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Transformations And Reforms Of European Health Care Systems: The Case Of Estonia

Abstract

The purpose of this article is to present the main directions of changes in the Estonian health care system following the transformation of the national economy and the accession of Estonia to the European Union. Special attention has been paid to the ways of sourcing, and the collection and redistribution of financial resources allocated to health care in different periods of the transformation. The initial changes introduced far-reaching decentralization of the health system, while further reforms led to his re-centralization. The intensity of the re-centralization of finance and health management processes was accelerated after 2008, when the impact of the global financial crisis on the condition of the economy of Estonia was significant. As a result of the introduced changes, Bismarck's mixed system – a hybrid system – has been formed.

Keywords: *transformation of the system, hybrid model, co-payments, health insurance*

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1. Introduction

The observed changes in the modern health systems in European countries, especially intensive in Central and Eastern Europe, may be characterized by two words: transformations and reforms. These processes are seen as an evolutionary, gradual and long-term transformation of the components of the system.

Transformation of the health systems in Central and in some Eastern European countries was launched in the late 1990s as a result of the democratic and economic transformation which swept through the region. It should be pointed out that the economic transformation is an element of economic policy and includes actions aimed at creating operating conditions for market members. These conditions should transcend beyond the realm of human attitudes and behaviors caused by these attitudes (Bałtowski, Miszewski 2006, pp. 23-24).

Changes occurring within the political system of each country were related mainly to the change of the system, but also to the changes in the quality of governance. The essence of the political transformation in Central Europe was well defined by Jan Szczepański (Szczepański 1999, p. 73), according to whom political transformation is a sequence of changes taking place in various fields, leading to a significant change for the entire social system. The transformation of the social reality can be brought about by reform, revolution or transformation.

Transformations of the health systems in European countries result from reforms, and in accordance with their substantive assumptions should be of an evolutionary character. The evolution of these systems indicates that reforms would be continued aiming at a higher quality of the organization and improvement of the health system (Golimowska, Włodarczyk et al. 2005, p. 3).

The health system consists of multiple elements, including those related to both the organizational and financing system, subordinated to meeting the health needs of the society and its individual members while at the same time complying of the principles of economic effectiveness, rationality and efficiency. Striving to meet these objectives means that the modern health systems are subject to constant reforms, in accordance with the transformations of the Central and Eastern European countries.

The economic effectiveness of the transformed or reformed health care system depends primarily on the intensity of creating common funds and on methods of collecting and disbursing the funds, as well as on determining the principles of equality in the financing of services provided under the new conditions. It follows that while analyzing health care systems it is crucial to distinguish between the financial and organizational functions, which have been assigned to different frames of the health sector model.

The proper relationship between the financing of the health services and the appropriate organizational system can be attained by:

- establishing the rules for the health care units' collection of income and the creation of the common funds;
- defining the role of the health services purchaser;
- outlining the safety conditions for the availability of medical services (Suchecka 2010, pp. 45-69).

Collection of revenues is a process of activating various sources of health care financing. The creation of common funds is aimed at spreading the financial risk over the entire population, or selected groups, by collecting advance payments to cover the operating costs of the health care institutions. On the other hand, the potential individual health services purchasers should contribute to achieving solidarity through, for instance, the appropriate level of funding irrespective of their economic status.

In sum, the efficiency of modern health systems depends on the intensity of creating common funds and their collection and disbursement.

In different countries, changes are introduced gradually by the adoption of new model solutions for health care systems (Depta 2011, pp. 47-59). Currently, national governments propose further modifications of health systems, which result mainly from the instability of the financial system and the economic slowdown arising from the financial crisis.

The countries of Central and Eastern Europe are subject to the strongest transformation processes (Rogoś, Skrzypczak 2006, pp. 47-61). Since the beginning of the transformation period, these processes have been and still are primarily directed at the following elements (Golinowska 2006, p. 23):

- changing the financing from budgetary planning to funding from contributions of employers and/or employees – mandatory health insurance, nowadays including additional private health insurance and co-payment;
- increasing the autonomy of the health sector at the local level, as well as the public sector health care facilities;
- privatization of certain types of health care;
- implementation of methods of financing which enable achievement of appropriate remuneration for the medical staff and personnel.

A characteristic feature of the reforms introduced in the 1990s was the focus on four areas:

- decentralization and privatization;
- devoting more resources to health care, mainly through the introduction of health insurance plans;

- planned reduction in "capacity" of health care;
- introduction of compulsory health insurance.[1]

The implementation of these principles involved the promotion of planned changes to the organization of the health sector and the modernization of its management.

