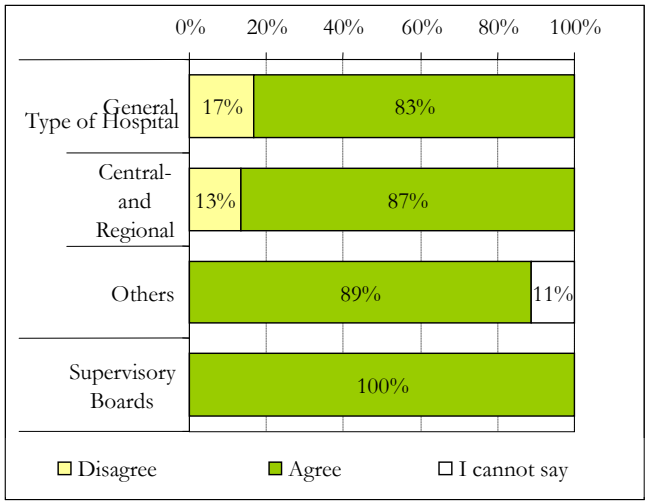

Figure 4. Autonomy of management board: the management board of your hospital has sufficient autonomy**.**

As one rationale in increasing the autonomy of hospitals has been to give more incentives to operate more efficiently, the respondents were asked to assess whether resources can be used more effectively in the hospital sector in general and within their own hospital. The prevailing attitude was that the effectiveness of resource utilization can be increased. However, the potential for increasing effectiveness was seen to be higher in the hospital sector in general than in respondents' own hospitals (see figure 5).

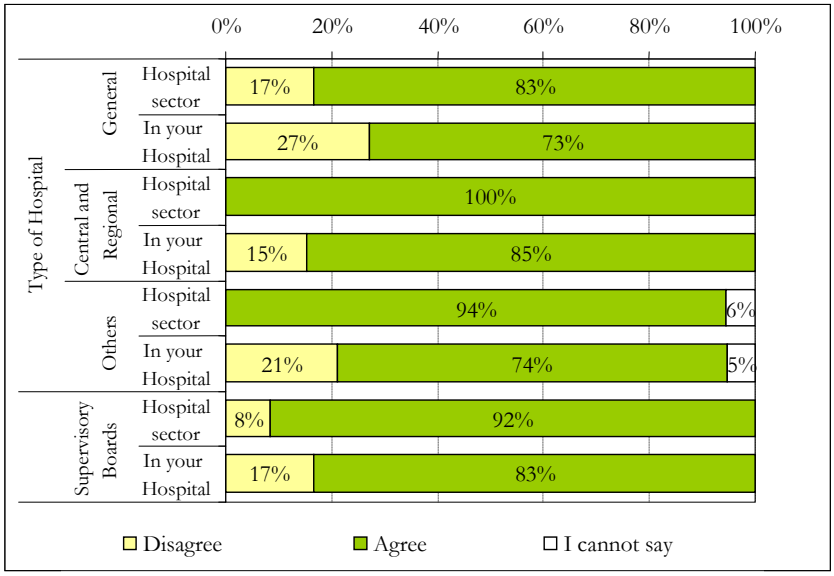

Figure 5. Efficient use of resources: resources can be used more effectively in the hospital sector/in your hospital

3.3. Hospital governance

The Estonian hospital governance structure is clearly defined. The supervisory board is the governing body of a hospital, whose members are nominated by the owners (or

founders in the case of foundations). Everyday operational management is the responsibility of the management board, whose members are elected by the supervisory board. The roles and responsibilities of both bodies are described in respective legislation and more details are given in hospital statutes.

To gain more insight into how the role of governance is exercised by supervisory boards, some questions were added to the hospital manager's survey and a separate survey was prepared for hospital supervisory board members. The influence of the supervisory board on everyday decision-making is relatively high in the assessment of managers and supervisory board members (see figure 6). The majority of supervisory board members (77%) and central and regional hospital managers (87%) considered the influence of the supervisory board on everyday decision-making to be significant. Conversely, the influence of the supervisory board was assessed to be insignificant by 58% of general hospital managers. This indicates that the role of supervisory boards is poorly exercised in smaller county-level hospitals. In addition, 69% of supervisory board members felt that supervisory boards should have a bigger role in hospital decision-making.