An overall change in the organization of the health sector consisted of introducing the position of 'family doctor' and opting out of polyclinics, isolating facilities for specialist treatment, care and hospices, and the creating of health institutions.

In contrast, changes in the management of health care institutions were dominated by creating health manager positions, launching information systems for evaluating health benefits and their costs, and at the same time preparing various analyses and forecasts. These analyses also included conducting patients' satisfaction surveys and using the results of the studies in improving the management style and the overall quality of health services.

In some countries of Central and Eastern Europe, principles of co-payment for some medical services were introduced. This form of an additional source of health care financing was also introduced in Estonia.

The process of transformation of the health system of Estonia, as in other countries of Central and Eastern Europe, began in the early 1990s. The changes were introduced gradually. Each stage of the reform allowed for making adjustments to the system in line with the changing economic, social and demographic conditions. The financing of health services has also been modified by relevant legal acts.

The aim of this article is to characterize, against the background of the centrally planned system (Siemaszko's health care model), the most important changes which have taken place in the functioning of the Estonian health care system in the years 1990-2013. The principles of revenue collection and the creation of common funds for the financing of health care are also emphasized in this paper.

[1] The health insurance system based on compulsory contributions came into force the latest in Poland (in 1999), while in other countries that introduced changes in the financing of health care, this process started much earlier, e.g. in 1992 in the Czech Republic, in 1991 in Lithuania, in 1993 in Russia, in 1994 in Slovakia, in 1990 in Hungary and in 1992 in Estonia.

2. General characteristics of European health care systems

The evolution of health care systems is a dynamic process, changing together with the modifications of the institutional and organizational environment, political and economic conditions of the country, its health needs, and the expectations of the society. An analysis of the evolution of the health care systems must take into account many concepts with different assumptions with respect to the functions that should be met and the structure of the health care system. However, the main reasons for introducing reforms are the aging of populations and the rising costs of medical procedures (Strzelecka 2011, p. 190). Hence, all kinds of changes are intended to create the conditions to achieve greater medical effectiveness and economic efficiency.

From the point of view of the reforms introduced in health care, it is crucial to evaluate the effectiveness of different ways of financing health services, conditioned on the legal and economic organization of the health system model.

Depending on the degree of state intervention in the financing of health care and the type of insurance systems functioning, as well as in accordance with the duties of the state in the field of public health, there are various classifications of health care systems models.

One of the most advanced classifications of models of health care systems is the classification proposed by the World Health Organization (WHO), which characterizes the following types of these models:

- based on the principle of public assistance;
- based on a system of health insurance (Bismarck's model);
- based on the financing of health care from the state budget (Beveridge's model);
- based on central planning of health care (Siemaszko's model);
- market, residual model.

In developing countries, (Latin America, Africa and Asia) the typical model is based on the principle of public assistance. The main assumptions of this model are focused on ensuring health care for the majority of society at the necessary minimum level, which usually means providing medical assistance in life-threatening conditions. Preventive health care and compulsory vaccinations are not included in this model. The allocation of medical resources concentrates in urban areas and involves the provision of hospital care and the access to health care services for certain privileged social groups.

In Bismarck's model, health care is financed by a compulsory insurance fund derived from premiums paid by the employer and the employee, managed by institutions independent from the government. The health benefits are provided

by public and private providers, while the responsibility for contracting services rests with the managing authorities. A characteristic features of this system is the presence of the "patient's own share" regardless of payable contributions and the wide scope of benefits (hospital and ambulatory services, and supply of medicines and medical items).

Universal and equal access to medical care, financed from the state budget, is the main assumption of Beveridge's model. This model is also called the National Health Care model (NHC). Health benefits for the entire population are financed from general taxation. The State guarantees full accessibility to medical care, however the patient participates in the cost of treatment – there exists a possibility of additional private insurance to guarantee quicker access to health services.

In the centrally planned system, which operated in the Soviet system, (Siemaszko's model), the primary objective is to finance health care through the state budget. The government provides full accessibility to health services and has full control over the system. The adoption of this type of solution precluded the functioning of private health care and at the same time assumed the absence of autonomy of health care entities.

The last of the aforementioned types of models is a residual one, based solely on individual's responsibility for their own health, while financing medical care from private health insurance. The state is only responsible for the provision of care to vulnerable groups.[2]

In European countries, two financial models of health care are used: a mixed Bismarck's model and Beveridge's model.

General characteristics of the classical models of health care systems demonstrate show that two sources of financing health services are assumed – financing from the state budget or the insurance premium, while the possibility of mixed systems should be emphasized. The adoption of a financing system should ensure its stability. This is extremely important when expenditures on health care grow rapidly and the expectations of society in terms of access to health care also increase.

In most European countries the primary source of financing health services is public funding, subject to the direct or indirect control by the state. With the use of central and regional budgets, the government also finances and controls investments into hospitals, as well as finances or subsidizes health care for the poor with no income and those socially excluded for various reasons (Suchecka 2010, p. 56).

[2] For more detailed characteristics of these health care systems models, see: J. Suchecka, (2010), Economics of health and health care, Wolters Kluwer Publishing, Warsaw, pp.49-50.

Public funding is usually carried out by social security contribution systems, while the amount of generated funds sometimes varies as a result of the different systemic solutions adopted.

Supplementary sources of financing health services include funds from voluntary private insurance and direct payments made by patients, introduced by various systems in a variety of scopes and sizes.

Private health insurance can also take the form of a supplementary payment, additional in relation to the social security system, or involve the same package of health benefits as social insurance.

The second source of supplementary health care financing is direct fees paid by the patient, so-called 'co-payment'. Co-financing often involves payment for drugs, and partial payments for the services of specialist doctors and for hospital services.

In each of these systems, the supply and the demand for health services and methods for the collection and disbursement of funds are defined by the existing regulations, which also include assumptions on the extent of income redistribution. Income redistribution financial instruments, which should be characterized by high fiscal efficiency and economic effectiveness, play a crucial role. The adopted financial instruments are the tools which affect the efficient use of health care resources and the rationality in providers' and patients' behavior.

Establishing the effective instruments of financing health services belongs, on one hand, to the tasks of public health policy, and on the other to the tasks created by the financial policy of the government.

In the literature, depending on the conditions of adopted organizational and institutional health system, such financial instruments are listed (Sobiech 2004, p. 443) as:

- contributions to public health insurance characterized by fiscal performance and economic effectiveness – fiscal, redistributive and allocative relevance;
- additional voluntary contributions for health insurance – redistributive and allocative relevance;
- co-payment as a direct payment for the provision of health care – fiscal and regulatory function.

Summarizing, it should be noted that in countries undergoing transformations or changes to the current health care system, the assigned financial mechanisms play an extremely important role.

3. The directions in health care system transformations in Central and Eastern Europe

By the end of the 1980s, the health care systems in the countries of Central and Eastern Europe were based on a centralized Siemaszko's model. This structure was built 50 years earlier in accordance with the concept of a National Health Service financed from taxes. The functioning of the system put the responsibility for public health on the state and at the same time guaranteed access to a wide range of health benefits. Currently, in most post-socialist countries this system has been changed, through transformation and reforms, into the German system based on the classic Bismarck's model (called the insurance model) and on a hybrid subsystem.

Over the years, Bismarck's health care model has been subjected to many modifications that led to the emergence of two subsystems:

- monopolistic health insurance, which is considered as a classic Bismarck's model;
- a pluralistic insurance subsystem, called hybrid (this system is characterized by the presence of co-payment and state interventions).

The processes of transformation of the health care systems in the countries of Central and Eastern Europe focused initially on the most important issue – determining the sources of funding and appropriate instruments for collecting funds. Implementation of new financial instruments should also affect the effectiveness of the use of health care resources and the rationality in providers' and patients' behavior.

Changes in the methods of the financing of health services should be included in a health policy created by the government of a country. The relationship between financing functions and health policy are presented in the following Table.

Table 1. Financing function and health policy goals

Financing function	Health policy goals (determinants)
Fundraising	How much and from whom should resources be gathered? To whom and for what kind of activity should resources be allocated?
Buyers' fund	From what sources should funds be raised? How should resources be allocated among providers?
Providing benefits	From whom to buy and how? At what price to buy?

Source: J. Figueras, M. Mecca, J. Cain, S. Lessof, (2006), Heath System in Transition: Learning from Experience, WHO Regional Office for Europe, p. 53.