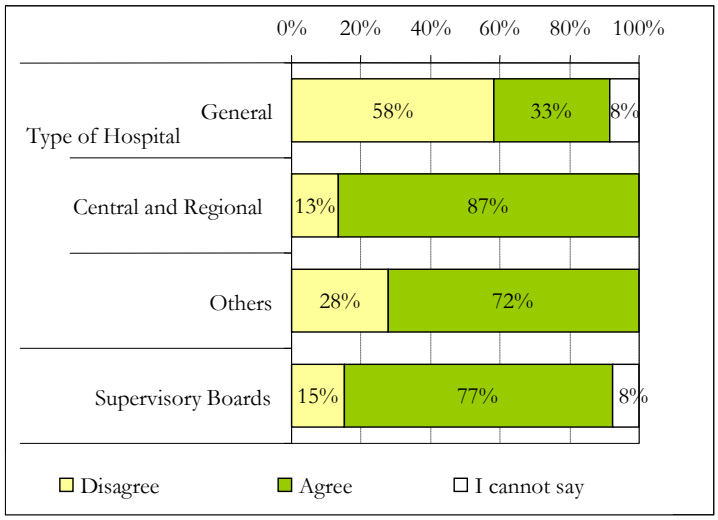

Figure 6. Role of supervisory board: the supervisory board has a strong influence on the decision-making process in your hospital.

3.4. Interviews with key shareholders

The results of the postal surveys enabled us to identify the topics (here the open-ended questions were most helpful) which were to be investigated in depth during interviews with key shareholders. Three different versions of the interview questionnaire were prepared depending on the position of the person interviewed and in total nine interviews were conducted between August and September 2006. The main topics that were studied in detail during the interviews were: hospital sector reform in general; the roles of management and supervisory boards; legal status; and politicizing of hospital boards. The results of the postal surveys and interviews were discussed during a round table with representatives of the Ministry of Social Affairs, the Health Insurance Fund, the World Health Organization and hospital managers in September 2006. The main discussion

points at the round table were the legal status of hospitals and how this influences hospital objectives and performance, and politicizing of hospital management.

4. Conclusions

Hospital sector reforms (and health system reforms in general) are considered to be successful. An important milestone in hospital sector reform has been the Hospital Master Plan, which sets out explicit objectives and directions for the hospital sector. However, the long-term objectives of the hospital sector today are no longer clear, which on the one hand may be the result of poor communication of achievements, while on the other hand the HMP 2015 prepared five years ago needs to be updated to better respond to current and future needs. It is expected by hospital managers that the ministry will take a leading role in setting long-term strategic objectives.

Since 2001 hospitals have been able to act as foundations or joint stock companies under private law. In addition, joint stock companies are acting under the Business Code, which has raised the question of whether these hospitals' top priority is to maximize profit or to work in the public interest (usually these objectives are contradictory). This was one of the most frequently mentioned negative aspects in hospital reform by supervisory board members in the postal survey (see above). Nevertheless, there is no significant difference between foundation and limited stock companies and the opposition to limited stock companies as a legal status is mainly an emotional one (i.e. hospitals cannot be businesses). Both statuses enable the achievement of objectives other than profit maximization, as this is more a question of the owners' will than legal status. One potential threat in the case of joint stock companies is the possibility that the owners will decide to take the profit out of the hospital rather than investing it in further development. As hospitals are owned by the public sector, this threat is mainly theoretical and could be counteracted by adding an extra provision to the statute of the hospital that dividends are not allowed to be taken out.

Another issue that is related to legal status is the role of owners. This is particularly pronounced in the case of foundations as there are no "owners", only "founders", and therefore the roles and responsibilities are less well understood. The situation may become even more confused if a hospital has multiple owners or founders (e.g. several municipalities jointly own one hospital) as responsibilities are then further diffused, adversely affecting hospital development.

We could say that hospital management structures are explicit and operational in Estonia. However, the role of supervisory boards has not achieved its full potential. Supervisory board members are nominated by hospital owners or founders. The selection of supervisory board members is mostly based on position (e.g. members of city councils) rather than competence and supervisory board members lack experience in governing large organizations. One of the chief characteristics of hospital governance over the last few years has been its politicizing. On the one hand it is seen as inevitable in democratic societies, but on other it is a threat to hospital performance if it affects the selection of hospital managers and brings instability to the whole organization. The situation can then

only be improved by offering systematic training to supervisory board members, which is currently lacking.

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