The transformation processes initiated were accompanied by numerous reforms introducing suitable organizational and institutional systems. The reforms were focused on (Golimowska 2006, p. 23):

- organization of the sector – the introduction of a family doctor function, moving away from polyclinics, and separation of specialists, hospices and care facilities, building health institutions;
- ownership privatization – private clinics in primary care and specialized private health care, private hospital services, rehabilitation, care services and hospices;
- financial privatization – additional and/or alternative insurance, co-payment in the public system;
- decentralization/centralization – decentralization of the ownership functions, a national network of hospitals, decentralization of payment functions;
- management modernization – the introduction of the profession of the manager of health services and costs system information, carrying out econometric analyses and forecasts, patient's satisfaction studies and their implementation in the management process;
- changes in the financing of institutions – in primary care: from charges for service to capitation; in the hospitals: from charges per person per day to DRG (Diagnosis Related Groups).

It should be noted that in reformed health systems the key task for national governments is to ensure the economic effectiveness of the modern system and to guarantee financial stability by achieving the right balance between the health system and public health and safety.

4. Health care system reforms in Estonia

Estonia was the first country of the Soviet's bloc since 1988 to start working on health care system reform, and in 1998 it signaled its will to accede to the European Union. Starting with that year, the government has consistently harmonized its legislation and the economy in accordance with the principles of the EU. Adjustments in health care systems, which by the end of the 20th century were subordinated to strong political influence, were also included in the transformation.

The first reform introducing fundamental changes in the existing, centrally planned system began in 1990. Siemaszko's health system model operated from 1940 to 1990. The approach assumed total health care financing from the state budget and provided free access to a wide range of benefits, which

were provided by employees remunerated by the government. This system can be characterized by five main indicators (Suchecka 2010, pp. 49-50):

- the idea of creating a system – the State is fully responsible for ensuring the health services of citizens of indicated nationality;
- the financing of the health care services – the total health care financing comes from the State budget, and the amounts of funds are irrespective of the financial possibilities of the budget and the real health needs of the population;
- the role of the State – the State has complete control over the health care system;
- patients' privileges – strict zoning of health care providers, patients are completely secured by health care provided by the State;
- the right to benefits – citizens of indicated nationality have equal access to health benefits free of charge, and the government has a monopoly on employment and setting wages for workers. All legal acts determining the health needs of the society and the organizational structure of the planned system, as well as the development of guidelines regarding the number of referenced clinics and hospitals, were centrally established by the government.

The idea underlying the creation of this system was associated with the full responsibility of the State for the health of citizens and the ensuring that all citizens of indicated nationality, regardless of whether they were employed or not, had a constitutionally guaranteed right to free health care services. This meant that the total health care financing came from the State budget, and funds allocation was dependent on the financial possibilities of the budget and their amounts were not correlated with the real health needs of the population.

Another characteristic feature of Siemaszko's health system model was the fact that the State possessed complete control over the system. The government was also responsible for patients' equal access to health benefits and had a monopoly on employment and setting wages for workers. All legal acts determining the health needs of the society and the organizational structure of a planned system, as well as the development of guidelines regarding the number of referenced clinics and hospitals, were centrally established by the government.

A centrally planned system also has limited the patients' privileges. This could be observed in health care zoning, the existence of occupational and school clinics, however patients were fully health secured by the State.

Persons over 50 years of age – the validity of this system resulted in the ineffectiveness of its operation and financial instability and induced efforts to complete transformation.

In the beginning, i.e. after 1990, two basic tasks were adopted: firstly, to suggest the method of transition from a centralized to a decentralized system; and secondly, to establish criteria for the transition from state funding to

a decentralized system of health insurance. These concepts emphasized the growing importance of primary care and public health. As a result of the changes gradually introduced beginning in 1990, the first licenses for private medical practice were granted, and two hospitals and five pharmacies have been privatized.

Fundamental problems occurred during the decentralization process, involving the lack of proper preparation of the relevant institutions to implement the reforms and the lack of responsibility for implementing the principles of sustainable development. This has contributed to further changes in the functioning of the new system, based on a mixed Bismarck's model.

The introduction of the compulsory health insurance scheme required the elimination of 15 regional offices responsible for health care planning, and resulted in the creation of 17 smaller health insurance funds instead (the German model).

The functioning of the health insurance funds caused a significant increase in transaction costs associated with the emergence of unpredictable, severe cases requiring extensive and expensive medical procedures.

The financing system based on an insurance premium was approved by the Estonian Parliament in July 1991 and went into effect on 1 January 1992.

Under this legislation, the transition led to the decentralization of health care finances and their autonomy, introducing the principle of determining the relationship between health care expenditures and the country's economic performance, while at the same time putting responsibility on society for generating the actual costs of health care.

Under the Insurance Law, compulsory health insurance was introduced and included in its scope all employed, self-employed, unemployed spouses of insured persons, children under the age of 18, students, pensioners, pregnant women and other clearly defined groups. In contrast, health benefits for the unemployed, military and three small groups mentioned in the Act were financed from the State budget. Among the main reasons for the Estonian government to take measures aimed at improving the functioning of the health care sector in the new economic and political system, three essential reasons should be mentioned:

1. health care resources exceeding the health needs of the population – a high dispersion and number of hospitals and medical specialists;
2. a poorly developed primary health care system and redundancy in second and third reference level health care services (including specialized health care);
3. not taking into account the actual costs of health care benefits for free medical services.

The above-specified reasons for the inefficiency and financial instability of the health sector required the elaboration of new aims for planned changes in

the organization and functioning of the scheme. Eventually, the new objectives of the reform were:

- strengthening activities for quality and effectiveness of health care;
- ensuring the financial stability of health care;
- public participation in health care;
- increasing the importance of health care in inter-sectoral decision-making policy concerning health services.

Discussions about the new shape of the health system led to the identification of directions for the system's decentralization. This decentralization was based on transferring the relevant competences and responsibilities for providing health care to district governments. The program has been formulated in accordance with applicable Law for Health Care Organization, adopted in April 1994. However, during its implementation some weaknesses were revealed, especially the lack of precision in defining the methods for licensing health care entities to conduct private service activities.

The main change in health care was related to primary care and involved the establishment of the function of the family doctor. In 1991 The Medical University of Tartu was entrusted with educating physicians in this specialty, and first GPs received nominations two years later. The scope of activities of a family physician included providing primary care and nursing services, and was under supervision of the State in terms of licensing and financing.

Further reform of the Estonian health care system proceeded in stages. Major changes were introduced in three consecutive stages, covering the years 2000-2004 (pre-accession period, introducing changes in Estonian health care systems consistent with EU law); 2004-2008 (the period of harmonizing law and the functioning of the health care system in accordance with the arrangements introduced by the EU); and after the year 2008 (taking into account the impact of the global economic crisis on the effectiveness of health care entities).

The contemporary health system in Estonia has been shaped by the implementation of a number of laws which changed the principles for the collection and the redistribution of funds. Among these laws, three should be mentioned, and relate to:

- health insurance (The Health Insurance Act);
- health services (Health Services Organization Act, The Law of Primary Health Care, The Family Practice Law);
- public health (The Public Health Act).

The main source of funding for health care after the year 1992 has been mandatory health insurance. Under the new laws, the changes introduced in the

financing of medical services (Health Care System in Transition. Estonia 2000, p. 15) have included:

- establishing autonomous finances for health care services;
- decentralizing the financing of health care;
- establishing a basis for increasing personal responsibility for health care;
- establishing an explicit link between health care expenditure and national economic performance.

As a result of the organizational changes, the collection of funds and their redistribution have been entrusted to the Estonian Health Insurance Fund (EHIF) and its four regional offices. Such a structure of funds was established as a result of the centralization of regionally distributed health insurance schemes.

Initially, the health insurance contribution was paid by the employer. This rate amounted to 13% of the employee's salary, and in 1994 this contribution was incorporated into social security deductions, according to which 20% accounted for pensions and 13% for health insurance. Further organizational changes led to isolating the health care contributions, and on this basis in 1994 Central Sickness Funds were created. In 1999, the accumulation of health care contributions was attributed to the Taxation Agency.

The process of centralization was aimed at improving the planning and redistribution of income between regions in order to ensure regional equity for the financing of the following health care components (Hit 2000, p. 49):

1. health care services (separate allocations for treatment, health promotion, disease prevention, rehabilitation, medical aids);
2. sickness cash benefits;
3. pharmaceuticals (compensations to the insured, centrally purchased pharmaceuticals);
4. high-technology equipment;
5. administrative costs of the Central Sickness Fund and regional sickness funds;
6. sickness fund information technology;
7. capital investments in sickness funds.

In the initial period, compulsory health insurance covered only 68.3% of the total expenditures on health care; 9.9% of these expenditures were supplemented from the State budget and 2.5% from city budget. Medical emergencies, medical prostheses and aids for the disabled were financed from the State budget. However, the health insurance excluded aesthetic surgery, alternative therapies and optics (Hit 2000, p. 50).

The list of benefits financed from health insurance was supplemented with new procedures, following an analysis of their medical effectiveness and economic efficiency. With the advances in medicine (as in other health systems) society's demand for expensive health services and modern pharmaceuticals has increased.

The limited financial health system resources contributed to the increase in the share of direct patients' payments (out-of-pocket payments). The method of co-payment as a form of additional resources to finance health benefits has both pros and cons. It was believed that the advantages of this form of payment were (Suchecka, Jewczak 2010, p. 53):

- more efficient usage of scarce systems by stimulating health demand;
- strengthening the principles of solidarity and subsidiarity;
- generating additional financial resources;
- significant improvement in the quality of services and the health of the population;
- numerous mechanisms for contracting services;
- limiting the moral hazard.

In contrast, the disadvantages of co-payment include:

- the emergence of barriers in access to services;
- postponement or cancellations of treatment adverse to health;
- the additional financial burden decreased the level of disposable income.

This unfavorable financial situation, threatening the balance of the system, influenced the decision of the Estonian government to introduce, as in western countries, the National Health Accounts system (NHA). The implementation of this tool was launched in 1999.[3] The assumption underlying NHA is based on data presented concerning the economic aspects of the health care system. It is a versatile tool for comparing expenditures on health (Strzelecka 2012).

Finally, the search for resources pointed toward patients' direct payments, voluntary health insurance, and external financing as a required complement to the public funds transferred to the health care system.

Direct patient surcharges may not, by statute, exceed 50% of the officially fixed price, and cover:

[3] By comparison, in Poland work on the introduction of National Health Accounts was launched in 2001. See, System of Health Accounts in Poland. Development and implementation of NHA in Poland. Project IBRD Development of Health Services in Poland, Warsaw, 2001, project manager: Markus Schneider. The detailed methodology for the purpose of international comparisons was developed by OCED in 2000.

- outpatient care – small fees for medical consultations and advice (pensioners, the handicapped, and children are exempt from charges);
- subsidies to private doctors' consultation visits (with the exception of family doctors) not included in guaranteed health services' basket;
- payment for abortion in equal parts by the Sickness Fund and the patient.

The importance of this form of health care financing indicates the currently increasing tendency, and nowadays it is estimated that it amounts to more than ¼ of the total expenditures on health (Domagała 2012).

The Health Insurance Act included additional voluntary health insurance schemes to cover the costs of complementary medical services. This type of insurance may be offered only by commercial, private insurance companies. Most tourist trips are covered using this form of insurance.

With respect to the external sources of financing, it should be noted that their participation in the financing of the total health care expenditures amounts toabout 1%. These funds were most frequently collected from external sources and used on investments in the health sector.

The World Bank has played a significant role in the external financing of the health sector. Thanks to its loans it was possible to launch initiatives that introduced the system of compulsory health insurance. The supervision of the health reform programs was also guaranteed and the reform of the hospital services sector was made possible. All these changes allowed for constructing a modern hospital, and completing the transition is scheduled for the end of 2015.

After 2000, some steps were taken in order to clarify the scope of activities and responsibilities of family physicians. The access to basic health care services had to be ensured as well. It was agreed in 2003 that residents, both insured and uninsured, should subscribe to a certain family physician. Ensuring common access to basic outpatient care has become a prerequisite for the centralization of specialized care and the creation of the hospitals system.

Further reforms adopted after 2002 tended to centralize EHIF (reduction from seven regional departments to four), introduced further regulation of the health insurance system, and created and updated lists of reimbursed drugs. The legal status of health benefit providers was also clarified – all hospitals were obliged to act as joint stock companies or foundations.

The deteriorating financial situation of the health sector has prompted policy makers to introduce the funding of hospital services according to strictly defined DRGs and payment systems for primary health care services – this direction of changes is also common for Western countries. Estonia's accession to the EU accelerated its works of adapting the domestic law to EU standards, especially the law on the functioning of public health care.

Within the framework of public health policy, a variety of programs such as HIV/AIDS and cancer prevention, tobacco control by prohibiting smoking in public places, and combating civilization and chronic diseases prevention were implemented.

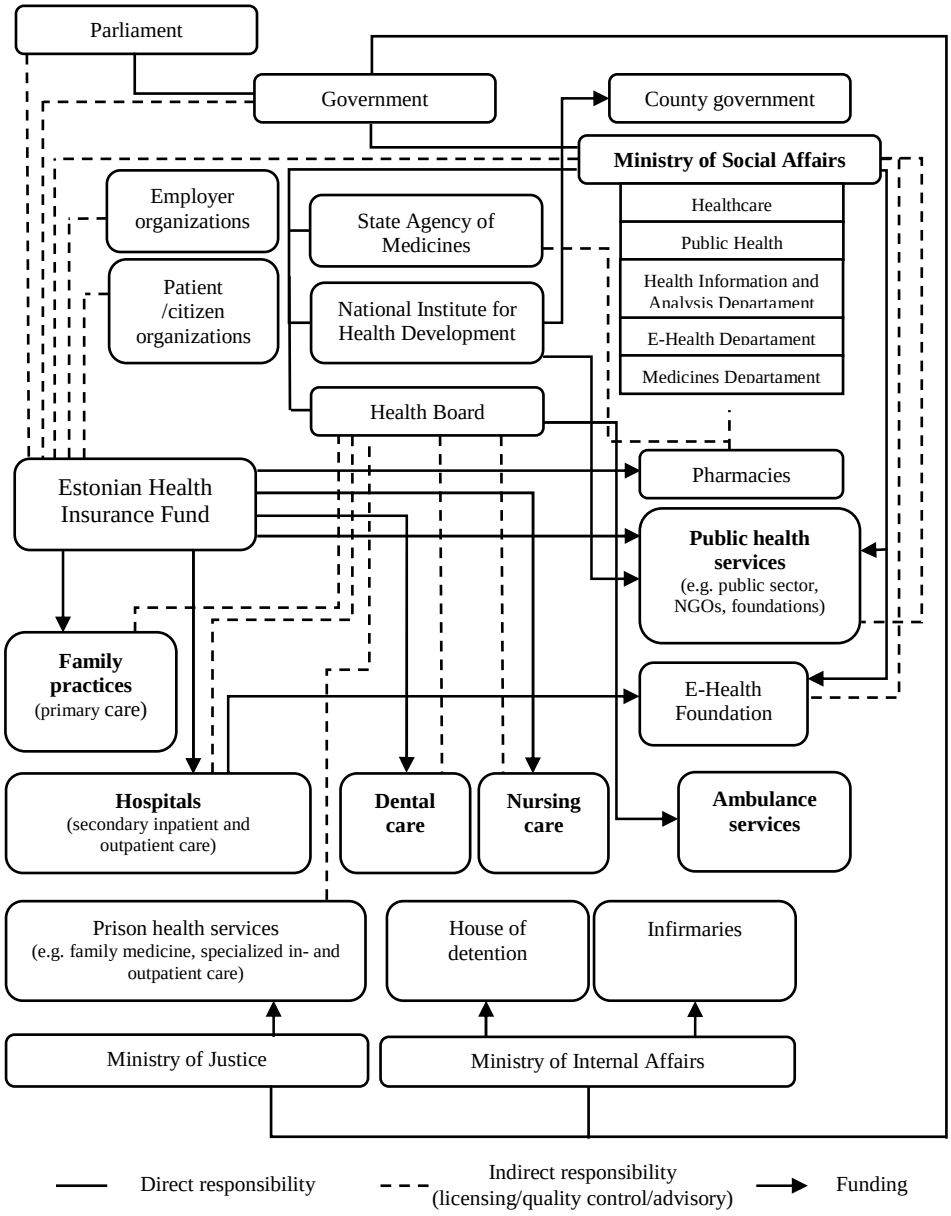
The financial crisis, which struck Estonia in 2008 also, had an impact on the efficiency and effectiveness of the health care system. During the crisis, the main objective of reforms implemented was to maintain the principles of health care financing without compromising the overall accessibility to health services. It was necessary to introduce an austerity package, which involved the exclusion of certain benefits from the health insurance package and keeping the drug prices at stable levels (mainly due to increases in the VAT level), and focused on primary health care, with limiting access to specialists. The introduction of these solutions has led to changes in the structure of certain medical services costs and lengthened the waiting time for the receipt of health benefits. The increase in the use of structural funds for financing the health sector is also noticeable.

The implementation of the savings program led in 2012 to a strike by the medical staff. They mainly expressed dissatisfaction with the lack of significant structural reforms and low medical personnel salaries. The condition of the health care system deteriorated further with the migration of nurses and specialists. By the end of 2012, negotiations between the government and the medical staff were undertaken. Compromises were reached that should lead to a greater stability in the health care system (Hit 2013).

In 2012, a re-centralization of primary health care and health statistics was launched. The changes introduced should gradually result in increased efficiency of the health system and the improved qualifications of the medical staff, while at the same time significantly reducing administrative costs. Many managerial functions concerning IT planning and the HR management have been centralized. As a result of the reforms introduced, in 2013 a new organizational structure of the health system has been formed (see Fig. 1).

In 2013, as a result of the consolidation of transformation and reforms, the new organizational structure of the health system in Estonia was established. Many actor–participants have been grouped according to their basic functions in the system: manager/owner, provider of medical services, financing and public health. Taking into account the directions of the country's socio-economic policy and the conditions of the economic growth determined by the global financial crisis, the Estonian government has introduced significant modifications of the Estonian health care system, paying particular attention to the sources of the income and cash flow.

Figure 1. Organizational structure of the Estonian health care system



Source: T. Lai, T. Habicht, K. Kahur, M. Reinap, R. Kiivet, E. van Ginneken, Estonia: Health system review. Health Systems in Transition, 2013; 15(6), p 19.

5. Conclusions and discussion

Similar as in other countries of Central and Eastern Europe, a number of initiatives to ensure the stability of the financial system and to guarantee public health and safety have been undertaken in the Estonian health care system. These changes have proceeded with varying intensity and efficiency and have been closely related to the processes of political and economic transformation of the entire country. Reforms in the health care system in Estonia have allowed (Liseckien 2007, pp. 105-113) for the:

- functioning of the system of social health insurances with the decentralization and re-centralization of services; and the implementation of regulations for creating and updating reimbursement lists;
- combining of public and private medical practice;
- provision of basic medical services and nursing care performed by family physicians;
- establishment of a specialization in family medicine and public health;
- implementation of new specialized programs;
- creation of a legal basis for the introduction of additional (commercial) health insurance;
- introduction of appropriate remuneration systems for medical and professional practices;
- financing of primary health care services on the basis of capitation and fee-for-service, and by DRG for hospital services;
- co-payment for certain health benefits specified in the relevant acts.

Currently, further changes in the organization and financing of health care are being introduced, which take into account the impact of the financial crisis and the changing demographic and health conditions of the Estonian society and the principles of sustainable development.

Summing up it should be stated that in countries introducing transformations or changes in their health care systems, an extremely important role has been assigned to the financial mechanisms. In the current Estonian organisational and institutional health system, complementary sources of financing health services operate alongside the mandated contributions to health insurance.

In Poland, despite the ongoing discussions on changes to the current health care system, it has proved impossible to introduce instruments such as additional voluntary contributions for health insurance (in the redistributive and allocative sense) and co-payment (a form of direct payment for health care services in the fiscal and regulatory function sense). This observation also applies to

the creation of a network of hospitals in order to improve the economic efficiency of their operation. The lack of appropriate legal regulations contributes to their financial instability and the deterioration in their economic efficiency, which in consequence leads to an imbalance in the health sector.

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Streszczenie

TRANSFORMACJE I REFORMY EUROPEJSKICH SYSTEMÓW ZDROWOTNYCH PRZYPADEK ESTONII

Celem artykułu jest prezentacja głównych kierunków zmian wprowadzanych w estońskim systemie zdrowia po transformacji systemowej gospodarki narodowej i przystąpieniu Estonii do Unii Europejskiej. Szczególna uwaga została zwrócona na sposoby pozyskiwania, gromadzenia i redystrybucji środków finansowych przeznaczonych na opiekę zdrowotną w poszczególnych okresach wprowadzania zmian. Początkowe zmiany wprowadzały daleko idącą decentralizację systemu zdrowotnego, natomiast kolejne reformy doprowadziły do ponownej jego centralizacji. Nasilenie się procesów ponownej centralizacji finansowania i zarządzania ochroną zdrowia nastąpiło po roku 2008, w którym zaobserwowano znaczny wpływ światowego kryzysu finansowego na kondycję gospodarki Estonii. W rezultacie wprowadzanych zmian ukształtował się mieszany system Bismarcka, zwany również hybrydowym.

***Słowa kluczowe**: transformacja systemu, model hybrydowy, współpłacenie, ubezpieczenie zdrowotne*